COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF INTEGRATED CARE

HEALTHY WAY L.A.
FREQUENTLY-ASKED QUESTIONS (FAQ)

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	Section 1: Claiming and Invoicing				
	1.1 Claimable Activities/Procedure Codes				
1.1.1	**Q: Are the DMH Referral Response forms reimbursable by HWLA? If so, under which procedure code?** A: Completing the DMH Referral Response Form for Legal Entities and Directly-operated Programs may be reimbursable under procedure code 90889 if the provider has assessed the client via a face-to-face contact. For Community Partners, this activity is included as part of the face-to-face contact.	√	√	√	
1.1.2	**Q: On the open episode form, for referral in code, should we use 01 (self) since there is no code for medical/health clinic?**				
1.1.3	**A:** For Referral in, select from one of the following: 65 Private physician or medical clinic 66 County health services medical clinic 69 Other medical outpatient service **Q: On the open episode form, for primary problem area, are Tier 2 clients not considered to be disabled, and as such we would not use code 1 (mentally ill, disabled)?**				
	A: For primary problem area, you should use code 1 (which includes mentally ill and mentally disabled). The client does not have to be disabled to use this code.				
1.1.4	**Q: As a Tier 2 Provider, I understand that we can only claim for services provided to individuals with moderate to mild diagnosis. Is there a list you can provide of specific codes that Healthy Way pays for?** A: Yes. We are currently updating the list and it will be posted on the DMH website once complete.	√	√	√	
1.1.5	**Q: If a patient meets Tier 1 criteria per diagnosis and impairment, can we still treat the patient and bill at Tier 2 level and get reimbursed?** A: If the individual does not have a history of long-standing mental illness , is appropriate to receive psychotropic medication in a primary care setting, and is not in need of comprehensive rehab services, initially treat at the level of Tier 2. If the individual's symptoms and impairment persist to the point they need medication management beyond the scope of a primary care provider, (i.e., they need close monitoring by a psychiatrist), and	√	√	√	

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	more comprehensive rehab services, the individual should be referred to the appropriate level of care for his/her diagnosis and impairment and not continue to be treated or billed as a Tier 2 patient.				
1.1.6	**Q: Will Legal Entity providers bill by the minute in a similar fashion as they do for their other DMH contracts?** A: Yes.		√		
1.1.7	**Q: Will a Tier 2 provider get reimbursed if, following an assessment, it is determined that that individual has a Tier 1 diagnosis? Can the Tier 2 entity get reimbursed for that initial visit? How should that patient's diagnosis be coded in the DMH system? For example, one mental health provider entered the initial visit into the DMH system but coded the patient with a Tier 1 diagnosis. Would this be rejected for payment?** A: Yes, the Tier 2 provider will be reimbursed for the initial visit even if it is determined via the assessment that the individual has a Tier 1 diagnosis and functional impairment. The individual should then be referred to the appropriate level of care for his/her diagnosis and impairment and not continue to be treated or billed as a Tier 2 patient.	√	√	√	
1.1.8	**Q: What is the time frame for opening an episode after meeting with the patient? Or, how many days after seeing the patient do we have in order to bill? Is it 10 days?** A: An episode should be opened in the IS by the end of the next business day after the first face-to-face encounter with the individual. All subsequent claims are to be entered in the IS within 15 calendar days after the end of the month in which the service was rendered.	√	√	√	
1.1.9	**Q: The DHS Community Partner indicated that they cannot bill physical health services and mental health services provided on the same day. What are the billing considerations for this if their physician is providing a consultation on the day of a physical exam?** A: The DHS Community Partner **can** bill a physical health visit under its DHS contract and a specialty mental health visit under its DMH contract for the same patient on the same day. Since the bundling of all visits provided during the same day only relates to FQHC services provided that are within scope of plan, DHS will not pay for two visits provided on the same day where one is specialty mental health and one is physical health, but the Community Partner is not precluded from billing DMH for the specialty mental health visit.	√			

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	1.2 Invoicing for MD Consultation Services				
1.2.1	**Q: When a DMH Legal Entity psychiatrist provides consultation services, how is the service claimed (procedure code) to HWLA?** A: The psychiatric consults apply only to Tier 2 services reimbursed through your DMH contract. There are two ways that a DMH Legal Entity psychiatrist can provide consultation: 1. PCP Consultation: Psychiatric consultation with the PCP for the purpose of developing appropriate plans for the clients. Contractors shall bill for this PCP Consultation service and receive reimbursement as previously done for case consultation – H0032. 2. Team Consultation: Psychiatric consultation is available to the MHIP team for the purpose of assessing, treatment planning, and fidelity adherence procedures. The contractor shall bill and receive reimbursement for Team Consultation using paper invoices provided by DMH.		√		
1.2.2	**Q: When a psychiatrist with a DHS Community Partner with a DMH contract provides consultation services, how is the service billed to HWLA?** A: The psychiatric consults apply only to Tier 2 services reimbursed through your DMH contract. There are two ways that a DMH Contract Agency psychiatrist can provide consultation: 1. PCP Consultation: Psychiatric consultation with the PCP for the purpose of assessing medication and treatment needs and developing appropriate plans for the clients. Contractors shall bill for this PCP Consultation service and receive reimbursement similar to the face-to-face services, by claiming H2016. This consultation will count as a visit. 2. Team Consultation: Psychiatric consultation is available to the MHIP team for the purpose of assessing, treatment planning, and fidelity adherence procedures for up to 2 hours per week per site. The contractor shall bill and receive reimbursement for Team Consultation using paper invoices provided by DMH.	√			
1.2.3	**Q: What are the requirements regarding invoicing for psychiatrist consultations with PCPs, which I understand can be up to 2 hours a week. Also, are there documentation requirements for this? For example, does the PCP need to write a note in the chart, the**				

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	psychiatrist, or neither? Does the consultation time include training on how to prescribe and monitor psychotropic medications? A: Please see above to answer the questions regarding invoicing for psychiatric consultation. Yes, both parties involved should document the consultation in their respective charts. Consultation time does not include training on how to prescribe and monitor psychotropic medications in general. The consultation must be specific to individual clients.	√	√		
	1.3 Matched-Pending and Unmatched				
1.3.1	**Q: Are Mental Health claims for both matched and unmatched patients covered by DMH? How should they be billed?** A: Effective January 1, 2012, and through June 30, 2012, DMH will reimburse HWLA Providers for mental health services delivered to HWLA Matched Program Pending patients until their HWLA application is approved. If the application is denied, DMH will reimburse for mental health services to those individuals for up to 30 calendar days from the date the application was denied.	√	√	√	
1.3.2	**Q: I have a patient who went from matched pending on August 2 to HWLA Matched on August 25. She was first seen on August 2 and her second visit was on August 25. Can I bill for her only under LACDMH with her visit on the 25th or can I retroactively bill for the visit on the 2nd?** A: HWLA coverage begins on the first day of the month in which the application was signed, not the day the client is enrolled in HWLA. For example, if your potentially-eligible client signed a HWLA application on August 2, 2011, and was later enrolled on September 25, 2011, the client's HWLA coverage will be effective as of August 1, 2011. If your agency provides mental health services to an individual pending HWLA enrollment, then that service should be billed for the day the service was provided. In your example above, both claims would be paid by DMH because the HWLA coverage is retroactive and would have begun August 1.	√	√	√	
1.3.3	**Q: We started treating a HWLA client, and apparently the client's status**				

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	with HWLA has expired (disenrolled) while in treatment in Tier II services. Can we continue to treat the client while they are temporarily dis-enrolled from HWLA? A: If they have begun treatment, do not abruptly discharge the client, but rather ensure that the client does whatever is required to get re-enrolled. If you continue to serve the person during the re-enrollment process, DMH will reimburse under the "Matched Program Pending" rule once an application has been accepted by DHS; however, if any services are delivered in-between the date the client was disenrolled and the date they filed a new application, or the client is no longer eligible for HWLA, DMH will not reimburse for services delivered during that period.	√	√	√	
	Section 2: Referral Process and Referral Tracking				
	2.1 Referral Forms				
2.1.1	**Q: Are the Department of Mental Health Referral forms used for HWLA patients only?** A: The Department of Mental Health Referral form is a DHS form, which should be used at all DHS facilities (directly-operated and Community Partners) for specialty mental health referrals (for HWLA members and non HWLA members).	√			
2.1.2	**Q: On the DMH Referral Response form, where it asks for psychotropic meds prescribed by DMH, won't this always be N/A since these clients are supposed to get their meds from their medical clinics?** A: In general, this will be N/A as the meds will be prescribed by the PCP.	√	√	√	
	2.2 Referral Process				
2.2.1	**Q: How can patients be referred to a Mental Health provider?** A: Patients may be referred for specialty mental health services in one of three ways: • Primary Care Providers (PCP) may refer a patient for specialty mental health services using the DHS "Department of Mental Health Referral" form. PCPs should use the DHS Referral Processing System (RPS) to refer the client. The DHS Central Referral Unit (CRU) will refer within the PCPs agency if they have a mental health contract, to a DMH Legal Entity provider	√	√	√	√

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	with whom they have a Memorandum of Understanding or Operational Agreement in place, or to the Service Area Navigator who will facilitate the scheduling of an appointment between the HWLA member and a local specialty mental health provider. • HWLA members may contact the DMH 24-hour ACCESS Line and request a referral for specialty mental health services. This request will be forwarded to the DMH Service Area Navigators who will facilitate the scheduling of an appointment between the HWLA member and a local specialty mental health provider. • A HWLA member may walk in to a DMH program and request services in-person.				
2.2.2	**Q: If a patient/client is self referred to our clinic and wants therapy does he/she have to be seen within 30 business days as do clients being referred by the Service Area Navigator or a PCP?**				
	A: If the client is HWLA, then the answer is yes to the 30 business day requirement. Any clients presenting to our clinics for services should at minimum receive an evaluation within the 30 business days to determine if they are appropriate for services. You would then determine the most appropriate track for those services (FSP, FCCS, CORS, CRS).				
2.2.3	**Q: Currently, as a DMH Contract agency (LE) we are receiving referrals from DHS Community Partners that are not listed as a partner. These referrals come from the Navigator because of the geographic location of the client. Will there be a specific allocation for these services? Is this process permanent or temporary?** A: The partnerships were developed to assist with establishing integrated care models. Providers are expected to accept referrals from anywhere, not just the partner(s). There is no specific allocation for HWLA Tier I services; there is a specific allocation of PEI funds for Tier 2 services. Once an agency is at 75% of the contract maximum a request for additional funds can be made to DMH.		√		
2.2.4	**Q: Who is the appropriate contact person for CP's to work with coordination of care and referral issues?**				

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	A: In general, Community Partners should work with the agency to which they are making referrals to develop a shared and mutually-agreeable understanding of how the coordination of care and referral issues will be handled. A Memorandum of Understanding or Operational Agreement should be developed between the agencies to clearly define these processes. DMH administration may be consulted on these matters.	√			
2.2.5	**Q: If a patient is a registered HWLA patient at another medical home, and then comes to our clinic (we are a Community Partner) asking for mental health services, are we supposed to refer them back to their clinic / medical home of registry?** **Specific example: I have a patient on my schedule today at 10:30am whose appointment note states "Pt already has HWLA registered at [Clinic]." I want to make sure that the patient is treated in the right location; also, that our claims will not get rejected because she isn't "our" patient.** A: HWLA enrollees ("matched" in DHS language) are assigned to a medical home. While it may make sense in many respects for all care to be delivered in the same setting, the primary consideration should be that of patient choice. This is a critical piece of the 1115 Waiver legislation/ HWLA program. The patient may not always be aware of their medical home, so we can educate them about the assignment to the medical home but they still have the right to request a change in their medical home and receive services, including mental health, in the setting of their choice. The claims for mental health services that you submit to DMH will not be turned away due to an association with a different medical home.	√	√	√	
2.2.6	**Q: We are a Legal Entity (LE) Provider, is our identified Community Partner able to refer directly to us, or do they have to go through the Service Area Navigator?** A: Yes, your identified Community Partner should refer to you directly without going through the Navigator. You must have an Operational Agreement in place with them that outlines the internal procedure for sharing referrals. The CP still needs to upload the Department of Mental Health Referral form through RPS for tracking purposes.	√	√		√
2.2.7	**Q: Some Community Partners have referred patients to their Tier 1**				

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	provider and have not received the feedback form from them explaining what follow-up may have occurred for that patient. What is the recourse if Tier 2 providers continue to fail to receive any follow-up documentation from the Tier 1 providers? A: While it is ideal that we receive feedback from the various providers, this is a new process that must become part of our ingrained daily activities. We will continue to reinforce this message; you are also free to contact provider and ask that the Referral Response Form be sent to you.	√	√	√	
2.2.8	**Q: If a client is seen in a Tier 2 setting and it is determined that they require Tier 1 services, does that referral and the 30-day requirement to be seen, need to be tracked?** A: No.	√	√	√	
2.2.9	**Q: Can a specialist at a specialty health center (i.e. Diabetes Specialty Clinic) complete the referral form or does it have to be the primary doctor at a Primary Care facility?** A: Yes, a specialty health center can complete the referral. Referrals are not required to originate from a Primary Care facility. With that said, it is important to make sure that there is a designated physician on the DHS side that will assume responsibility for prescribing any psychotropic medications while the patient is seen for Tier 2 services.	√	√	√	
2.2.10	**Q: The Navigation team received a referral for a HWLA client and attempted to refer the individual to the mental health agency that was paired with the medical home. However, that mental health agency responded that since a different mental health program (not listed as a partner) was closer to the client's house, then the referral must be sent there. Is this true?** A: Not necessarily. If services are available at the medical home or with the medical home's partner, the client should be notified of such. The important thing to keep in mind is that the clients or prospective clients have freedom of choice in terms of where they receive the services. With that said, the client may or may not know that they have an association with a medical home and it is also quite possible that they are unaware that their medical home may have services on-site. Many clients who may be attached to a medical home may have never been there or be unaware of what that means, and they can opt to change medical homes on a monthly basis. If for some reason the				√

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	client decides to receive services at an alternate location, then they can be linked to that location.				
2.2.11	**Q: How long does a DHS patient have to wait until they are scheduled for a mental health appointment?** A: HWLA members must be offered an appointment within 30 business days from the date the patient requested mental health services.	√	√	√	
2.2.12	**Q: How will patients be notified of their mental health appointment?** A: This depends on the mental health provider. It is typically by phone, or mail if they can not be reached by phone.	√	√	√	
2.2.13	**Q: How will the referring DHS site be notified of the appointment?** A: The mental health provider must complete the DMH Referral Response Form and send to the referring DHS site.	√	√	√	
	2.3 Referral Tracking Log/Referral Tracking System				
2.3.1	**Q: Do all mental health referrals need to be entered into the DHS RPS system or just those where there is no mental health provider contracted or in-house?** A: Yes, all referrals for specialty mental health services made by a DHS or Community Partner provider must be entered into the DHS RPS, including in-house (internal) referrals. DMH directly-operated and Legal Entity contract providers do not have access to the RPS so their referrals will be tracked in the DMH Referral Tracking System (RTS).	√	√	√	
2.3.2	**Q: How do staff track in the referral log when they have made an appointment for a new HWLA referral but then have to reschedule the appointment for a later date on the HWLA enrollees request?** A: Record the original initial appointment date in the Referral Log. If the client requests to reschedule the appointment then select "Code 12 – Rescheduled for future appointment" in the Disposition column.	√	√	√	
2.3.3	**Q: How are new HWLA clients tracked that come into the Directly-operated DMH clinic through a source other than the Service Area Navigator, for example a walk-in?** A: The mental health provider must create a new record in the Referral Tracking System (RTS).			√	√
2.3.4	**Q: If someone walks-in and is already an HWLA member, do we track them too?** A: Yes. All new clients to mental health providers who are enrolled in HWLA must be tracked with the Referral Tracking Log.	√	√	√	

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	2.4 DMH to DHS Referrals				
2.4.1	**Q: How should DMH refer clients for medical care? If it does not already exists, can a form be developed that allows our mental health program to formally refer our HWLA consumers to our partner clinic for needed medical services?** A: Once an individual is registered with HWLA they are offered a choice of medical homes to select and receive medical care. A referral is not necessary for an individual to access medical care from their medical home. Individuals may not always be aware of their medical home, or may want services elsewhere. DHS is developing a referral form that DMH can use to refer to DHS partner clinics for needed medical services.	√	√	√	
2.4.2	**Q: Some Tier 1 clients may not require health care services at the time of enrollment in HWLA by DMH - although everyone could use a physical. Are these clients expected to be linked to a DHS clinic, and if so, how quickly?** A: Please see above. DMH is expected to encourage Tier 1 clients to seek necessary medical services with their medical home as needed. According to the Special Terms and Conditions of the 1115 Waiver, "primary care appointments [for HWLA members] will be made available within 30 business days of request during the Demonstration term through June 30, 2012 and within 20 business days during the Demonstration term from July 1, 2012 through December 31, 2013.	√	√	√	
	Section 3: Contracts and Funding				
3.1	**Q: Is there a maximum dollar amount to HWLA Tier 2 contracts?** A: Agencies must check their DMH contract for the maximum dollar amount. Once a program has reached 75% of the contact amount a request can be made to DMH for additional dollars.	√	√		
3.2	**Q: Will the dollars be added to PEI, since this is an early intervention EBP?** A: HWLA is not an early intervention EBP, but it is PEI.		√		
3.3	**Q: Will LE HWLA providers be able to move dollars around within the PEI programs as needed as long as they do not exceed their maximum allocation for PEI?** A: No.		√		
3.4	**Q: What expenses qualify for the $100,000 one time start up costs?**				

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	A: DMH will reimburse for certain one-time costs associated with MHIP implementation, pursuant to the terms outlined within Attachment III, Exhibit B, Section C.3.(b) titled "One-Time Funding." General billing categories are listed on the invoice. Expenditures for reimbursement require prior DMH approval, so please consult with Lisa Wicker.	√	√		
3.5	**Q: Is DMH paying for the training hours of non-clinical staff who attended your trainings (like on IT and billing)?** A: No.	√	√		
3.6	**Q: Please clarify whether Legal Entity Providers have to use indigent funds to pay for services to HWLA clients and whether or not there will be HWLA dollars which will be allocated to Providers based on their treatment of these clients.** A: Tier 1 services to HWLA clients are provided using existing unmatched (i.e., non-Medi-Cal) MHSA CSS or CGF funds. Tier 2 services to HWLA clients are provided using PEI_Special_Programs non-Medi-Cal funds. Once providers have used 75% of PEI Special Programs contract dollars additional funds may be requested.		√		
3.7	**Q: As a new Community Partner providing HWLA services for DMH I understand that we must implement policies and procedures for mental health services. I would like to know if you have samples of such policies and procedures so that we could adapt them for our use.** A: There are actually two different types of procedures that a Community Partner agency should have in place. First, if you are partnered with a mental health agency that is delivering either Tier 1 services only or Tier 1 and Tier 2 services for your HWLA beneficiaries, you should negotiate either an MOU or an operational agreement. Second, the Department has a list of policies and procedures that are generally required for our legal entity providers. It is possible that not all of these policies (which may relate to the Medi-Cal program) would apply to your agency.	√			
3.8	**Q: What are the expected per client costs for the Tier 2 clients are for HWLA?** A: There currently is no per client cost for Tier 2 services. This is a short-term brief-intervention model for individuals who do not have chronic or persistent mental health issues. If the client appears to have severe and persistent mental health issues they should be referred to a Tier 1 provider.	√	√	√	

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3.9	**Q: What is the process for a DMH Contract Agency (LE) to be added as a Tier 2 partner for more than one of the DHS Community Partners?** A: Talk with the DHS Community Partner, develop an MOU and notify DMH HWLA Administration.		√		
	Section 4: Psychiatric Consultation				
4.1	**Q: Can you confirm that both Tier 3 and Tier 2 providers are allowed psychiatric consultation for up to 2 hours per week with primary care providers and the mental health team each month?** A: Psychiatric consultation for up to 2 hours per week is only for Tier 2 and for consultation between the psychiatrist and the MHIP team, and is invoiced to DMH	√	√		
4.2	**Q: Is psychiatric consultation excluded from the "six visits?"** A: The "six visits" requirement has been suspended. Please see the OTAR section for additional information.	√	√	√	
4.3	**Q: After a patient has completed Tier 2 services, can the psychiatrist continue to consult with primary care providers on medication issues? In essence, the psychiatrist is now consulting under Tier 3 services, since no other mental health services are being provided and the case is closed. However, in cases where medications have to be changed and adjusted, this could clearly take more time than is anticipated under Tier 2. How do we handle these cases and bill for them?** A: Tier 3 is not part of the HWLA DMH contract. However, if the PCP requires additional consultation, this should be provided to ensure quality of care.	√	√	√	
4.4	**Q: How many hours of consultation can a psychiatrist provide that is not face to face each month?** A: There is no specific number of face-to-face hours associated with psychiatric consultation with the care manager. Consultation with the care manager may be conducted by phone. With that said, it is extremely important for the consulting psychiatrist to develop a strong working relationship with the care manager which will be facilitated by face-to-face contact.				
4.5	**Q: How will the mental health consultation process be conducted?** A: As per above, the consulting psychiatrist should meet and become familiar with the care managers. All clients who are not progressing as anticipated should be discussed with the consulting psychiatrist or				

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	whenever clinical consultation is warranted. Psychiatric Consultation should occur on all patients prior to transfer to Tier I.				
4.6	**Q: Does the psychiatric consults apply to Tier 3 services?** A: No, the psychiatric consults apply only to Tier 2 services reimbursed through your DMH contract. Psychiatric consults for a Tier 3 patient cannot be billed to either DHS or DMH.	√	√	√	
4.7	**Q: We are a CP; if our psychiatrist consults by phone to a doctor or MHIP team member for 5 minutes – can we add that all up by the week and bill for it (as long as that and the team meetings don't exceed two hours of course)? In other words – can we add up all of his consults that aren't in a team meeting format and bill for that?** A: The question combines two different types of psychiatric consultation services. Consultation to the MHIP team is claimed by invoice and should be combined with other consults to the MHIP treatment team that week. DMH will reimburse the CP for a maximum of 2 hours per week for clinical consultation. Consultation to a PCP doctor is claimed similar to face-to-face visits, by claiming 1 unit of service to procedure code H2016. The face-to-face requirement with a client is waived for psychiatric consultation between the psychiatrist and the PCP.	√			
4.8	**Q: For Clinical Psychiatry support – is it a requirement or recommendation for weekly sessions with providers i.e. if the patient is responding well to medication management initiated by the primary care provider, is co-management still needed? Or is availability as needed sufficient?** A: Based upon the question, it is more a recommendation. The consulting psychiatrist would consult on the status of cases being managed by the clinical team. You would certainly want the mental health team to let you know of anyone who is not responding to interventions as expected, e.g. their PHQ scores are not improving or getting worse; they are not on any meds and there are indications that this would be very helpful for the pt.; or in situations where there may be questions in terms of differential diagnosis. If the patients symptoms are improving, they are progressing as expected in treatment, then contact with the PCP would not be necessary. Your	√	√	√	

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	first line of consultation will be with the team and then, as indicated, with the PCP.				
4.9	**Q: What do we do when PCP's are scared to increase therapeutic dosage when patient/client is not responding to treatment? Can the psychiatrist see the patient/client face-to-face? Will the PCP and consulting psychiatrist have direct communication?**				
	A: A psychiatric consultation is recommended when patient/client is not responding to treatment based on PHQ-9, GAD-7 and/or PCL-C scores and /or is reporting acute distress or other serious risk factors, such as suicidality, homicidality or grave disability. A care manager may request a psychiatric consultation (consulting psychiatrist could have face-to-face contact with patient/client or provide consultation with care manager and/or PCP without face-to-face contact with patient/client) to assess the patient/client's need for a higher level of care (Tier 1) or the possibility of a change in psychotropic medication(s). This recommendation is forwarded to the PCP for their consideration. It would be ideal that the PCP and consulting psychiatrist have face-to-face contact to discuss patient/client case load on a regular basis; however, in reality this may not be the case. The care manager would be the liaison/vehicle in which the PCP and consulting psychiatrist communicate with one another.	√	√	√	
	Section 5: Staffing / Licensing Requirements				
5.1	**Q: Can doctoral psychology interns be used to provide HWLA services, (which in other programs is allowed for legal entities), but which is not stipulated in the documents handed out which only allowed for MFT interns, social work interns/associates, and waived psychologists?**				
	A: For FQHCs with mental health services in scope of program only MDs, licensed psychologists, licensed social workers and certified psychiatric mental health nurse practitioners can be used to provide services.	√	√	√	
	FQHCs without mental health services in scope of program, Legal Entities and Directly Operated providers may use interns, associates and waived staff, and should refer to the DMH Organization Provider's Manual for additional information.				

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5.2	**Q: Is the scope of the FQHC mental health services and their requisite licensing requirements the same standards DMH LE's have to use when providing IMPACT model therapy? FQHC's follow the Federal CMS guidelines around who, specifically what licenses, can provide mental health services to HWLA clients. Following these guidelines, only LCSW, Licensed Psychologists and MD's can provide mental health services.** **Assuming the above is correct, any explanation of why would be helpful. We assumed that if we were having to open an episode and provide and bill mental health services through the DMH system, that our existing LPHA standards worked.** A: The licensing requirements that are applicable to the FQHC mental health services providers do NOT apply to the DMH Legal Entity providers when delivering the MHIP (IMPACT) model therapy to HWLA clients under Tier 2. For the DMH Legal Entity providers the existing standards are applicable, which allow for the use of licensed-waivered staff and MFTs.	√	√	√	
	Section 6: OTAR				
6.1	**The OTAR process has been suspended. Instead, DMH will monitor service delivery to Tier II clients and will compile agency-specific and aggregated data regarding the number of clients seen, number of sessions provided, and total length of Mental Health Integration Program (MHIP) treatment.** **Please refer to the September 9, 2011, memo from Dr. Robin Kay regarding "Suspension of Treatment Authorization Request (TAR) Requirement for Healthy Way L.A. Beneficiary Services" for additional information.**	√	√	√	
	Section 7: IS / IT				
7.1	**Q: One of our clients reflects HWLA, but indicates his eligibility started 1/1/1900. That must be a glitch, right? Since this screen reflects ID #, would our billing clerks have to manually input this ID # in any of the integrated system screens?** A: Many of the clients in WebSphere show the eligibility starting 1/1/1900 and have been identified for re-enrollment to "clean up" their record. For the most part, if the client's status in enrolled you	√	√	√	

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	are able to proceed even though the start date is obviously incorrect.				
7.2	**Q: How do I know if we are approved to enter the IS system?** A: The Application Access Form grants access to the IS; the user is sent a SecurID card and IS logonID instruction packet and a confirmation notice is sent to the provider's designated contact person. Rendering Provider Form associates Rendering Providers to Reporting Unit(s); the provider's designated contact person is sent a confirmation notice.	√	√		
7.3	**Q: We are having difficulty accessing the billing module of Healthy Way** A: Please contact the DMH Help Desk at 213-251-6623	√	√	√	
7.4	**Q: Do we need to resubmit our denied HWLA claims due to the pending HWLA status in the previous month?** A: No, you do not need to resubmit these claims. The department will just hold them in suspense until the next processing month.	√	√	√	
	Section 8: Outcomes / Screening Tools				
8.1	**Q: Who fills out the PHQ Form?** A: The PHQ is a client self-administered screening tool available in a variety of languages. In some facilities, the patients will fill out the PHQ at registration and in other facilities staff may assist patients to complete the screening tool. A PHQ screening tool must be completed for each patient that is referred for specialty mental health services. The only exception will be for those patients who are either cognitively disorganized or psychotic and unable to complete the screening tool.	√	√	√	
8.2	**Q: We currently do not have the adult YOQ outcome measure, therefore we are currently using the PHQ-9 at this time, is that sufficient?**				
	A: The outcome measures that will be used for clients receiving Tier 2 MHIP will be the PHQ-9, and/or the GAD-7 and/or the PCL-C. The selection of screening tools that will serve as clinical outcome measures will be based upon the client's presenting problems/symptoms. While the YOQ may be an outcome measure used in other Prevention and Early Intervention services, it is not used with MHIP.	√	√	√	

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	Section 9: Clinical Documentation				
9.1	**Q: Does the psychiatrist need to sign the CCCP?** A: The psychiatrist must sign the CCCP when a medication services is being provided. If the provider is a Community Partner or Legal Entity the medications are being provided through the medical home. In this case the psychiatrist would not sign the CCCP. In the Directly Operated programs if the client has not been referred from a medical home the psychiatrist may be prescribing the medication. In that instance the psychiatrist would sign the CCCP.	√	√	√	
9.2	**Q: Are both the IA and the CCCP to be included as part of the six sessions?** A: There is no longer a six session maximum. However, the time spent with the client gathering information and developing the assessment and CCCP are billable services.	√	√	√	
9.3	**Q: Can't all current taxonomy codes for Legal Entity providers be used to deliver clinical services and not just the one's listed as an AMHD? For example, K2 - Other Psychologist trainee - paid (OTH PSY- PT) Taxonomy Code - 101YM0800X is currently permitted as a taxonomy code for Legal Entities to deliver clinical services.** A: Please follow the terms outlined in your contract. More information on Taxonomy codes are be found in pages 122 – 132 of the Integrated System Codes Manual http://lacdmh.lacounty.gov/hipaa/documents/CODESMANUAL-IS2Version4.6_002.pdf		√		
9.4	**Q: Under Plan, it lists 2K-IMPACT. Actual training on June 23-24 was on Problem Solving Treatment, which is not the IMPACT model. How do providers proceed?** A: The training on June 23 – 24 was for the MHIP model, which is the 2K – IMPACT (MHIP) Plan. Of the 2-day training, day 1 was on MHIP and day 2 was on Problem Solving Treatment. Providers who attend both days of the training are able to provide MHIP services and claim to the 2K – IMPACT (MHIP) Plan.	√	√	√	
9.5	**Q: How should recommendations/communications for medication and/or other consultations issues be documented at the health home**				

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	subsequent to the submission of the original referral form to the SA Navigator?				
	A: The method for documenting any medication recommendation or consultation on the health side is the responsibility of DHS. DMH is currently working on parameters to address documentation related to consultations (direct and indirect) that are conducted by DMH providers (MD, DO, NP).	√	√	√	
9.6	**Q: We are a CP; I've learned from the IS training that we are to put only "1" minute in the IS. Do we need to document elsewhere i.e. in the medical record of the time spent? In the contract, it says the duration of billable visit must be at least 20 min with at least 15 min of face-to-face time.** A: You are correct with the billing and IS instructions and am pleased that you ask about the medical record. The clinical staff who provide the services should document the face-to-face and other time (documentation) in the actual medical record along with whatever the intervention may have been provided. Please see the documentation guidelines in Section 7 of the HWLA Toolkit, Medical Records Requirement section, under Progress notes. The compliance with the contract requirements (minimum 20 minute session) can be handled via the medical record documentation of the time spent in the clinical service.	√			
	Section 10: HWLA Eligibility / Enrollment Process				
10.1	**Q: What is the status of DMH Contract agencies having access to the DHS system to check HWLA client eligibility? I am familiar with the current process outlined in RMD Bulletin NGA11-020.** A: For the time being, contract agencies will not have access to the DHS Websphere system to check eligibility for HWLA (the DMH directly-operated clinics do not have access either). RMD is still coordinating this centrally, so please continue to use the current process.		√	√	
10.2	**Q: If clients are referred to us who are potentially eligible for HWLA, are we to assist them with the enrollment process? How do we know what the enrollment process is? And how would/should we bill for the staff time?** A: For the potential HWLA eligibles that do not have an open IS episode, (i.e., they are not in our system), DHS has six "enrollment centers" around the county to send folks to. You can call the DHS HWLA call center at 1-877-333-HWLA for more information.	√	√	√	

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10.3	**Q: Why do we need to complete the Patient Financial Info form when they are already HWLA patients and did it all already with HWLA?** A: This is a state, not a county requirement. The DMH Revenue Management Division is exploring possible work-arounds with the state, but for now it remains a requirement.	√	√	√	
10.4	**Q: We have been informed that it will take up to 2 months to get the HWLA "pending" status to "accepted". Is it possible to provide services to this client during the 2 month period?** A: Effective January 1, 2012, and through June 30, 2012, DMH will reimburse HWLA Providers for mental health services delivered to HWLA Matched Program Pending patients until their HWLA application is approved. If the application is denied, DMH will reimburse for mental health services to those individuals for up to 30 calendar days from the date the application was denied.	√	√	√	
10.5	**Q: If a client scores below a 5 on the PHQ 9 form, is the primary care physician able to refer the client (with documentation) if they believe the client is in need of therapy? For example, the PCP speaks with the client and notices the client was beaten as a child.** A: A 5 out of 9 is pretty much the baseline as far as the low end of PHQ scores. The issue with the client being beaten as a child is not necessarily relevant. What is the client's current DSM diagnosis and what functional impairment does the client have as a result of the diagnosis? Those are really the questions that should be asked to assist in deciding if the referral to specialty mental health is warranted. Referring simply because of a belief that someone needs therapy is not sufficient.	√	√	√	
	Section 11: MHIP Model				
11.1	**Q: In the IMPACT model there is a care coordinator that checks in with all patients receiving meds only (not therapy) and helps manage their care, but I don't see that as part of the requirement for MHIP, is that accurate?** A: The coordination of meds prescribed by the PCP by a care manager has not been included as part of the roll-out for which DMH will reimburse. If the client is receiving meds only, then they are Tier 3 and would not be covered under your contract. This function would need to be assumed as part of your primary care responsibilities.	√	√	√	

	Frequently-Asked Questions	Community Partners	Legal Entities	Directly-Operated	Service Area Navigators
11.2	**Q: When is it appropriate to leave a case open if you've already completed PST?** A: The length of treatment is not pre-determined. It is based on the patient's symptoms and resulting functional impairment. For most patients receiving PST, the first session in the program will NOT be the first PST session. The first session in the MHIP program should include behavioral activation and treatment planning. The treatment planning component might include selecting PST as a treatment intervention. If so, you will schedule a time for the patient to return for the first PST session. Once the PST sessions are concluded you will determine whether or not the patient's level of symptoms and functional impairment indicate continued care management. If yes, you will continue to provide service until it is no longer warranted or the patient is determined to need Tier 1 service. If the patient is so improved after 6-8 sessions of PST so as to no longer meet medical necessity then you will terminate them from care.	√	√	√	
11.3	**Q: How many sessions are allowed? Over how many weeks?** A: There is no specific cap on the number of sessions associated with MHIP. Please keep in mind that the Tier 2 services are expected to be short-term in duration as these are early intervention services.	√	√	√	
11.4	**Q: One of our clinicians was recently trained in MHIP and she is currently seeing a client under seeking safety, will she be able to transition the ct to the MHIP model now that she is trained?** A: The answer should be determined by the clinical need of the client. In many cases, it would be disruptive to change treatment modalities mid-course. DMH does not require that you change treatment modalities once trained in MHIP/PST. The decision to change treatment modalities to MHIP/PST should be based on patient need. After staff have been trained in the MHIP/PST model, DMH expects that PST will be the evidenced-based treatment that will be used for Tier 2 clients seen in primary care settings ONLY if it's clinically appropriate.	√	√	√	
11.5	**Q: We were told that we would be receiving the anxiety scale, however we have not received this measure, will it be sent shortly?** A: This has been added to the LA County MHIP website or can be accessed directly here: http://phqscreeners.com.	√	√	√	
11.6	**Q: If a care manager sees a client using PST consistently for 45 minute**				

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	sessions opposed to 30 minute sessions would they be out of compliance with the intervention? A: If the whole 45 minutes combines PST and case management then yes, that's appropriate (30 minutes for PST, 15 for case management). If it's all PST then the care manager needs to work on their time management skills because this component is very structured and needs to follow the format. It does happen that occasionally you need more time, for instance in a crises situation, but as a regular rule, the first meeting is 45 minutes to an hour, the subsequent meetings are 30 minutes, and as the patient improves, the sessions should naturally become shorter.	√	√	√	
11.7	**Q: Does the completion of admin forms (e.g., open episode, face sheet, payer financial form, etc.) and Adult Short Assessment count as one session?** A: Completion of administrative forms (e.g. open episode, face sheet, PFI, etc) are never claimable. The Adult Short Assessment is considered clinical documentation and thus a claimable service. It does not count as one (PST) session though and remember that the cap of 6 sessions was lifted previously by DMH.	√	√	√	
11.8	**Q: How can we obtain the PST forms in other languages, specifically Spanish and Armenian?** A: The PST forms are available in Spanish and are posted to the LA MHIP website: http://uwaims.org/lacounty/pst-languages.html. They are also available in traditional Chinese characters (for people who speak Cantonese, Mandarin). At this time, PST forms are not translated into Armenian, but we are willing to work with anyone who would want to translate the forms into a different language.	√	√	√	
11.9	**Q: What is the purpose of the adherence forms? Are they related to the PST Certification process?** A: Yes. The purpose of the adherence forms is to document that PST trainees participated in and understood the key concepts from each of the group training sessions. The forms are used EXCLUSIVELY for this purpose and are not used for data collection, research or any other activity.	√	√	√	
11.10	**Q: If a client has HWLA and is self referred to a clinic for therapy can I provide MHIP and do I need to send a referral form to the SA navigator regarding the patient/client's treatment status?**				

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	A: First off, it may be helpful to keep in mind that clients with HWLA may receive a range of services based on their clinical presentation and may be either Tier 1, 2, or 3. DMH provides services to those individuals who are either Tier 1 or Tier 2, while Tier 3 services are provided only in health settings. MHIP is the treatment model that we are using for services to Tier 2 clients who have been referred by their PCP. If the client is self-referred, you do not have a PCP to collaborate with so this may not be the EBP of choice for Tier 2 and you may wish to consider Seeking Saftey and CORS or FCCS for a Tier I self-referral. Further, if you did not receive a Referral from the PCP, you do not need to send a Response to Referral form to the SA Navigator.	√	√	√	√
11.11	**Q: When collaborating with HWLA health home and health care providers, is their a liaison that communicates with the health care home about the necessity for reciprocal communication and/or are we to only communicate with one person regarding patient/client care? (As patients are seen by multiple health care providers e.g. NP, RN, MD etc. communication is often difficult and disjointed.)** A: DHS has identified liaisons for each clinic. List is attached for the various clinics. I would not assume that that also implies any degree of reciprocity, at least not at this point in time. If you receive a Referral from DHS PCP, clearly the Referral Response would be back to the PCP. If you are choosing to make contact in the absence of a DHS referral, you may wish to identify the PCP or as appropriate to the clinical situation, their specialty health provider. Please keep in mind that the PCP may be either and MD, DO, NP or PA.	√	√	√	
11.12	**Q: If the patient/client is doing well and/or treatment is to be terminated should we communicate this to the health home in writing? (e.g. use the Exchange of Behavioral Health and Primary Health forms???)** A: Yes. You may send a copy of the Discharge Summary form to the PCP. The exchange of information forms are for SPD use only.	√	√	√	
11.13	**Q: If the patient/client responds well to the initial round of treatment (i.e. PHQ9 or GAD-7 scores improve, patient/clients functioning has improved etc.) and patient/client self refers back for treatment do we proceed with the provision of 6 sessions again?** A: If you have a patient/client who has completed a 6-8 week course of PST as part of their treatment, you can continue to provide other care	√	√	√	

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	management services (e.g. measuring clinical symptoms, tracking treatment outcomes, facilitating changes in treatment based on outcomes, behavioral activation, supporting medication therapy) to them until they have improved to the point that service is no longer medically necessary. If the patient/client has reached treatment goals and objectives and symptoms have subsided, but they wish to continue treatment to support current gains or address other issues that are not related to care management services, then an appropriate referral should be given. The patient/client may return to access another 6-8 week course of PST if they meet medical necessity and if they are returning for a separate reason and not because they didn't respond well to the original treatment.				
11.14	**Q: If a patient/client shows for their initial appointment and does not come back for follow-up or respond to multiple outreach attempts and then the client returns do we proceed with providing the 6 sessions at that point. Are we to adhere to a 30-business day timeline in this situation?** A: In situations where you have opened a case and the client fails to show for appointments or fails to respond to attempts to contact and reschedule, it is recommended that the case not be kept open. Three failed appointments with no client contact in between should prompt notification to the patient of our inability to contact the patient, and plans to terminate services as a result of no contact but with the caveat that should they wish to reenter services that they may by consulting their PCP and obtaining a new referral. If the patient/client returns prior to you terminating their services the care manager should continue treatment; however, having a session addressing follow-through issues would be appropriate. There is no longer a cap in the number of sessions under MHIP but understand that this is still a short term treatment model.	√	√	√	
11.15	**Q: Is PST the only EBP that we can use for MHIP?** A: Problem Solving Treatment is the preferred EBP for the MHIP model, but it can be exchanged with another approved EBP, if clinically appropriate.	√	√	√	
11.16	**Q: Is there any flexibility with PST in order to provide additional clinically appropriate techniques?** A: In order to be "true to the model" and provide the treatment as it was intended, care managers need to follow the proper stages; however,	√	√	√	

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	this does not mean that the care managers need to forgo their clinical skills and just read from a manual. Being able to provide a safe holding environment in which the patient/client can feel comforted, supported, and encouraged will be important in building a healthy therapeutic rapport. This will also help in patient/client willingness to participate in the PST process. Implementing other cognitive behavioral techniques may be done when clinically appropriate and as to support PST (e.g., relaxation techniques prior to brainstorming stage of PST).				