Evidence-Based Practice and Service Strategy Codes

Background

In July of 2006, the State Department of Mental Health mandated that all counties report the use of Evidence-Based Practices (EBP) and Service Strategies (SS) on all data records reported to the State's Client and Services Information System (CSI). Los Angeles County Department of Mental Health (LAC-DMH) implemented the use of EBP and SS codes in November 2006. Since that time, LAC-DMH has implemented many new programs under the Mental Health Services Act - Prevention and Early Intervention (MHSA-PEI) which utilize EBPs. When claiming to MHSA-PEI funding, there are special requirements regarding the use of EBP Codes.

The purpose of this Bulletin is to I) remind Providers of the "*General Guidelines in the Use of EBP/SS Codes*", II) identify the "*Special Requirements for Using EBP codes for MHSA-PEI Claims*", and to III) direct staff to "*Where to Find the Current List of EBP/SS Codes*".

I. General Guidelines in the Use of EBP/SS Codes

- EBP/SS codes are chosen for each service provided
- All claims submitted must have at least one code from the EBP/SS code list
- Up to three (3) codes may be chosen from the EBP/SS code list
- A claim may contain only one (1) EBP code and up to two (2) SS codes (See section on EBP Codes for PEI Claims)
- EBP/SS code "99-Unknown or Unlisted EBP/SS" should be used if the program has <u>not</u> been certified or approved by LAC-DMH to use an EBP and the program is utilizing an EBP or if the program is providing an EBP that is not yet listed as an EBP code
- EBP/SS code "00-No EBP/SS" should be used for programs that are not using any of the EBP or SS codes that are listed in the IS Codes Manual. (See section on EBP Codes for PEI Claims)
- If EBP/SS code 99 or 00 is chosen, no other codes may be associated with the claim
- EBP/SS code selection is independent from the Procedure Code selection

A. General EBP Code Usage Instructions

EBP codes reflect services that are provided as part of an Evidence-Based Practice when the program using the EBP meets the fidelity and criteria of the EBP model. In order to use an EBP code, programs must <u>minimally</u> ensure that they have been certified or approved by LAC-DMH. Certification/approval verifies that the program meets the fidelity and criteria of the EBP model. In addition to program certification/approval in order to use an EBP code for a service, the client must meet the criteria identified by the EBP model and ensure that the treatment approach is appropriate to the mental health needs and treatment plan of the client. Additional criteria for using EBP codes may be in place depending on the funding source of the service (see below for additional criteria for PEI funding).

Note: EBP codes include Evidence-Based Practices as well as Community–Defined Evidence (CDE) and Promising/Pilot Practice (PP).

B. General SS Code Usage Instructions

SS codes are used to describe the intervention strategies reflected by the service provided. Unlike EBP codes, there are no criteria regarding certification or approval in order to use the SS Codes; there are no fidelity or criteria measurements for SS codes. Any program, regardless of funding source, may use SS codes if the program/staff person feels the service meets the definition of the SS. Attachment 1 provides additional information regarding the definition of each SS code.

II. Special Requirements for Using EBP Codes for MHSA-PEI Claims

A. Additional Requirements for EBP Codes under MHSA-PEI Funding

All services for clients claimed to a PEI Plan must have a PEI-approved EBP code selected for the claim. If the EBP code is not yet listed in the IS drop down menu, then "Other/Unknown EBP/SS" (Code 99) may be chosen. "No EBP/SS" (Code 00) **may not** be selected for claims under the PEI Plans.

Unless otherwise specified by the lead DMH Administrative staff responsible for the PEI-approved EBP model, Rendering Providers do not have to be trained/certified in the EBP in order to associate the EBP code to a claim under a PEI Plan. However, because PEI funding requires the use of EBP models, it is expected that the majority of services provided are intrinsic to the EBP model. Therefore, if a Rendering Provider is not trained/certified in the EBP model, it is expected that he/she is coordinating services with someone who is trained in the EBP model. Services rendered by treatment staff not trained in the EBP model should be minimal and should support the client's participation in the EBP model.

Note: Previously Providers claiming to PEI Plans were instructed to select an EBP code only for "Core" services. This Bulletin replaces that instruction: EBP codes may be used for both "Core" and "Ancillary" services in accord with the instructions above.

B. Special Additional Criteria for the use of the MHIP EBP ONLY

In addition to the instructions noted above for claims under the PEI Plans, to use the Mental Health Integration Program (MHIP) EBP code (listed as IMPACT_MHIP in the IS), the Rendering Provider of the service MUST also be certified/trained in the use of the MHIP model by either LAC-DMH or the developer of the model.

Directly Operated and Legal Entity Providers:

If the Rendering Provider of the service has not been certified/trained in the use of the EBP model, then a different EBP code must be selected for the service in accord with the instructions noted above for PEI claims.

Community Partner Providers:

If the Rendering Provider of the services has not been certified/trained in the use of the MHIP model, the Provider must obtain approval from Kathleen Kerrigan at 213-738-3111 or KKerrigan@dmh.lacounty.gov before selecting a different EBP code in accordance with the instructions noted above for PEI claims.

III. Where to Find the Current List of EBP/SS Codes

The IS Codes Manual contains the most current list of available EBP and SS codes. It may be accessed on-line at http://lacdmh.lacounty.gov/hipaa/index.html.

c: Executive Management Team   Judith Miller, Compliance Program Office
    District Chiefs   Nancy Butram, Revenue Management
    Program Heads   Pansy Washington, Managed Care
    Department QA staff   TJ Hill, ACHSA
    QA Service Area Liaisons

Service Strategies (Definitions of values from CSI System Documentation)

Peer and/or Family Delivered Services (50)
Services and supports provided by clients and family members who have been hired as treatment program staff, or who provide adjunct supportive or administrative services, such as training, information dissemination and referral, support groups and self-help support and empowerment. Please note that if the service/support is to be reimbursed by Medi-Cal, client and family member staff duties and credentials must meet Medi-Cal provider certification requirements.

Psychoeducation (51)
Services that provide education about:
   •   Mental health diagnosis and assessment
   •   Medications
   •   Services and support planning
   •   Treatment modalities
   •   Other information related to mental health services and needs

Family Support (52)
Services provided to a client's family member(s) in order to help support the client.

Supportive Education (53)
Services that support the client toward achieving educational goals with the ultimate aim of productive work and self-support.

Delivered in Partnership with Law Enforcement (54) (includes courts, probation etc.)
Services that are integrated, interdisciplinary and/or coordinated with law enforcement, probation or courts (e.g., mental health courts, jail diversion programs, etc.) for the purpose of providing alternatives to incarceration/detention for those with mental illness/emotional disturbance and criminal justice system involvement.

Delivered in Partnership with Health Care (55)
Integrated, interdisciplinary and/or coordinated physical and mental health services, including co-location and/or collaboration between mental health and primary care providers, and/or other health care sites.

Delivered in Partnership with Social Services (56)
Integrated, interdisciplinary and/or coordinated social services and mental health services, including co-location and/or collaboration between mental health and social services providers.

<u>Delivered in Partnership with Substance Abuse Services (57)</u>
Integrated, interdisciplinary and/or coordinated substance use services and mental health services, including co-location and/or collaboration between mental health providers and agencies/providers of substance use services. This strategy is distinguished from the Federal evidence- based practice, "Integrated Dual Diagnosis Treatment", in that for this strategy the integration does not need to occur at the level of the clinical encounter.

<u>Integrated Services for Mental Health and Aging (58)</u>
Integrated, interdisciplinary and/or coordinated services for mental health and issues related to aging, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to the aging (e.g., health, social, community service providers, etc).

<u>Integrated Services for Mental Health and Developmental Disability (59)</u>
Integrated, interdisciplinary and/or coordinated mental health services and services for developmental disabilities, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to developmental disabilities.

<u>Ethnic-specific service strategy (60)</u>
Culturally appropriate services that reach and are tailored to persons of diverse cultures in order to eliminate disparities. Includes ethnic-specific strategies and community cultural practices such as traditional practitioners, natural healing practices, and ceremonies recognized by communities in place of, or in addition to, mainstream services.

<u>Age-specific service strategy (61)</u>
Age-appropriate services that reach and are tailored to specific age groups in order to eliminate disparities. Age-specific strategies should promote a wellness philosophy including the concepts of both recovery and resiliency.