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Children & Youth Services Behavioral Health Services

1. Welcome

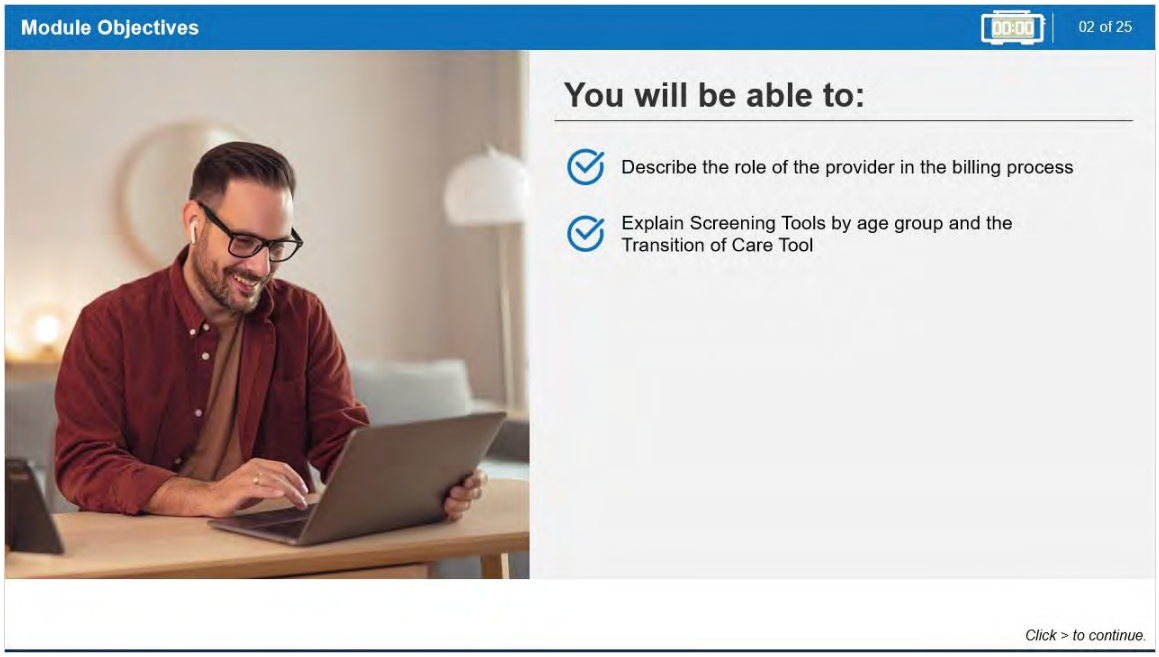
1.1 Welcome

Notes:

Welcome to the 'Children & Youth Services Behavioral Health Services'.

Click the 'Help' on the top right of your screen to learn how to navigate through this module. You can proceed directly if you've been here before.

1.2 Module Objectives

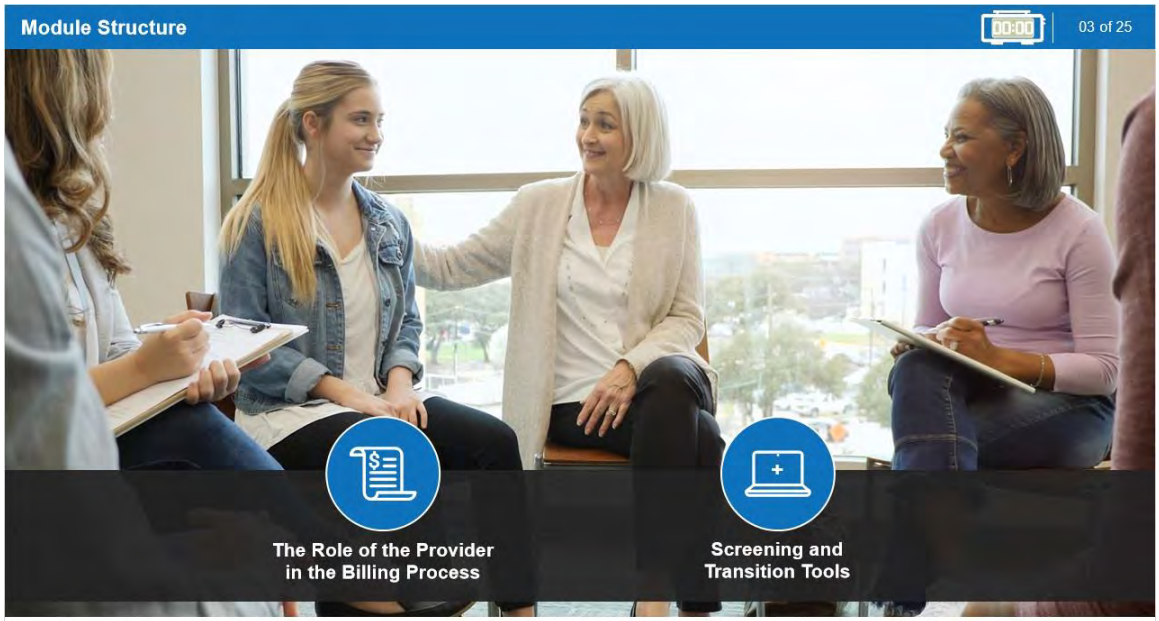


Notes:

So…what can you expect out of this module?

By the end of this module, you will be able to describe the role of the provider in the billing process, and explain Screening Tools by age group and the Transition of Care Tool.

1.3 Module Structure



Notes:

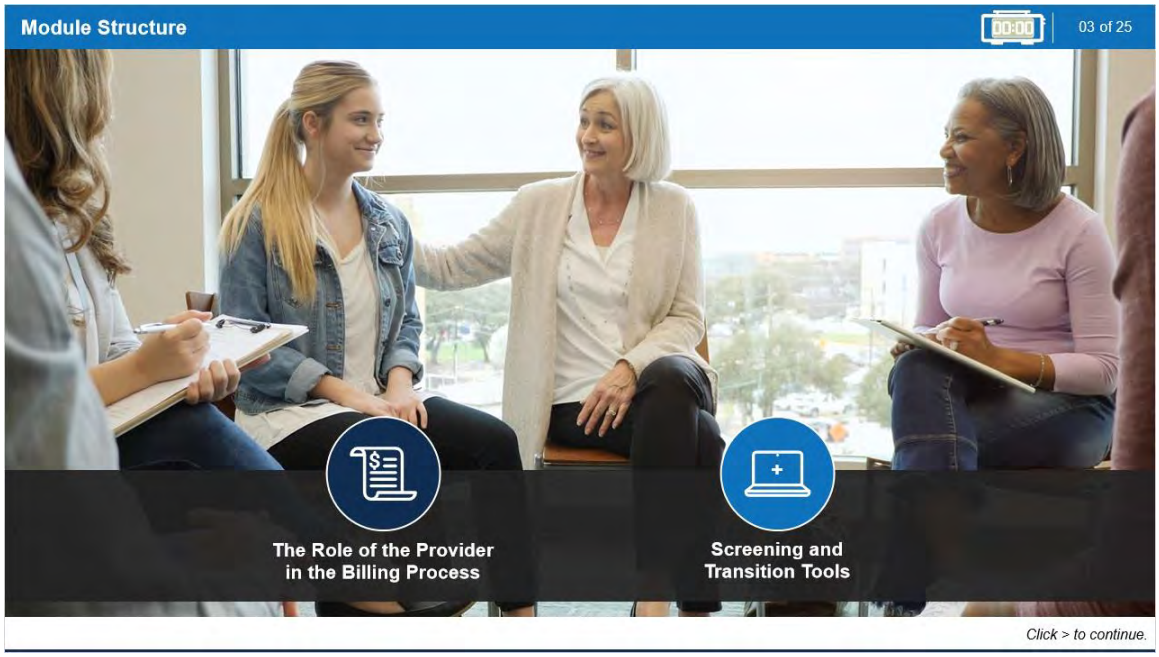
This module is divided into two units.

- The Role of the Provider in the Billing Process,
- Screening and Transition Tools.

At the end, we will wrap up with a Summary.

2. The Role of the Provider in the Billing Process

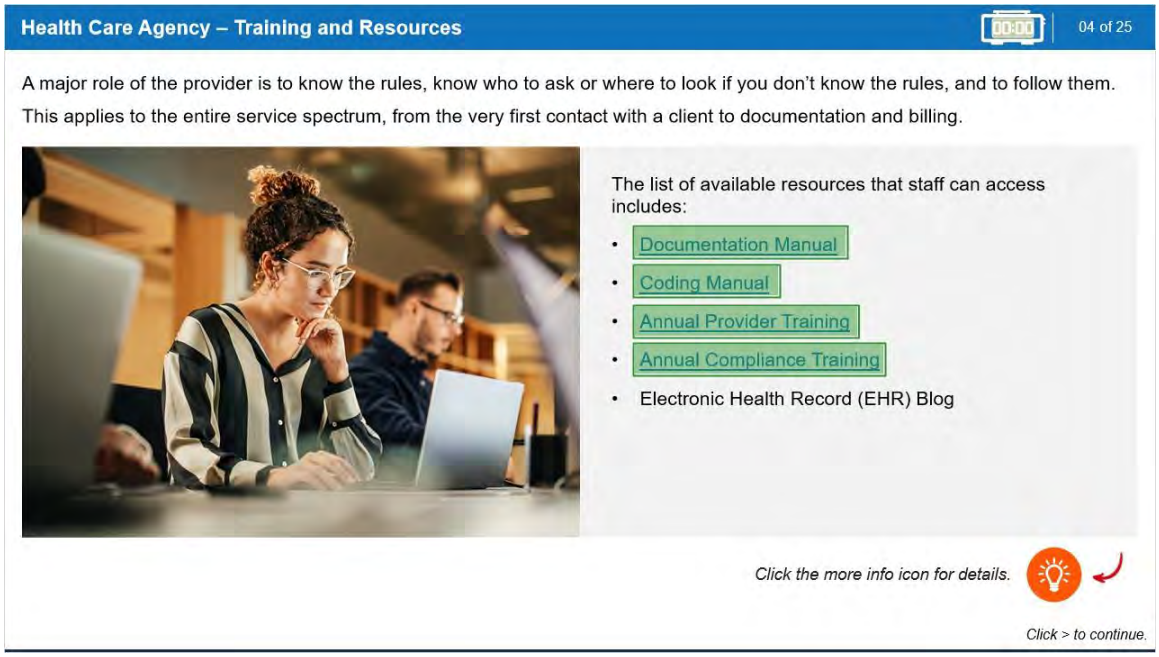
2.1 The Role of the Provider in the Billing Process



Notes:

Let's start with the Role of the Provider in the Billing Process.

2.2 Health Care Agency – Training and Resources



Notes:

A major role of the provider is to know the rules, know who to ask or where to look if you don't know the rules, and to follow them.

This applies to the entire service spectrum, from the very first contact with a client to documentation and billing.

The Health Care Agency (HCA) requires and provides a number of staff trainings and resources.

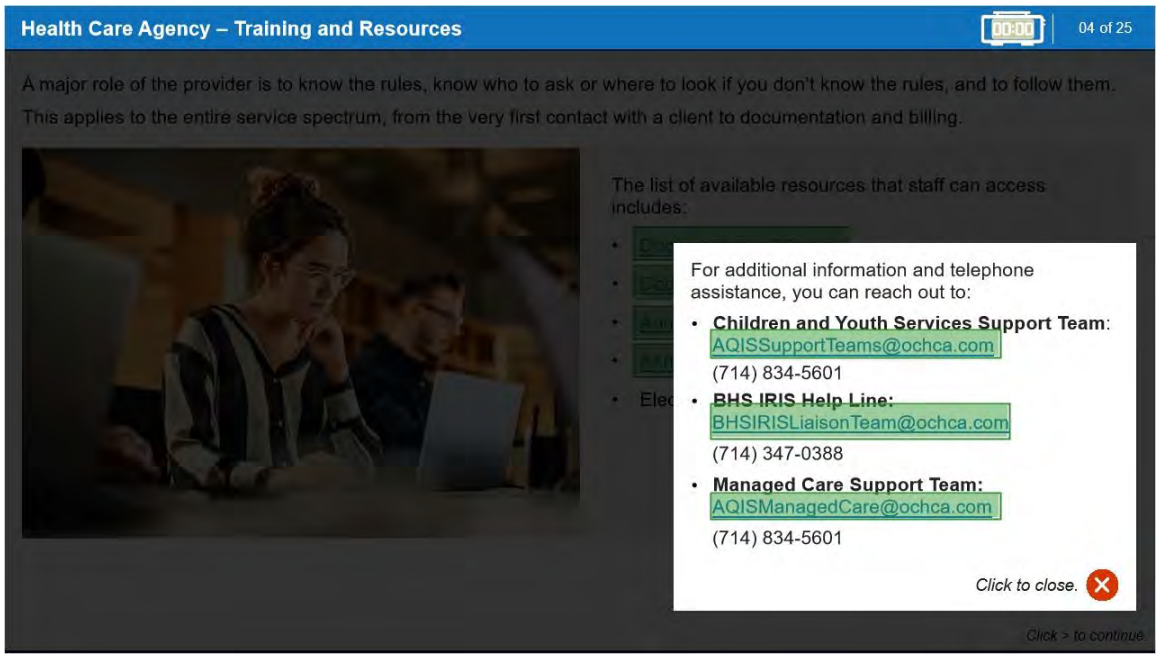
Displayed here is a list of available resources that staff can access, which include:

- Documentation Manual,
- Coding Manual,
- Annual Provider Training,
- Annual Compliance Training, and
- Electronic Health Record (EHR) Blog.

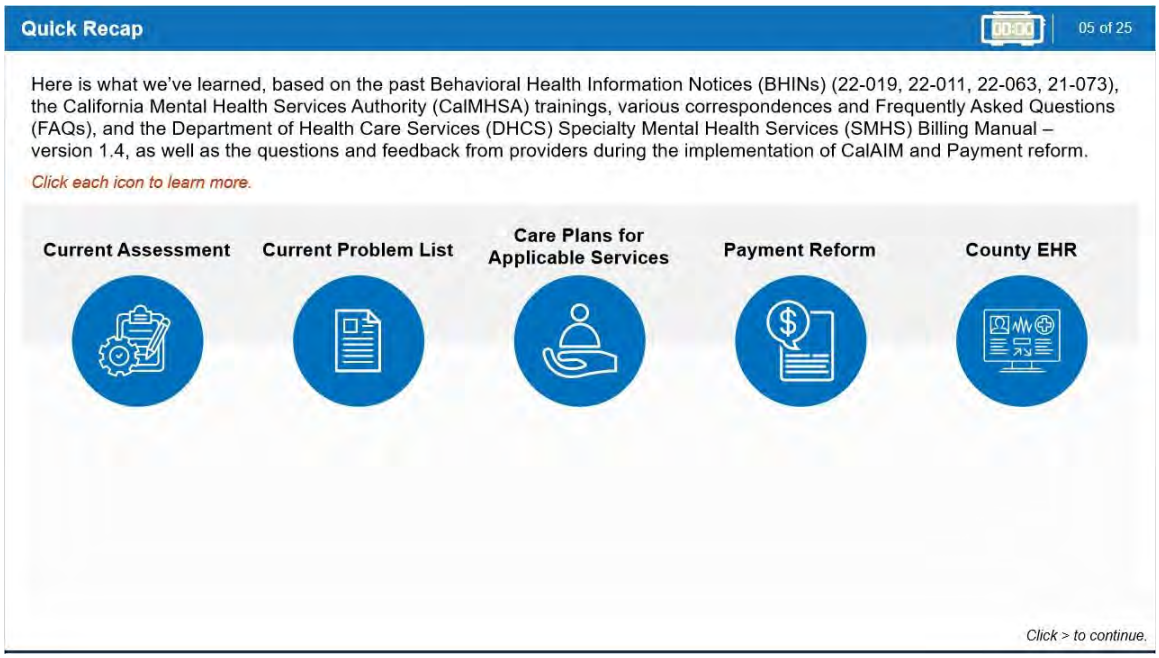
For additional information and telephone assistance, you can reach out to:

- Children and Youth Services Support Team,
- BHS IRIS Help Line, and
- Managed Care Support Team.

More Info (Slide Layer)



2.3 Quick Recap



Notes:

Here is what we've learned, based on the past Behavioral Health Information Notices (BHINs), the California Mental Health Services Authority (CalMHSA) trainings and office hours held from April to August 2022, various correspondences and Frequently Asked Questions (FAQs), and the Department of Health Care Services (DHCS) Specialty Mental Health Services (SMHS) Billing Manual – version 1.4, as well as the questions and feedback from providers during the implementation of CalAIM and Payment reform.

The current assessment process requires the evaluation of seven domains and the utilization of any assessment tools by the Mental Health Professional (MHP), such as the Child and Adolescent Needs and Strengths (CANS) or the Pediatric Symptom Checklist-35 (PSC-35).

The current Problem List contains ICD-10 diagnoses and may also include SNOMED codes along with Social Drivers of Health, and it is updated periodically to support the medical necessity for ongoing treatment.

Care Plans for applicable services (such as TCM, ICC, Medi-Cal Certified Peer Support Specialist, and additional services requiring Care Plans like TBS and STRTPs) may be in Care Plan progress note format.

Payment Reform has introduced more CPT codes and rules related to 'Direct Patient Care,' place of service, time ranges, limits, telehealth/telephone services, lockouts, and overriding modifiers.

The Electronic Health Records (EHR) system undergoes significant changes as a result of the new CalAIM and Payment Reform rules.

Image1 (Slide Layer)

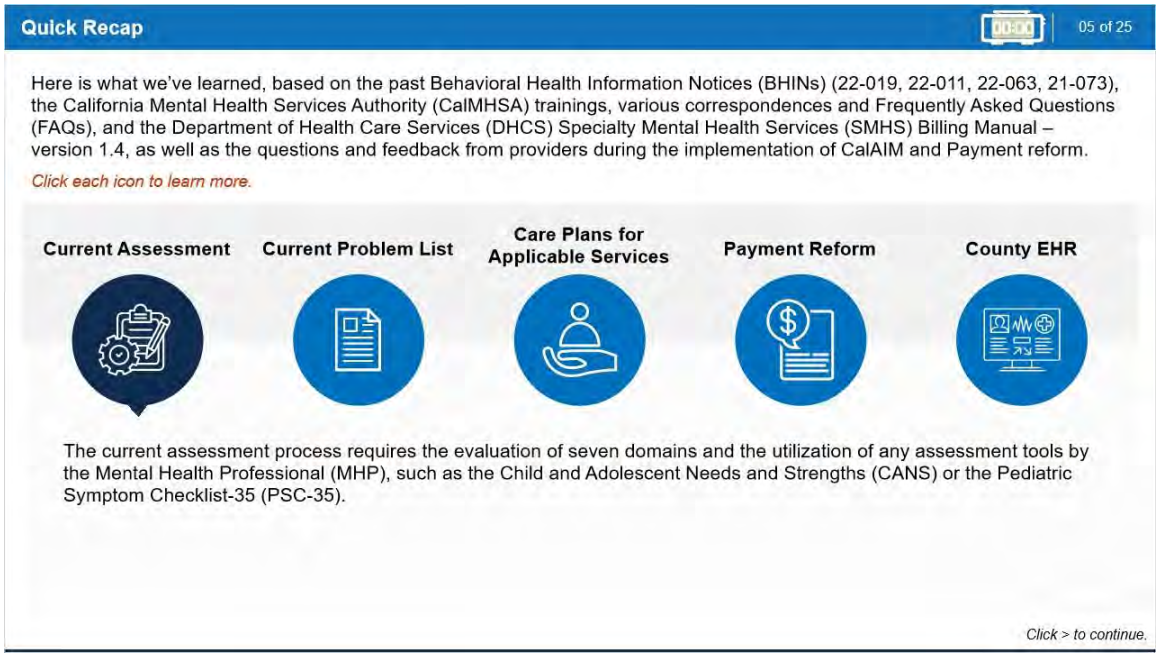


Image2 (Slide Layer)

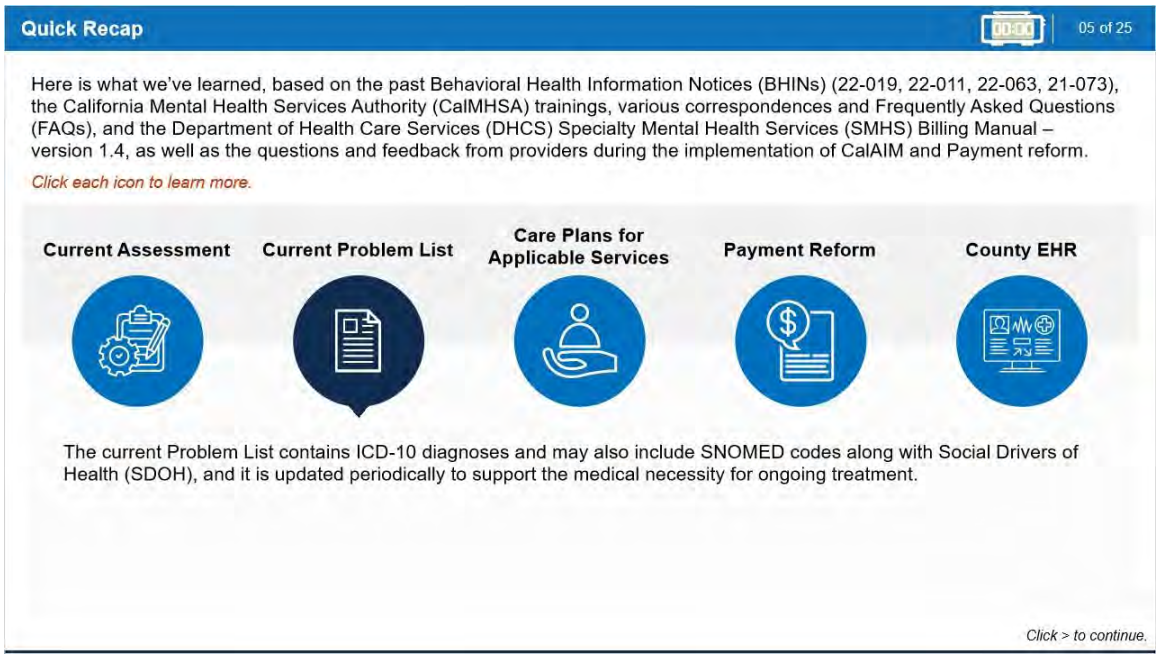


Image3 (Slide Layer)

Quick Recap 05 of 25

Here is what we've learned, based on the past Behavioral Health Information Notices (BHINs) (22-019, 22-011, 22-063, 21-073), the California Mental Health Services Authority (CalMHSA) trainings, various correspondences and Frequently Asked Questions (FAQs), and the Department of Health Care Services (DHCS) Specialty Mental Health Services (SMHS) Billing Manual – version 1.4, as well as the questions and feedback from providers during the implementation of CalAIM and Payment reform.

Click each icon to learn more.

Current Assessment | **Current Problem List** | **Care Plans for Applicable Services** | **Payment Reform** | **County EHR**

Care Plans for applicable services (such as Targeted Case Management (TCM), Intensive Care Coordination (ICC), Medi-Cal Certified Peer Support Specialist, and additional services requiring Care Plans like Therapeutic Behavioral Services (TBS) and Short Term Residential Therapeutic Programs (STRTPs)) may be in Care Plan progress note format.

Click > to continue.

Image4 (Slide Layer)

Quick Recap 05 of 25

Here is what we've learned, based on the past Behavioral Health Information Notices (BHINs) (22-019, 22-011, 22-063, 21-073), the California Mental Health Services Authority (CalMHSA) trainings, various correspondences and Frequently Asked Questions (FAQs), and the Department of Health Care Services (DHCS) Specialty Mental Health Services (SMHS) Billing Manual – version 1.4, as well as the questions and feedback from providers during the implementation of CalAIM and Payment reform.

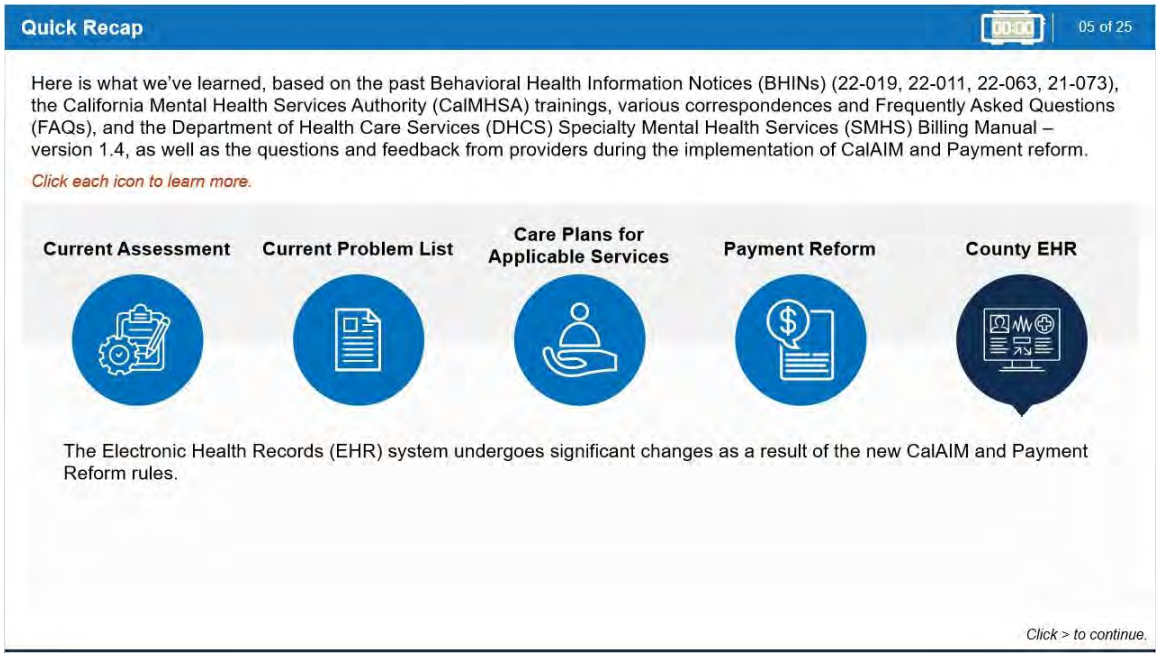
Click each icon to learn more.

Current Assessment | **Current Problem List** | **Care Plans for Applicable Services** | **Payment Reform** | **County EHR**

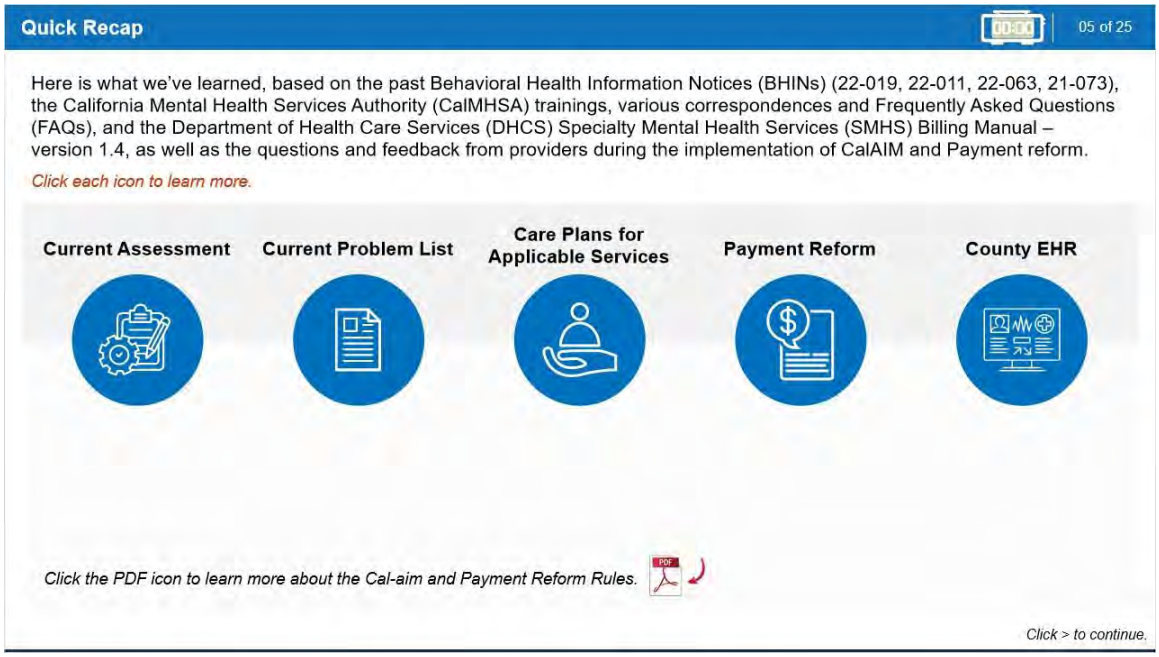
Payment Reform has introduced more CPT codes and rules related to 'Direct Patient Care,' place of service, time ranges, limits, telehealth/telephone services, lockouts, and overriding modifiers.

Click > to continue.

Image5 (Slide Layer)



Pdf (Slide Layer)



2.4 What is Medical Necessity and Access Criteria?

What is Medical Necessity and Access Criteria? 06 of 25

In order to qualify for MHP services, individuals must meet **access criteria**, as determined by the score on the Screening Tool by the Beneficiary Access Line or BAL (also referred to as the Administrative Service Organization or ASO).

Services provided to a client of any age must be **medically necessary** and clinically appropriate to address the client's presenting condition.

Click each image to learn more about the medical necessity and access criteria by age group.

Clients Under 21 Years of Age

Clients 21 Years of Age or Older

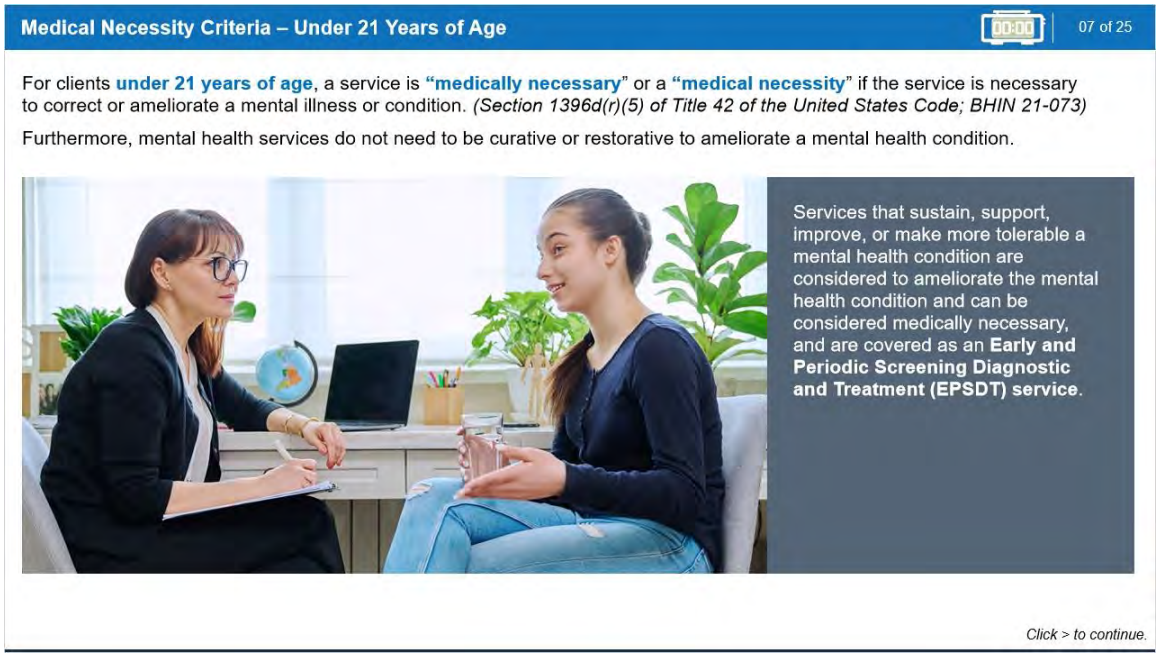
Click > to continue.

Notes:

In order to qualify for MHP services, individuals must meet access criteria, as determined by the score on the Screening Tool by the Beneficiary Access Line or BAL (also referred to as the Administrative Service Organization or ASO), or by walk-in/call-in to a provider site through an assessment.

Services provided to a client of any age must be medically necessary and clinically appropriate to address the client's presenting condition.

2.5 Medical Necessity Criteria – Under 21 Years of Age



Notes:

For clients under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate a mental illness or condition.

Furthermore, mental health services do not need to be curative or restorative to ameliorate a mental health condition.

Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and can be considered medically necessary and covered as an Early and Periodic Screening Diagnostic and Treatment (EPSDT) service.

2.6 Access Criteria – Under 21 Years of Age

Notes:

For clients under 21 years of age, an MHP shall provide SMHS to enrolled clients who meet either of the following criteria.
The client has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system and/or juvenile justice system, or experiencing homelessness.
The client meets both of the following requirements in a) and b), below:

a) The client has at least one of the following:
   I. a significant impairment,
   II. a reasonable probability of significant deterioration in an important area of life functioning,
   III. a reasonable probability of not progressing developmentally as appropriate, and
   IV. a need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The client's condition as described by the criteria above is due to one of the following:
   I. a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD),
   II. a suspected mental health disorder that has not yet been diagnosed, and
   III. a significant trauma placing the client at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

Tab 01 (Slide Layer)

Access Criteria – Under 21 Years of Age 08 of 25

For clients **under 21 years of age**, an MHP shall provide SMHS to enrolled clients who meet either of the following criteria, (1) or (2) below.

Click each number to learn more.

1 2

*The client **has a condition placing them at high risk for a mental health disorder due to experience of trauma** evidenced by* any of the following: **scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare** system and/or juvenile **justice system,** or experiencing **homelessness**.

Click > to continue.

Tab 02 (Slide Layer)

Access Criteria – Under 21 Years of Age 08 of 25

For clients **under 21 years of age**, an MHP shall provide SMHS to enrolled clients who meet either of the following criteria, (1) or (2) below.

Click each number to learn more.

1 2

The client meets **both of the following** requirements in a) and b), below:

a) The client has at least one of the following:

I. a significant impairment
II. a reasonable probability of significant deterioration in an important area of life functioning
III. a reasonable probability of not progressing developmentally as appropriate
IV. a need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

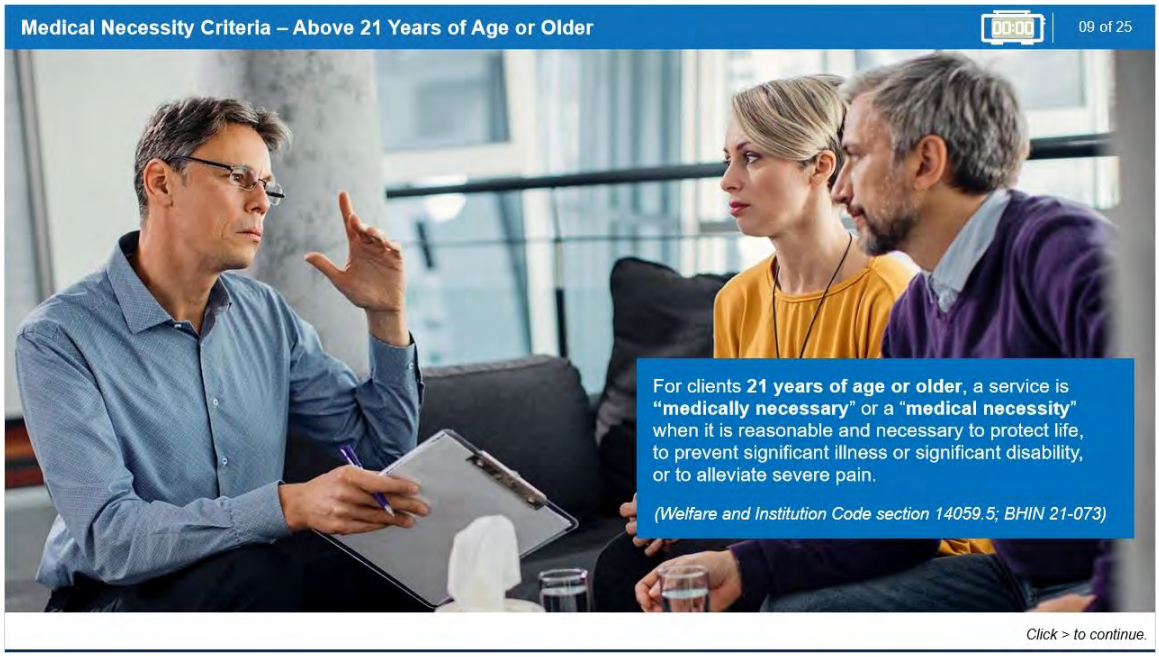
AND

b) The client's condition as described by the criteria above is due to one of the following:

I. a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD)
II. a suspected mental health disorder that has not yet been diagnosed
III. a significant trauma placing the client at risk of a future mental health condition, based on the assessment of a licensed mental health professional

Click > to continue.

2.7 Medical Necessity Criteria – Above 21 Years of Age or Older



Notes:

For clients 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

It is important to note that CYS providers should notice that the criteria for medical necessity changes as your client turns 21 years of age.

2.8 Access Criteria – Above 21 Years of Age or Older

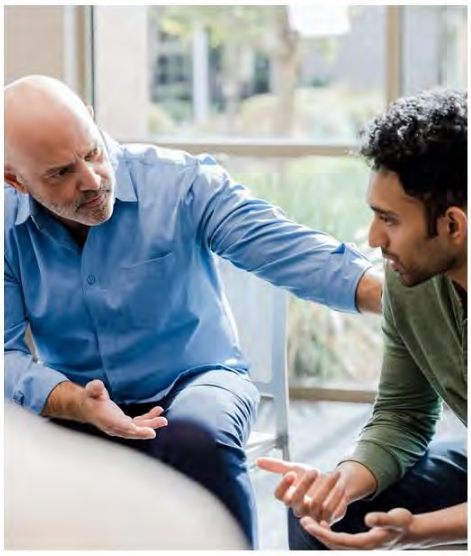
Notes:

For clients 21 years of age or older, an MHP shall provide covered SMHS for clients who meet both of the following criteria, (1) and (2).
The client has one or both of the following:
a)a significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities,
b)a reasonable probability of significant deterioration in an important area of life functioning.
The client's condition, as described in paragraph (1), is due to either of the following:
a)a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD),
b)a suspected mental disorder that has not yet been diagnosed.

Tab 01 (Slide Layer)

Access Criteria – Above 21 Years of Age or Older

10 of 25



For clients **21 years of age or older**, an MHP shall provide covered SMHS for clients who meet both of the following criteria, (1) and (2) below.

Click each number to learn more.

1 2

The client has one or both of the following:

a) a significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities

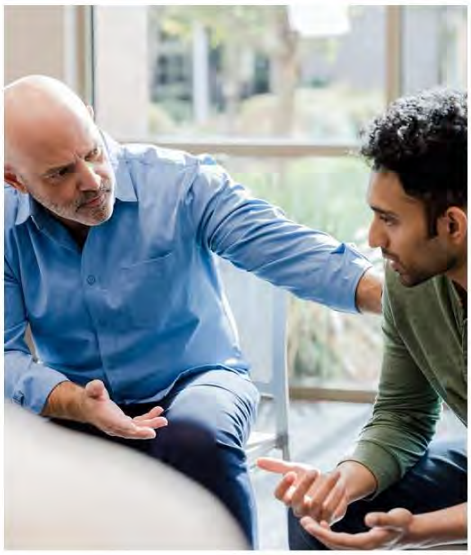
b) a reasonable probability of significant deterioration in an important area of life functioning

Click > to continue.

Tab 02 (Slide Layer)

Access Criteria – Above 21 Years of Age or Older

10 of 25



For clients **21 years of age or older**, an MHP shall provide covered SMHS for clients who meet both of the following criteria, (1) and (2) below.

Click each number to learn more.

1 2

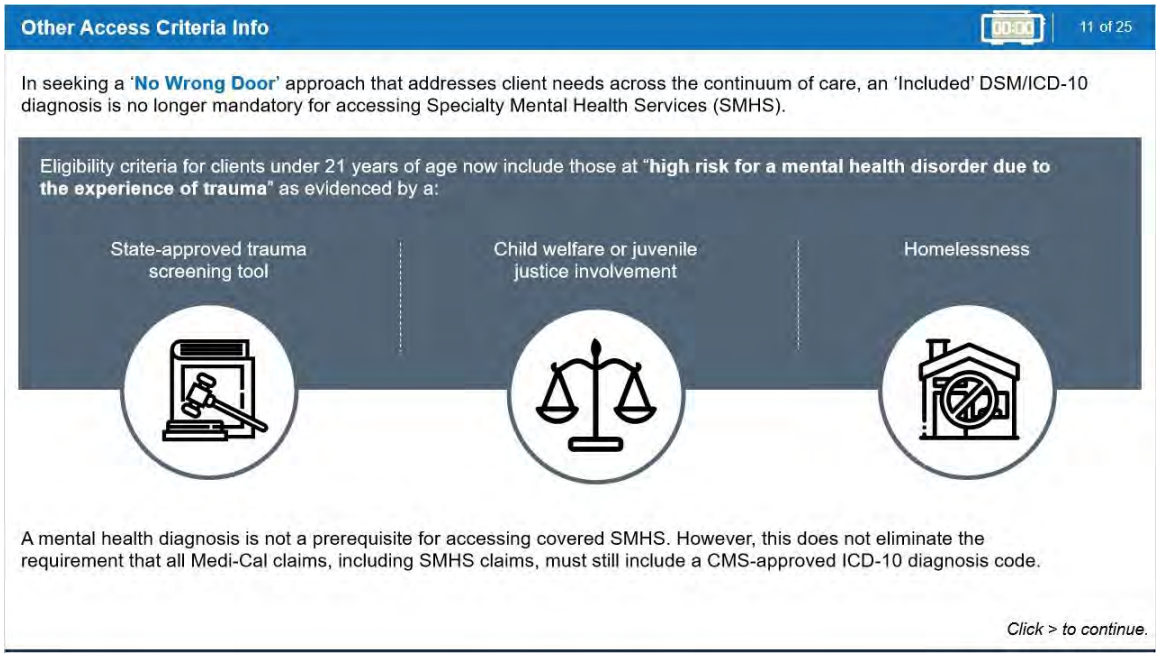
The client's condition, as described in paragraph (1), is due to either of the following:

a) a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD)

b) a suspected mental disorder that has not yet been diagnosed

Click > to continue.

2.9 Other Access Criteria Info



Notes:

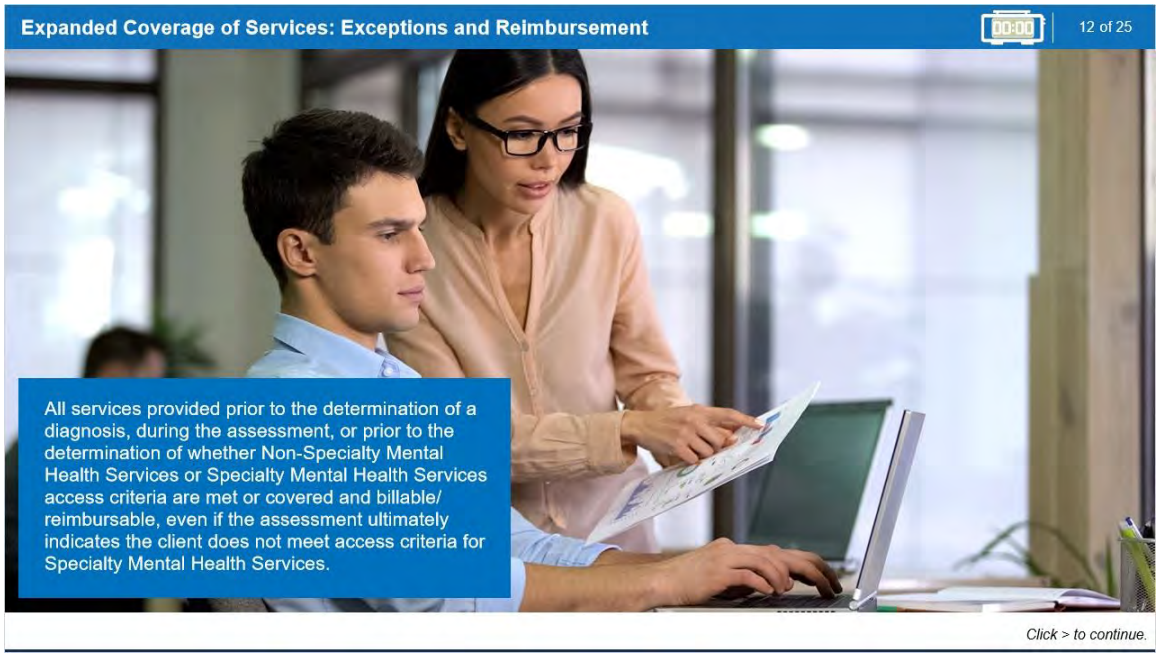
In seeking a 'No Wrong Door' approach that addresses client needs across the continuum of care, an 'Included' DSM/ICD-10 diagnosis is no longer mandatory for accessing Specialty Mental Health Services (SMHS).

Eligibility criteria for clients under 21 years of age now include those at "high risk for a mental health disorder due to the experience of trauma" as evidenced by a state-approved trauma screening tool, child welfare or juvenile justice involvement, and/or homelessness.

Importantly, a mental health diagnosis is not a prerequisite for accessing the covered SMHS.

However, this does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, must still include a CMS-approved ICD-10 diagnosis code.

2.10 Expanded Coverage of Services: Exceptions and Reimbursement



Notes:

Coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service is not excluded under any of the following circumstances:

Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.

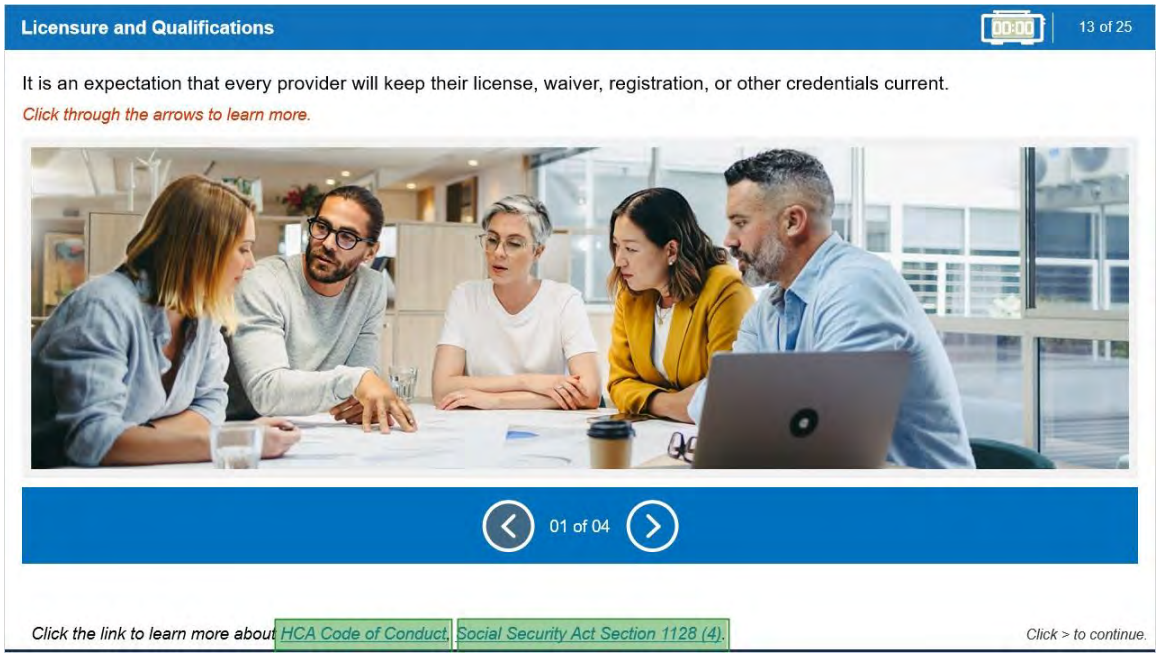
The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

The client has a co-occurring substance use disorder.

These types of claims will no longer result in disallowances.

This means all services provided prior to the determination of a diagnosis, during the assessment, or prior to the determination of whether Non-Specialty Mental Health Services or Specialty Mental Health Services access criteria are met or covered and billable/reimbursable, even if the assessment ultimately indicates the client does not meet access criteria for Specialty Mental Health Services.

2.11 Licensure and Qualifications



Notes:

It is an expectation that every provider will keep their license, waiver, registration, or other credentials current.

Providers must immediately stop providing services and notify their Supervisor if authorization lapses, as there is no ‘grace period’ allowed by California licensing bodies.

Providing and billing for services without proper credentials may result in legal and civil penalties.

Both federal and State agencies responsible for Medicare and Medi-Cal maintain lists of providers who have been excluded (those with licenses that are expired, suspended, or revoked) from participation in Medi-Cal and/or Medicare-funded programs.

Agencies have a responsibility to ensure that clinical staff are not on the excluded list.

Additionally, to avoid potential fines and penalties to the agency, it is required that any provider who is placed on one of these lists or knows they may be eligible to be placed on the lists immediately notify their Supervisor, Quality Management System (QMS), or the Office of Compliance.

Tab 01 (Slide Layer)

Licensure and Qualifications 13 of 25

It is an expectation that every provider will keep their license, waiver, registration, or other credentials current.

Click through the arrows to learn more.

Providers must immediately stop providing services and notify their Supervisor if authorization lapses, as there is no 'grace period' allowed by California licensing bodies.

Providing and billing for services without proper credentials may result in legal and civil penalties.

02 of 04

Click the link to learn more about HCA Code of Conduct, Social Security Act Section 1128 (4).

Click > to continue.

Tab 02 (Slide Layer)

Licensure and Qualifications 13 of 25

It is an expectation that every provider will keep their license, waiver, registration, or other credentials current.

Click through the arrows to learn more.

Both federal and State agencies responsible for Medicare and Medi-Cal maintain lists of providers who have been excluded (those with licenses that are expired, suspended, or revoked) from participation in Medi-Cal and/or Medicare-funded programs.

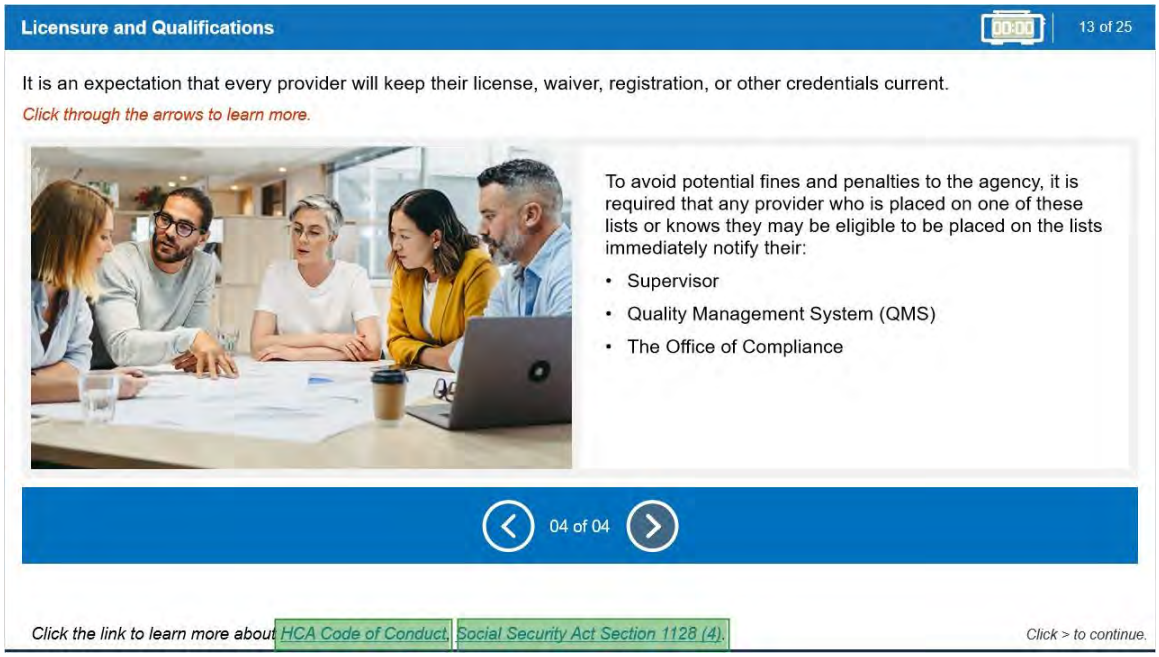
Agencies have a responsibility to ensure that clinical staff are not on the excluded list.

03 of 04

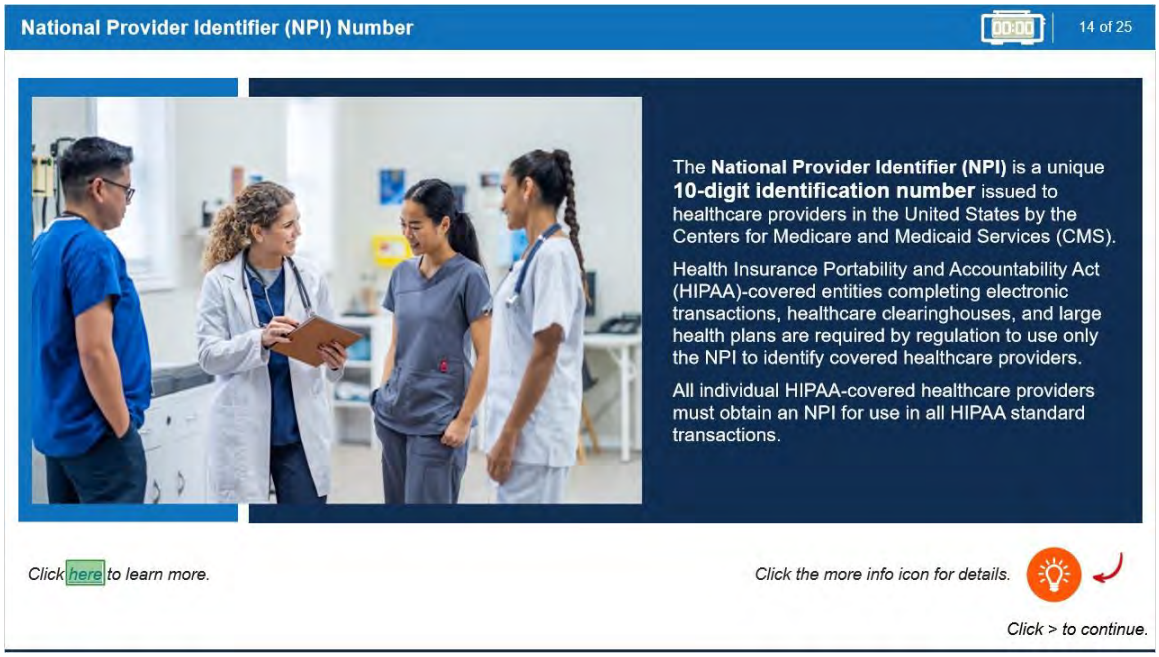
Click the link to learn more about HCA Code of Conduct, Social Security Act Section 1128 (4).

Click > to continue.

Tab 03 (Slide Layer)



2.12 National Provider Identifier (NPI) Number



Notes:

Let's now learn about the National Provider Identifier (NPI) number. The National

Provider Identifier (NPI) is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

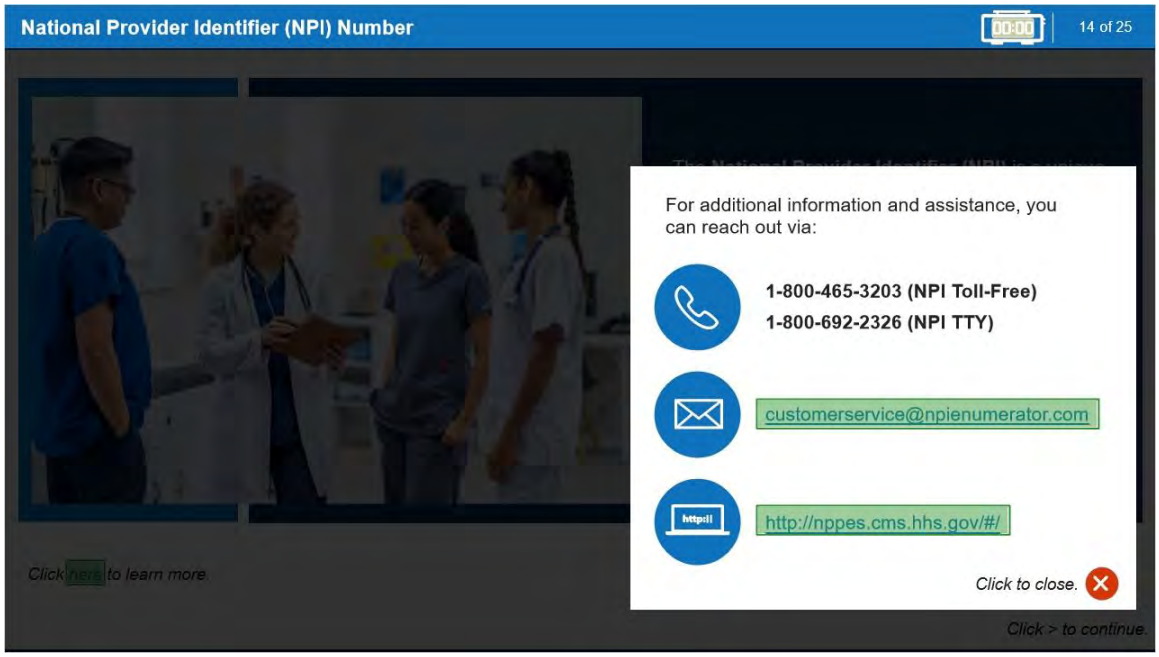
It is a permanent individual provider number.

Health Insurance Portability and Accountability Act (HIPAA)-covered entities completing electronic transactions, healthcare clearinghouses, and large health plans are required by regulation to use only the NPI to identify covered healthcare providers.

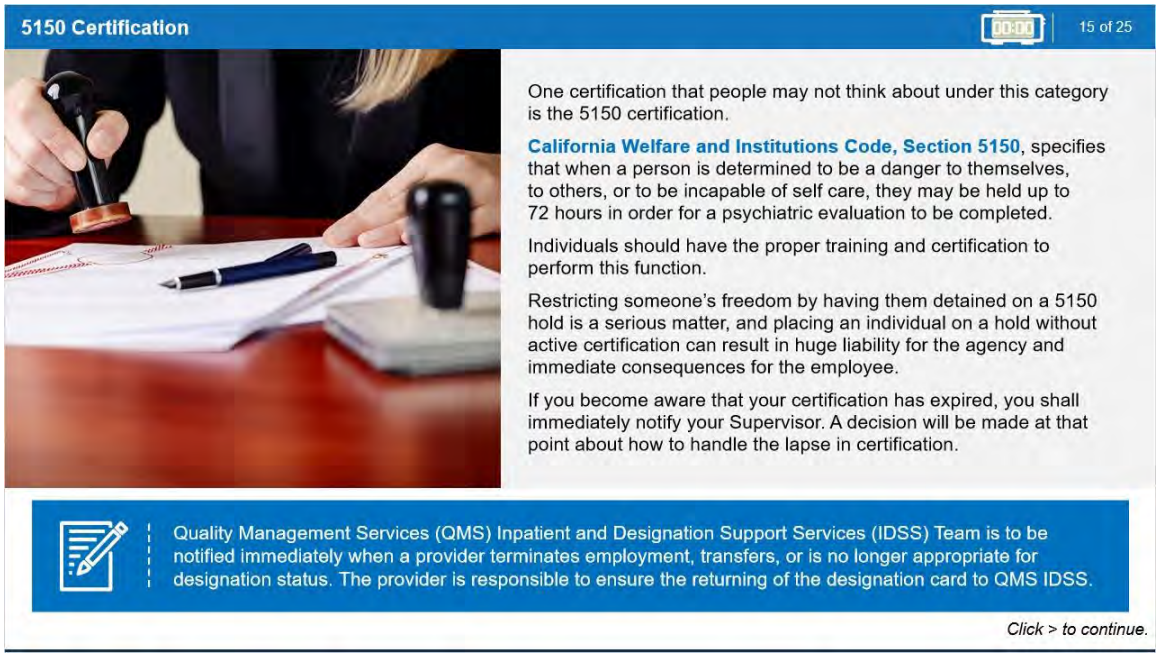
All individual HIPAA-covered healthcare providers (such as, physicians, pharmacists, physician assistants, psychologists, nurse practitioners, clinical social workers, marriage and family therapists, professional counselors, physical therapists, occupational therapists, and pharmacy technicians) must obtain an NPI for use in all HIPAA standard transactions.

For additional information and assistance, you can reach out via phone, email, or by visiting the website.

More Info (Slide Layer)



2.13 5150 Certification



Notes:

One certification that people may not think about under this category is the 5150 certification.

California Welfare and Institutions Code, Section 5150, specifies that when a person is determined to be a danger to themselves, to others, or to be incapable of self care, they may be held up to 72 hours in order for a psychiatric evaluation to be completed.

Individuals should have the proper training and certification to perform this function.

Restricting someone's freedom by having them detained on a 5150 hold is a serious matter, and placing an individual on a hold without active certification can result in huge liability for the agency and immediate consequences for the employee.

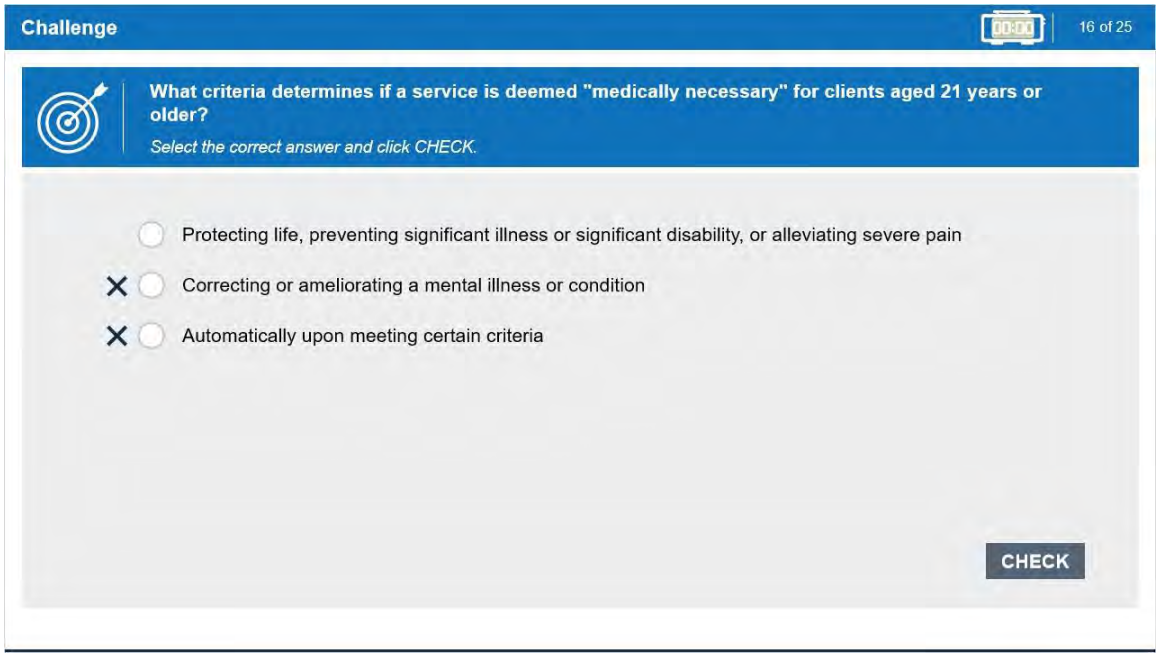
If you become aware that your certification has expired, you shall immediately notify your Supervisor. A decision will be made at that point about how to handle the lapse in certification.

Please note that Quality Management Services (QMS) Inpatient and Designation Support Services (IDSS) Team is to be notified immediately when a provider terminates employment, transfers, or is no longer appropriate for designation status.

The provider is responsible to ensure the returning of the designation card to QMS IDSS.

2.14 Challenge

(Pick One, 10 points, 1 attempt permitted)



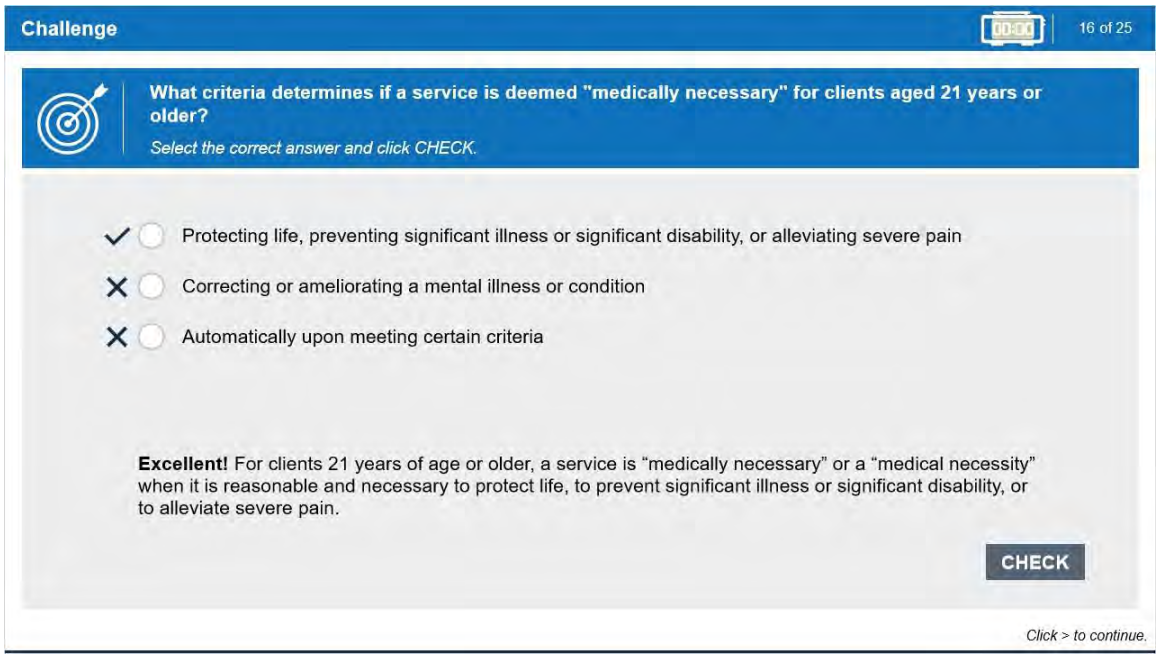
Correct	Choice
X	Protecting life, preventing significant illness or significant disability, or alleviating severe pain
	Correcting or ameliorating a mental illness or condition
	Automatically upon meeting certain criteria

Notes:

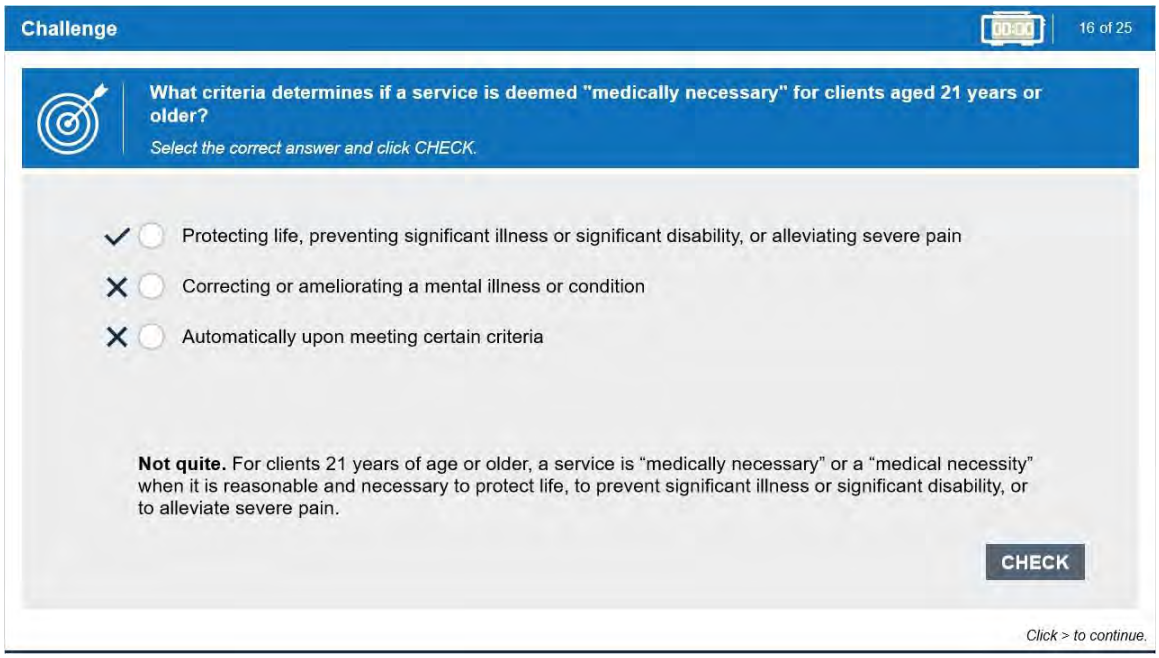
It's time for an activity.

What criteria determines if a service is deemed "medically necessary" for clients aged 21 years or older?

Correct (Slide Layer)

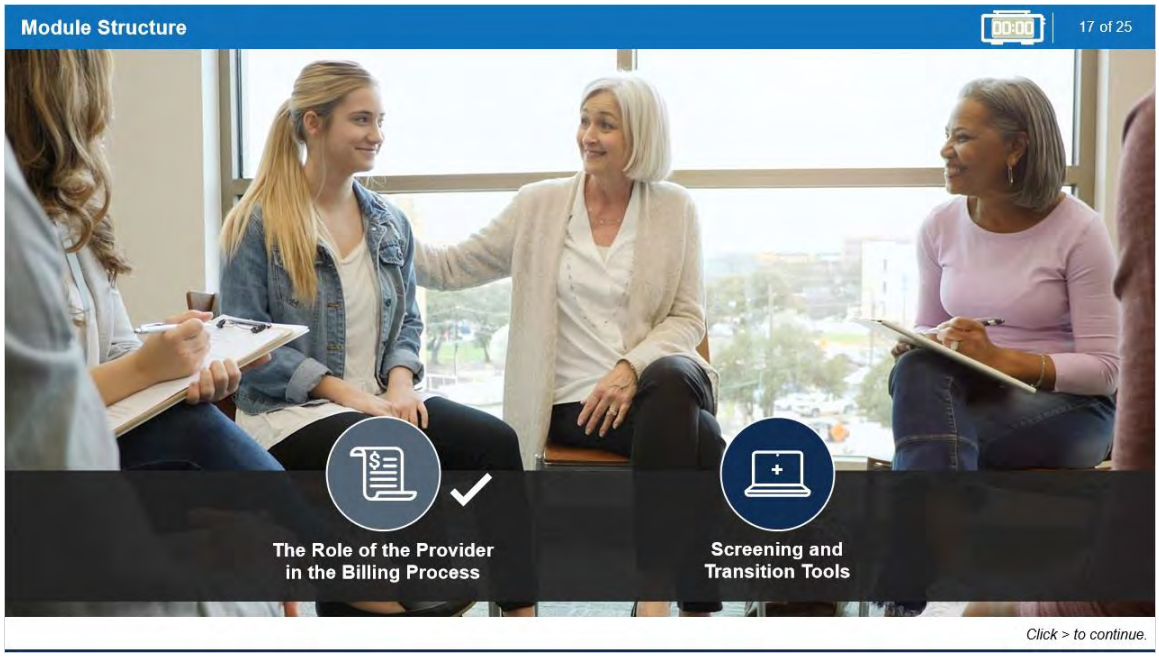


Incorrect (Slide Layer)



3. Screening and Transition Tools

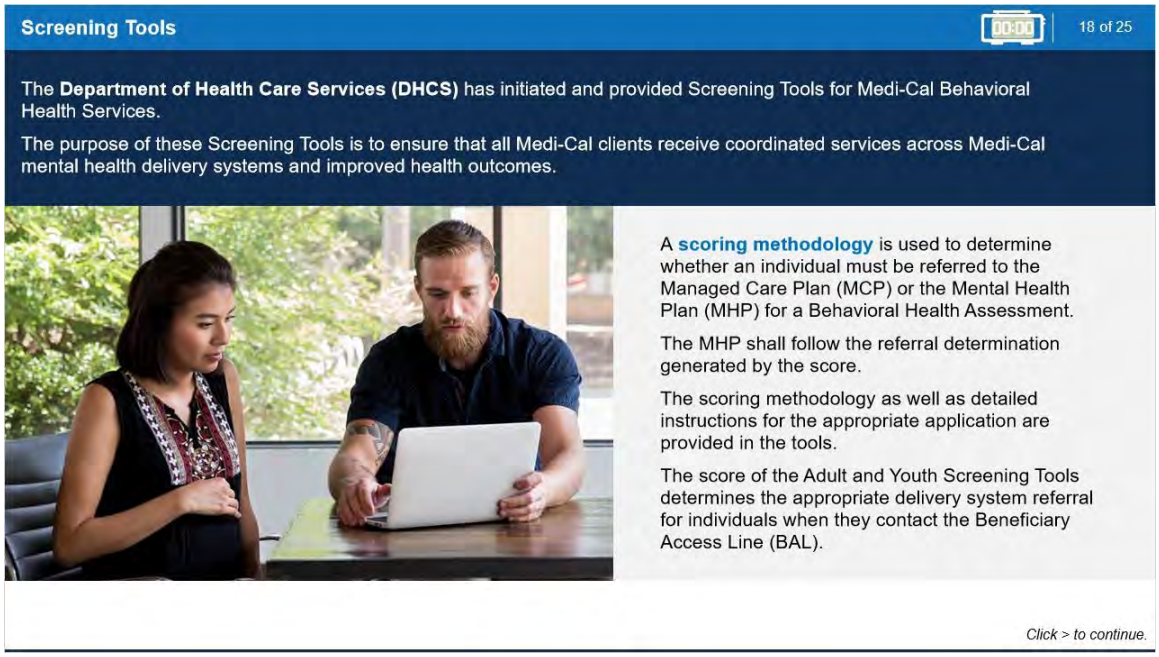
3.1 Screening and Transition Tools



Notes:

Now that we've gone through the Role of the Provider in the Billing Process, let's move on to Screening and Transition Tools.

3.2 Screening Tools



Notes:

The Department of Health Care Services (DHCS) has initiated and provided Screening Tools for Medi-Cal Behavioral Health Services.

The purpose of these Screening Tools is to ensure that all Medi-Cal clients receive coordinated services across Medi-Cal mental health delivery systems and improved health outcomes.

The Screening Tools cannot be altered, nor can additional questions be asked as part of the screening process.

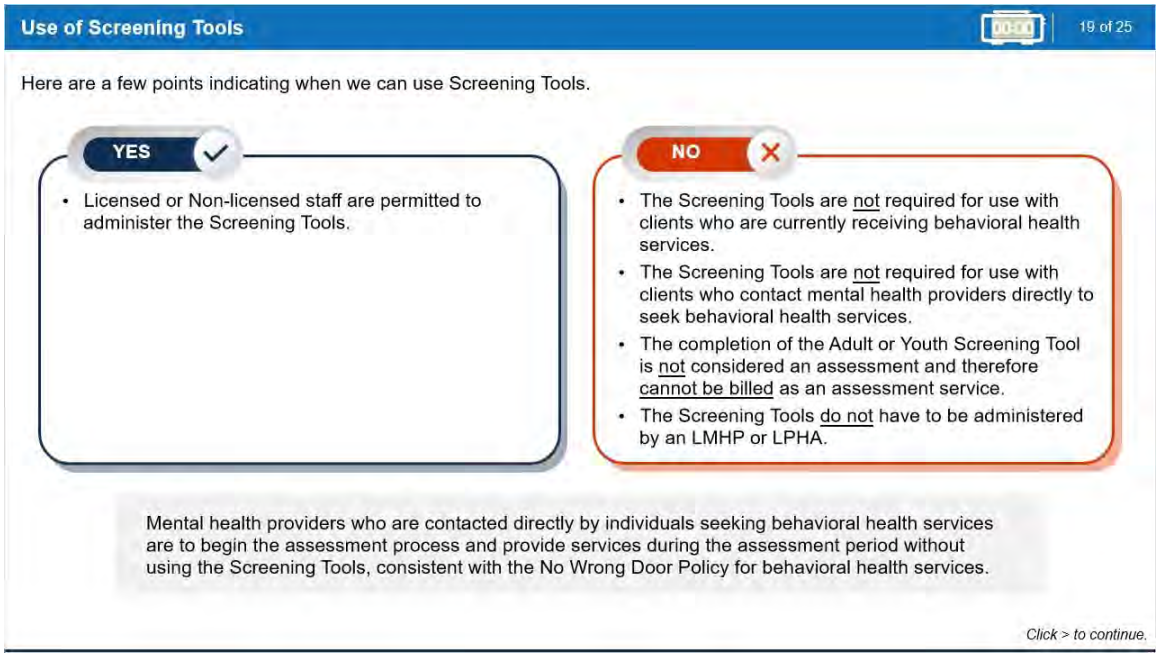
A scoring methodology is used to determine whether an individual must be referred to the Managed Care Plan (MCP) or the Mental Health Plan (MHP) for a Behavioral Health Assessment.

The MHP shall follow the referral determination generated by the score.

The scoring methodology as well as detailed instructions for the appropriate application are provided in the tools.

The score of the Adult and Youth Screening Tools determines the appropriate delivery system referral for individuals when they contact the Beneficiary Access Line (BAL).

3.3 Use of Screening Tools



Notes:

Let's learn about when we can use Screening Tools.

Licensed or Non-licensed staff are permitted to administer the Screening Tools.

The Screening Tools are not required for use with clients who are currently receiving behavioral health services.

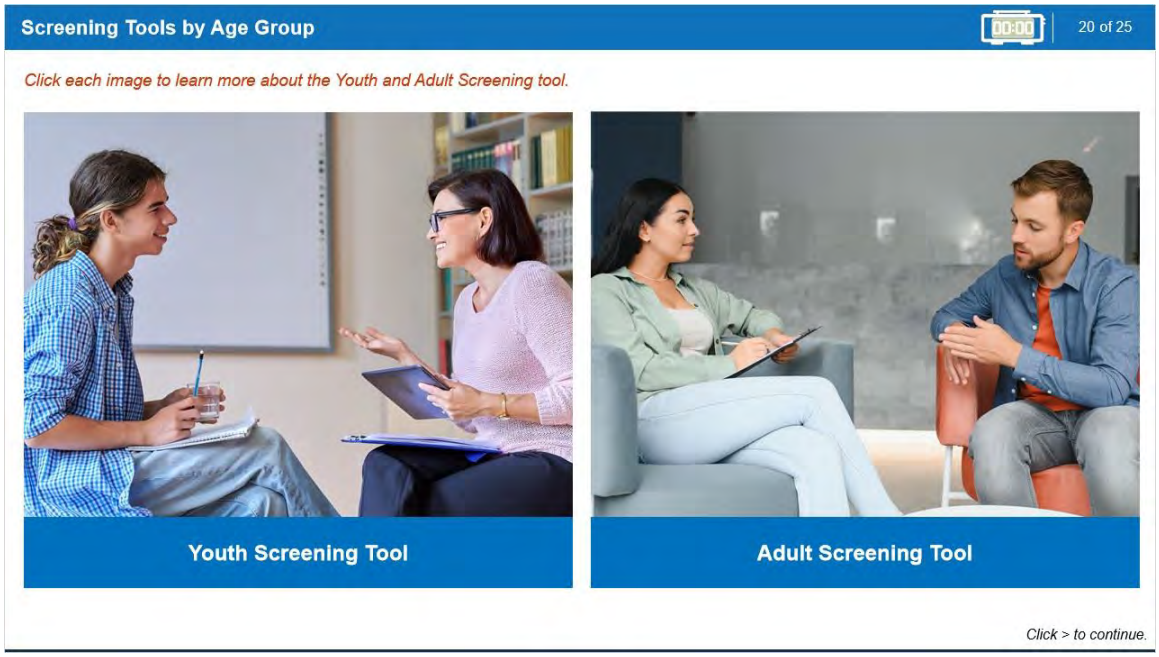
The Screening Tools are not required for use with clients who contact mental health providers directly to seek behavioral health services.

It is important to note that the completion of the Adult or Youth Screening Tool is not considered an assessment and therefore cannot be billed as an assessment service.

The Screening Tools do not have to be administered by an LMHP or LPHA.

Mental health providers who are contacted directly by individuals seeking behavioral health services are to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door Policy for behavioral health services.

3.4 Screening Tools by Age Group



Notes:

Now that you're aware of the purpose of Screening Tools, let's have a look at Screening Tools by age group.

The Youth Screening Tool is administered to all individuals under the age of 21.

The Youth Screening Tool has two versions depending on who is calling. One version is for the client if he or she is the caller. The second version is for the caregiver if he or she is calling to seek services on behalf of the client.

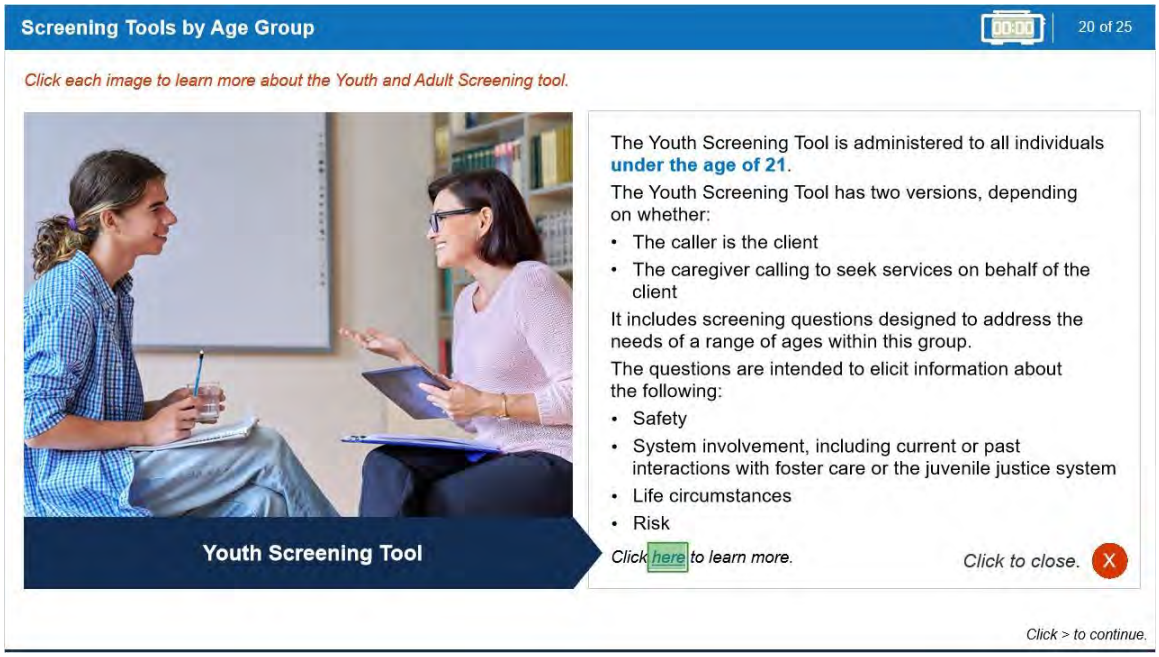
It includes screening questions designed to address the needs of a range of ages within this group.

It includes screening questions that are intended to elicit information about the individual's safety, system involvement (including current or past interactions with foster care or the juvenile justice system), life circumstances, and risk.

The Adult Screening Tool is to be administered to all individuals 21 years of age and older.

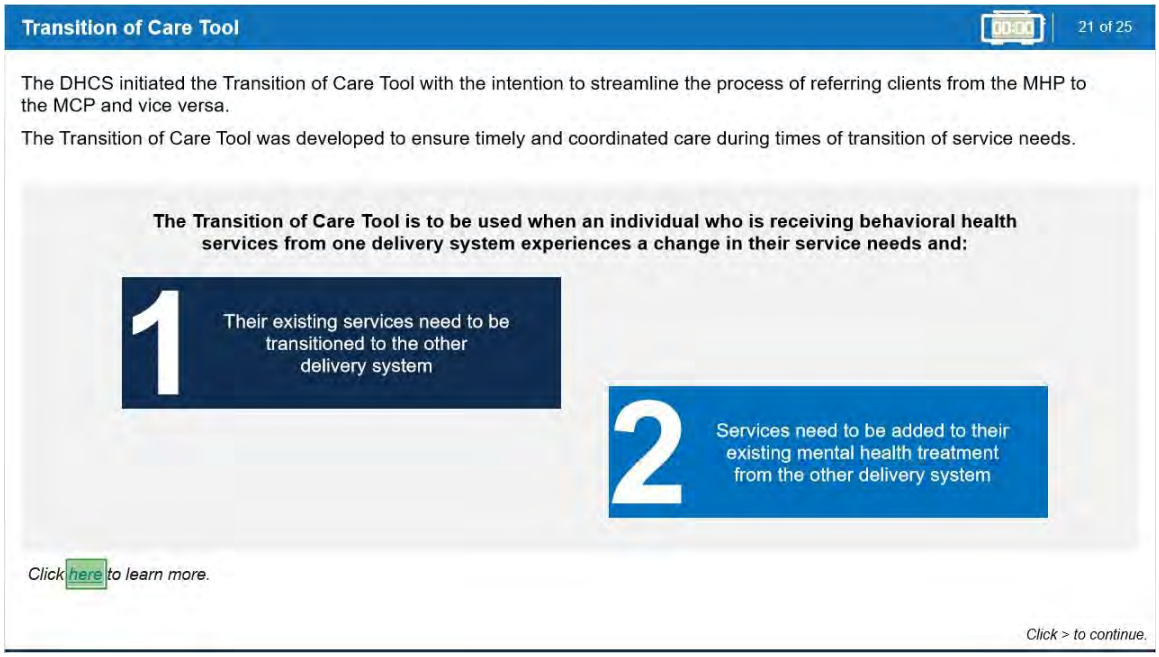
It includes screening questions that are intended to elicit information about the individual's safety, clinical experiences, life circumstances, and risk.

Youth Screening Tool (Slide Layer)



Adult Screening Tool (Slide Layer)

3.5 Transition of Care Tool



Notes:

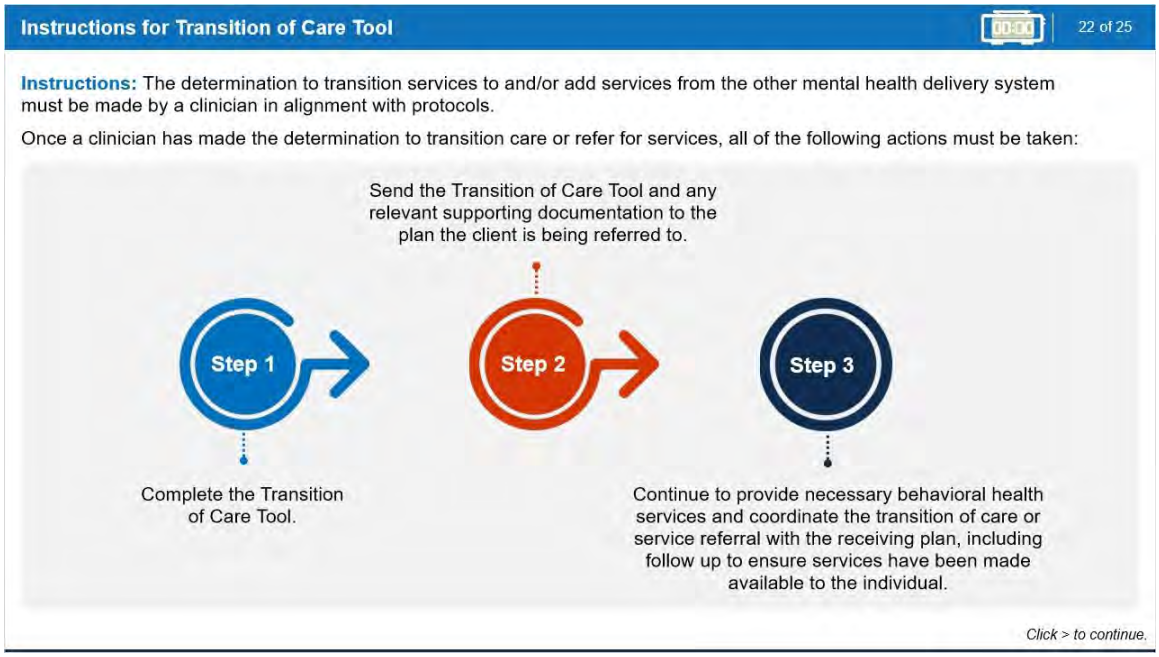
The DHCS initiated the Transition of Care Tool with the intention to streamline the process of referring clients from the MHP to the MCP and vice versa.

The Transition of Care Tool was developed to ensure timely and coordinated care during times of transition of service needs.

The Transition of Care Tool is to be used when an individual who is receiving behavioral health services from one delivery system experiences a change in their service needs and:

1. Their existing services need to be transitioned to the other delivery system, or
2. Services need to be added to their existing mental health treatment from the other delivery system.

3.6 Instructions for Transition of Care Tool



Notes:

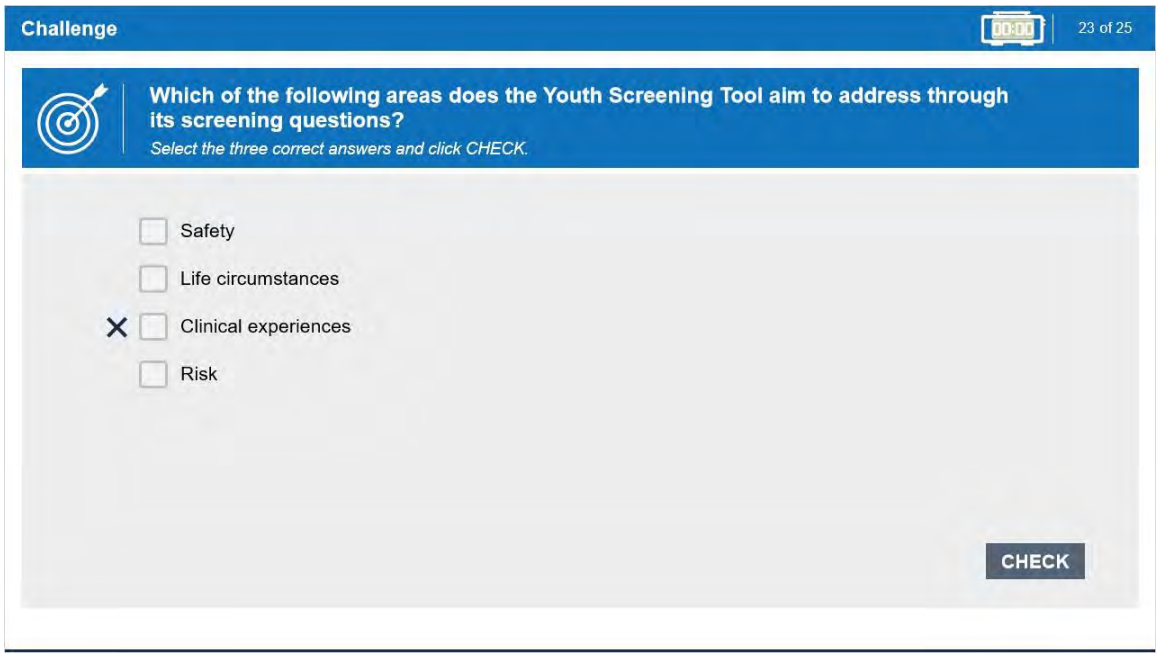
Let's now look at the instructions for the Transition of Care Tool.

The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician in alignment with protocols. Once a clinician has made the determination to transition care or refer for services, all of the following actions must be taken:

- First, complete the Transition of Care Tool,
- Then, send the Transition of Care Tool and any relevant supporting documentation to the plan the client is being referred to, and
- Finally, continue to provide necessary behavioral health services and coordinate the transition of care or service referral with the receiving plan, including follow up to ensure services have been made available to the individual.

3.7 Challenge

(Pick Many, 10 points, 1 attempt permitted)



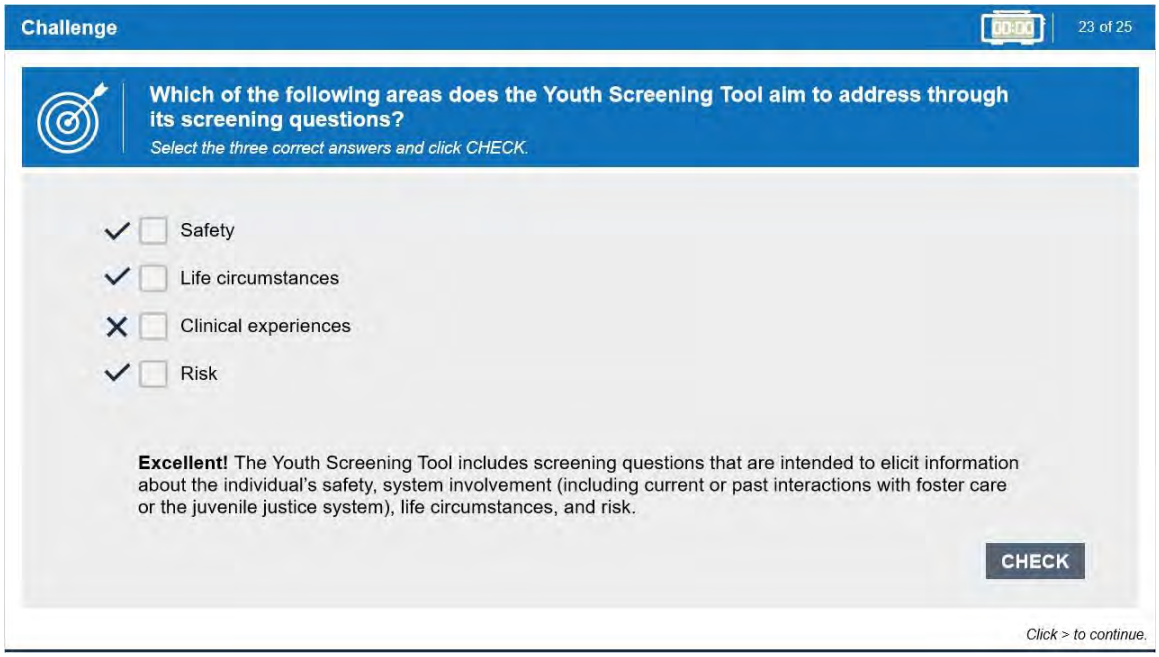
Correct	Choice
	Clinical experiences
X	Risk
X	Safety
X	Life circumstances

Notes:

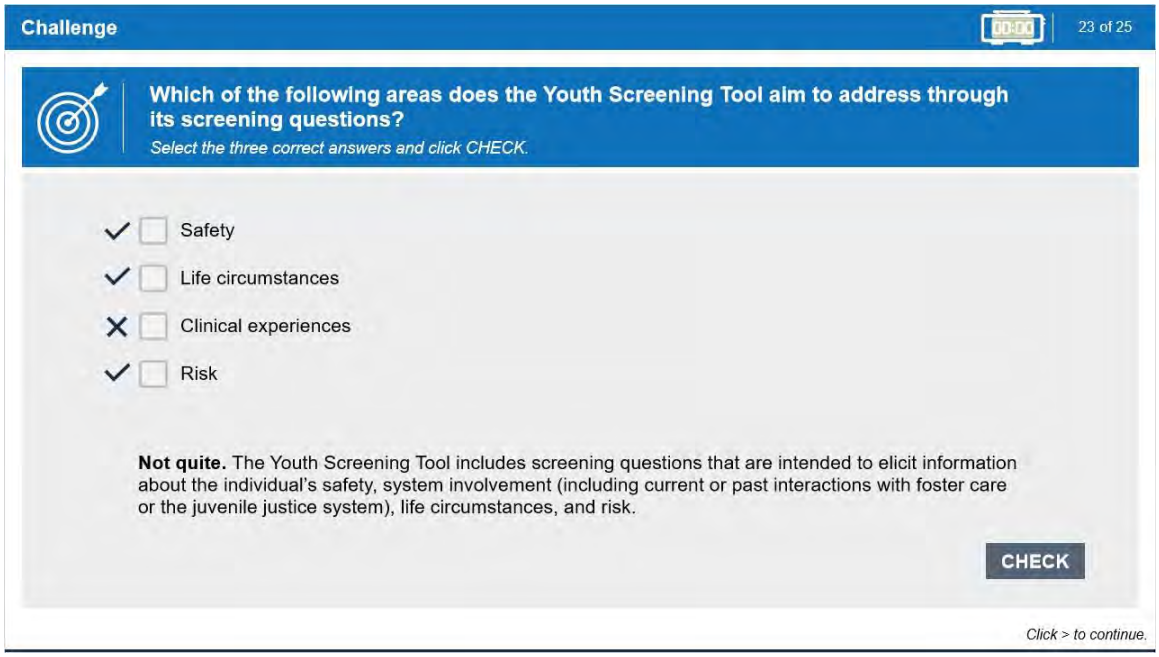
It's time for an activity.

Which of the following areas does the Youth Screening Tool aim to address through its screening questions?

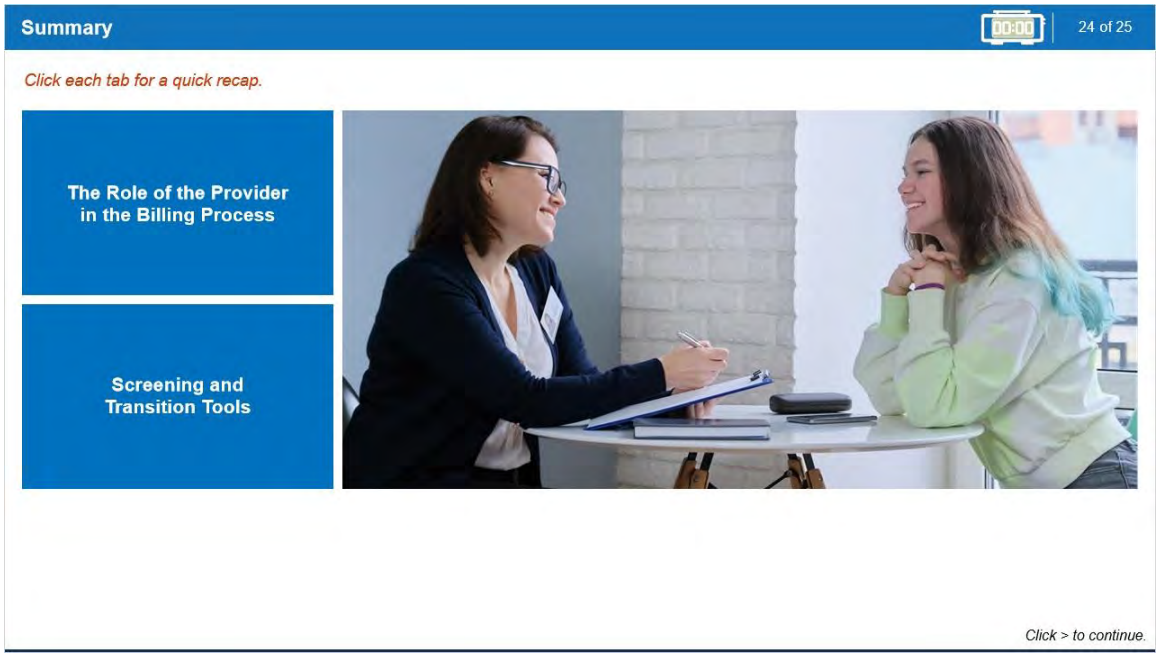
Correct (Slide Layer)



Incorrect (Slide Layer)



3.8 Summary



Notes:

We have come to the end of this module, let's summarize.

In order to qualify for MHP services, individuals must meet access criteria, as determined by the score on the Screening Tool by the Beneficiary Access Line.

Services provided to a client of any age must be medically necessary and clinically appropriate to address the client's presenting condition.

For clients under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate a mental illness or condition.

For clients 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

The purpose of these Screening Tools is to ensure that all Medi-Cal clients receive coordinated services across Medi-Cal mental health delivery systems and improved health outcomes.

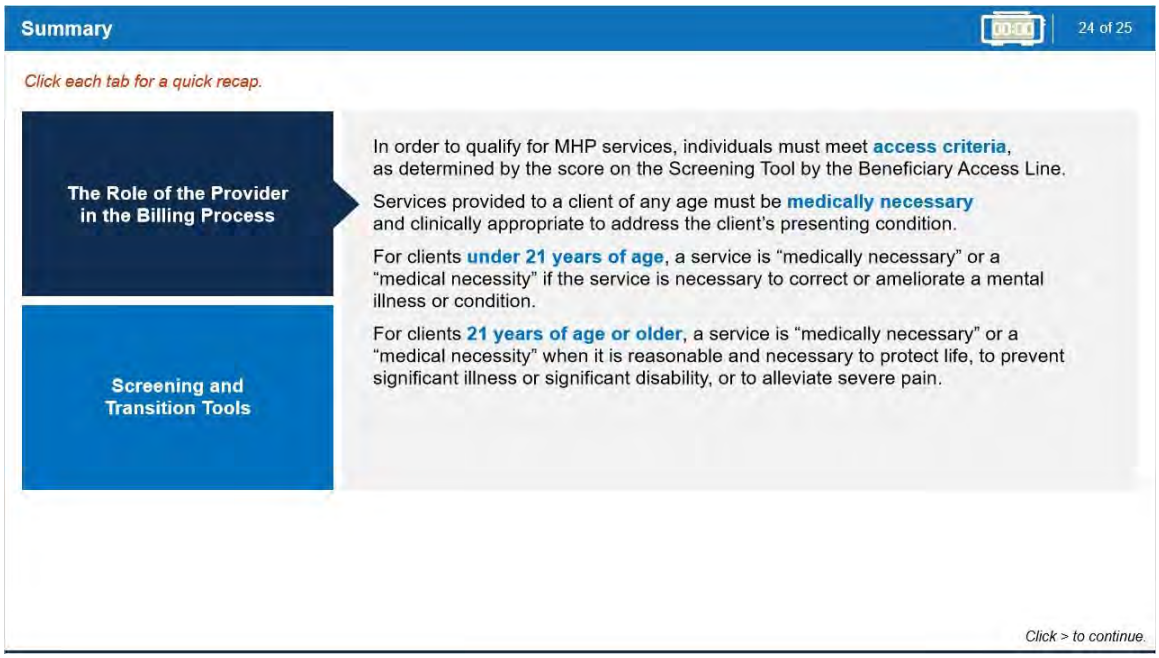
A scoring methodology is used to determine whether an individual must be referred to the Managed Care Plan (MCP) or the Mental Health Plan (MHP) for a Behavioral Health Assessment.

The Transition of Care Tool is to be used when an individual who is receiving

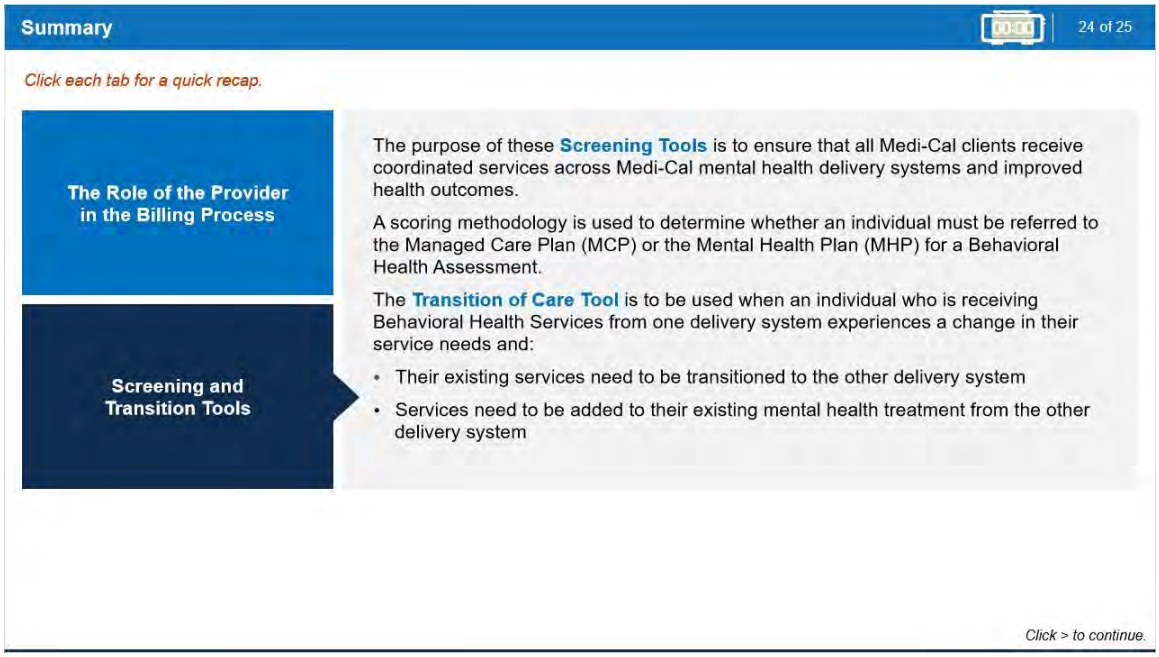
Behavioral Health Services from one delivery system experiences a change in their service needs and:

- Their existing services need to be transitioned to the other delivery system, or
- Services need to be added to their existing mental health treatment from the other delivery system.

Layer 1 (Slide Layer)



Layer 2 (Slide Layer)



3.9 Thank you

Notes:

Thank you for completing the 'Children & Youth Services Behavioral Health Services'

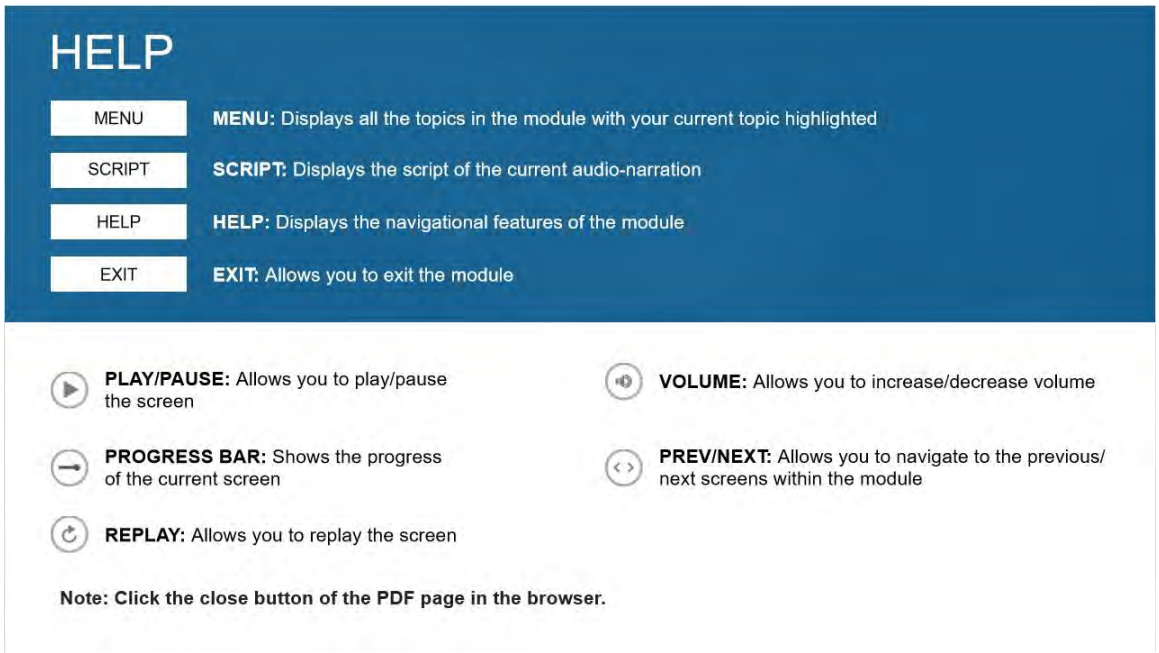
module.

In the next module ‘Children & Youth Services Documentation Standards’, you will learn about material and references to the County Electronic Health Record system that is different from County Contract clinics.

Click the link to start with the next module 'Children & Youth Services Documentation Standards'.

4. Help

4.1 Help



Notes:

Children & Youth Services Documentation Standards

1. Welcome

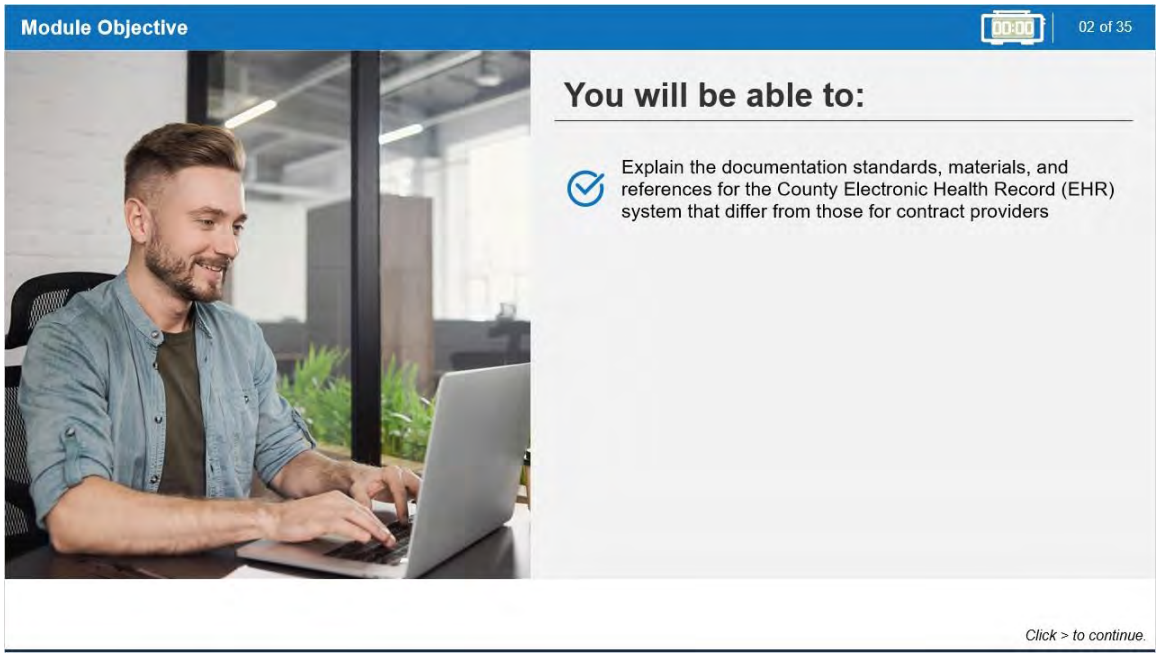
1.1 Welcome

Notes:

Welcome to the module 'Children & Youth Services Documentation Standards'.

Click the 'Help' on the top right of your screen to learn how to navigate through this module. You can proceed directly if you've been here before.

1.2 Module Objective



Notes:

So…what can you expect out of this module?

By the end of this module, you will be able to explain the documentation standards, materials, and references for the County Electronic Health Record (EHR) system that differ from those for contract providers.

1.3 Documentation Standards and Scope of Practice for Providers

Notes:

A key aspect of documentation standards as it relates to providing services is that providers must operate within their scope of practice.

As defined by the California Code of Regulations, Title 9, and the Mental Health Plan, Scope of practice refers to the range of activities and services licensed professionals may do in their licensed practice. It is expected that, within their scope of practice, professionals will provide those services for which they have been adequately trained.

Waivered or Registered Mental Health Professionals may direct services, but only under the supervision of a Licensed Mental Health Professional (LMHP).

Mental Health Rehabilitation Specialists (MHRS), under LMHP direction, may provide behavioral health services, including contributing to assessment, but cannot provide psychotherapy services. They can offer Targeted Case Management, Crisis Intervention, and Rehabilitation Services.

It is important to remember that Rehabilitation Specialists are commonly known as 'Mental Health Rehab Specialists and Mental Health Specialists'.

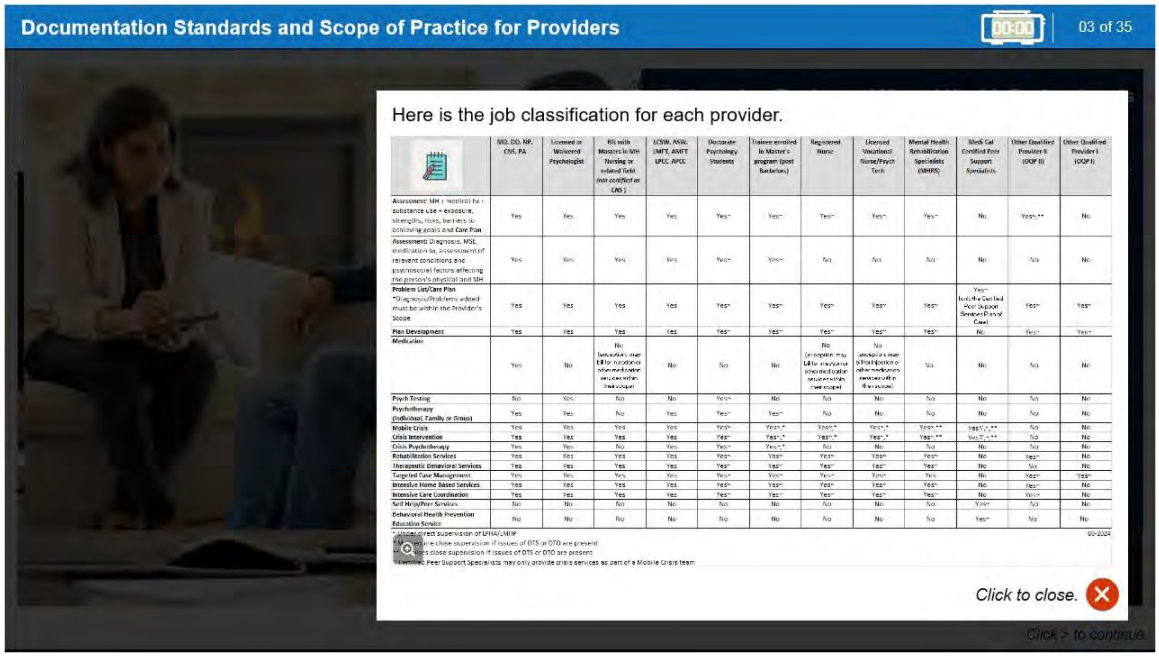
Displayed here is the job classification for each provider. Take a minute to go through it.

Providers whose job classification is not listed here should consult with their

Supervisor and QMS prior to completing any documentation.

Providers are expected to refer to the Coding and Documentation Manuals and consult with their Supervisors and/or QMS for more information and clarity about what services they may legally and ethically provide.

More Info (Slide Layer)

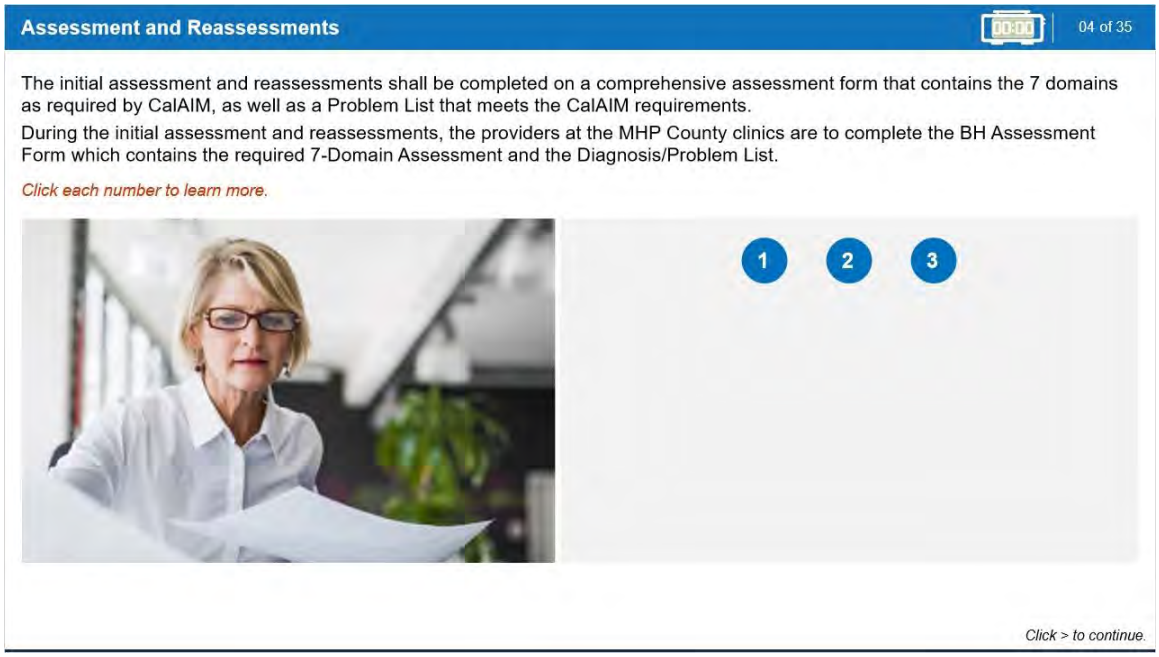


	MD, DO, NP, CNS, PA	Licensed or Waivered Psychologist	RN with Masters in MH Nursing or related field (not certified as CNS)	LCSW, ASW, LMFT, AMFT LPCC, APCC	Doctorate Psychology Students	Trainee enrolled in Master's program (post Bachelors)	Registered Nurse	Licensed Vocational Nurse/Psych Tech	Mental Health Rehabilitation Specialists (MHRS)	Medi-Cal Certified Peer Support Specialists	Other Qualified Provider II (OQP II)	Other Qualified Provider I (OQP I)
Assessment: MH (medical be substance use + exposure, strengths, risks, barriers to achieving goals and **Care Plan**	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	No	Yes*,**	No
Assessment: Diagnosis, MSE, medication hx, assessment of relevant conditions and psychosocial factors effecting the person's physical and MH	Yes	Yes	Yes	Yes	Yes*	Yes*	No	No	No	No	No	No
Problem List/Care Plan *Diagnosis/Problems added must be within the Providers Scope	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	Yes* for the Certified Peer Support Services Plan of Care	Yes*	Yes*
Plan Development	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	No	Yes*	Yes*
Medication	Yes	No	No (education, medication or other medication services within their scope)	No	No	No	No (exception: may utilize medication or other medication services within their scope)	No (exception: may utilize medication or other medications services within their scope)	No	No	No	No
Psych Testing	No	Yes	No	No	Yes*	No	No	No	No	No	No	No
Psychotherapy (Individual, Family or Group)	Yes	Yes	No	Yes	Yes*	Yes*	No	No	No	No	No	No
Mobile Crisis	Yes	Yes	Yes	Yes	Yes*	Yes*,*	Yes*,**	Yes*,*	Yes*,**	Yes*,*,**	No	No
Crisis Intervention	Yes	Yes	Yes	Yes	Yes*	Yes*,*	Yes*,*	Yes*,*	Yes*,**	Yes*,*,**	No	No
Crisis Psychotherapy	Yes	Yes	No	Yes	Yes*	Yes*,*	No	No	No	No	No	No
Rehabilitation Services	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	No	Yes*	No
Therapeutic Behavioral Services	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	No	No	No
Targeted Case Management	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes	No	Yes*	Yes*
Intensive Home Based Services	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	No	Yes*	No
Intensive Care Coordination	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	No	Yes*	No
Turf Help/Peer Services	No	No	No	No	No	No	No	No	No	Yes*	No	No
Behavioral Health Prevention Education Service	No	No	No	No	No	No	No	No	No	Yes*	No	No

*Under direct supervision of LPHA/LMHP
**Require close supervision if issues of DTS or DTD are present
***Requires close supervision if issues of DTS or DTD are present
****Certified Peer Support Specialists may only provide crisis services as part of a Mobile Crisis team

01-2024

1.4 Assessment and Reassessments



Notes:

The initial assessment and reassessments shall be completed on a comprehensive assessment form that contains the 7 domains as required by CalAIM, as well as a Problem List that meets the CalAIM requirements.

During the initial assessment and reassessments, the providers at the MHP County clinics are to complete the BH Assessment Form which contains the required 7-Domain Assessment and the Diagnosis/Problem List.

According to Orange County's MHP, an initial assessment should be completed as expeditiously as possible, in accordance with each client's clinical needs and generally accepted standards of practice.

Reassessments are to be completed based on clinical discretion, but at minimum to be completed every 3 years from the last assessment or reassessment.

Certain programs may have earlier timeline requirements based on the program's needs (i.e., crisis programs and short-term programs). If your program has these earlier requirements, please include your timelines in writing in your policies and procedures.

It is expected that reassessments will include progress towards treatment and objectives on the last plan, significant changes and achievements since the last assessment, and newly identified impairments, symptoms, and/or Social Drivers of

Health.

T1 (Slide Layer)

Assessment and Reassessments 04 of 35

The initial assessment and reassessments shall be completed on a comprehensive assessment form that contains the 7 domains as required by CalAIM, as well as a Problem List that meets the CalAIM requirements.

During the initial assessment and reassessments, the providers at the MHP County clinics are to complete the BH Assessment Form which contains the required 7-Domain Assessment and the Diagnosis/Problem List.

Click each number to learn more.

1 2 3

According to Orange County's MHP, an initial assessment should be completed as expeditiously as possible, in accordance with each client's clinical needs and generally accepted standards of practice.

Click > to continue.

T2 (Slide Layer)

Assessment and Reassessments 04 of 35

The initial assessment and reassessments shall be completed on a comprehensive assessment form that contains the 7 domains as required by CalAIM, as well as a Problem List that meets the CalAIM requirements.

During the initial assessment and reassessments, the providers at the MHP County clinics are to complete the BH Assessment Form which contains the required 7-Domain Assessment and the Diagnosis/Problem List.

Click each number to learn more.

1 2 3

Reassessments are to be completed based on clinical discretion, but at minimum to be completed every 3 years from the last assessment or reassessment.

Certain programs may have earlier timeline requirements based on the program's needs (i.e., crisis programs and short-term programs).

Click > to continue.

T3 (Slide Layer)

Assessment and Reassessments 04 of 35

The initial assessment and reassessments shall be completed on a comprehensive assessment form that contains the 7 domains as required by CalAIM, as well as a Problem List that meets the CalAIM requirements.

During the initial assessment and reassessments, the providers at the MHP County clinics are to complete the BH Assessment Form which contains the required 7-Domain Assessment and the Diagnosis/Problem List.

Click each number to learn more.

1 2 3

It is expected that reassessments will include progress towards treatment and objectives on the last plan, significant changes and achievements since the last assessment, and newly identified impairments, symptoms, and/or Social Drivers of Health.

Click > to continue.

1.5 Components of a Behavioral Health (BH) Assessment

Components of a Behavioral Health (BH) Assessment 05 of 35

The CalAIM documentation standards dictate 7 domains that are required to be part of the assessment.

Domain 1
- Presenting Problem(s)
- Current Mental Status
- History of Presenting Problem(s)
- Member-Identified Impairment(s)

Domain 2
- Trauma

Domain 3
- Behavioral Health History
- Co-occurring Substance Use

Domain 4
- Medical History
- Current Medications
- Co-occurring Conditions (other than substance use)

Domain 5
- Social and Life Circumstances
- Culture/Religion/ Spirituality

Domain 6
- Strengths, Risk Behaviors, and Protective Factors

Domain 7
- Clinical Summary and Recommendations
- Diagnostic Impression
- Medical Necessity Determination/Level of Care/Access Criteria

Click > to continue.

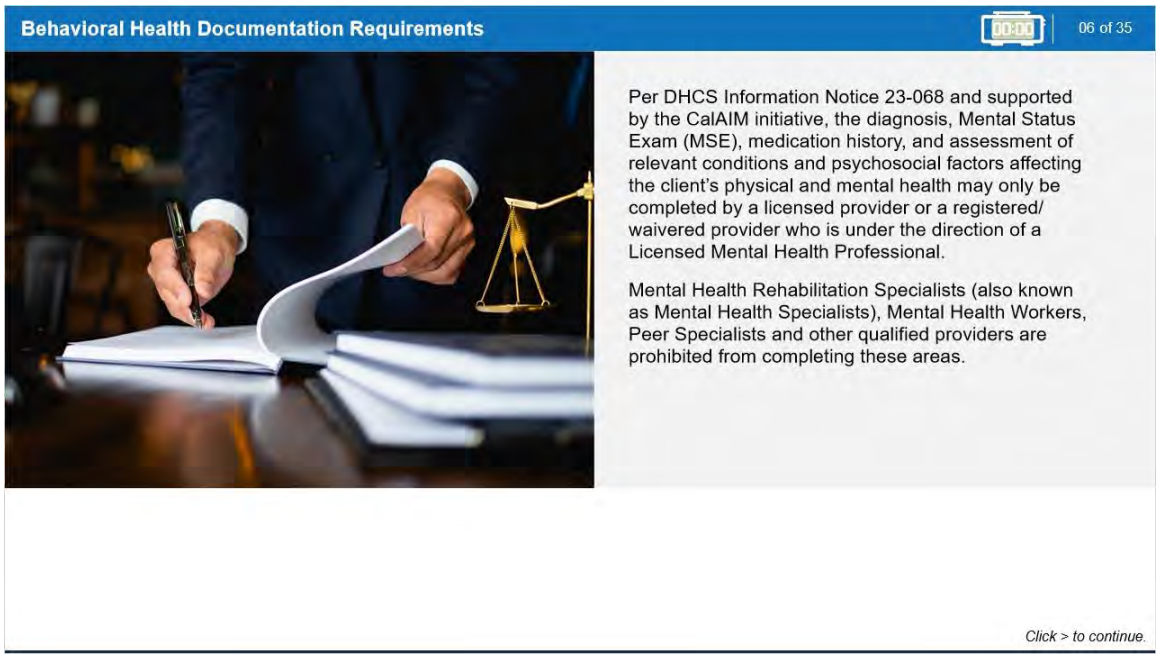
Notes:

The CalAIM documentation standards dictate 7 domains that are required to be part

of the assessment.

Take a minute to go through the 7 domains.

1.6 Behavioral Health Documentation Requirements



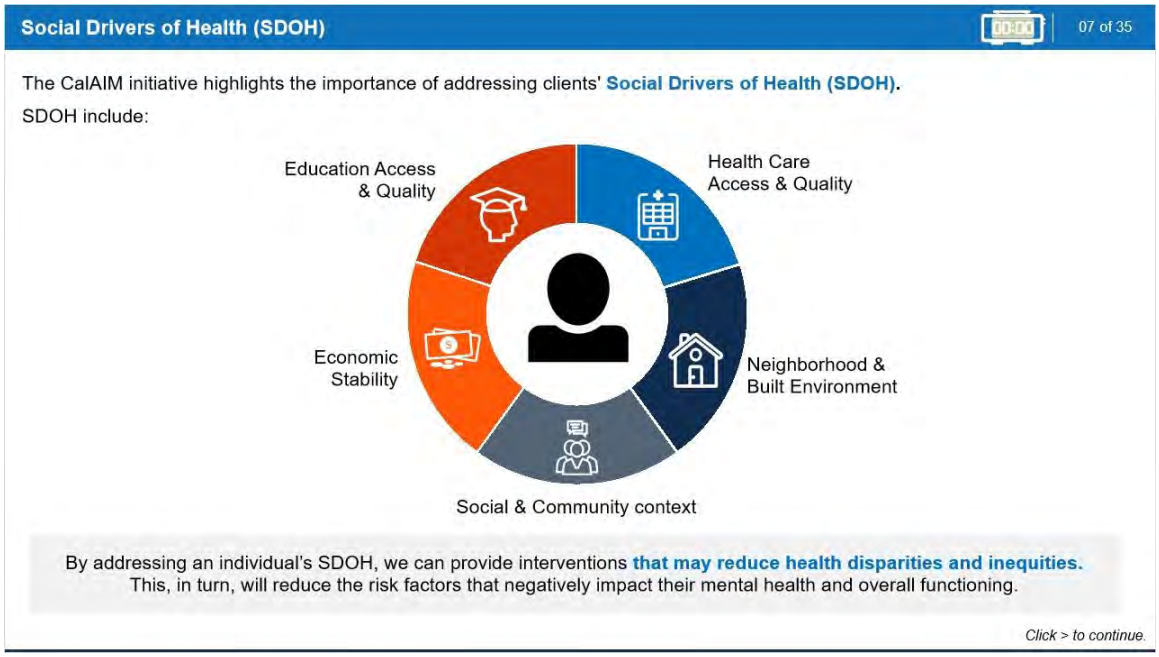
Notes:

Per DHCS Information Notice 23-068 and supported by the CalAIM initiative, the diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the client's physical and mental health may only be completed by a licensed provider or a registered/waivered provider who is under the direction of a Licensed Mental Health Professional.

Mental Health Rehabilitation Specialists (also known as Mental Health Specialists), Mental Health Workers, Peer Specialists and other qualified providers are prohibited from completing these areas.

However, the MHP may designate certain other qualified providers to contribute to the assessment, including gathering the client's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

1.7 Social Drivers of Health (SDOH)



Notes:

The CalAIM initiative highlights the importance of addressing clients' Social Drivers of Health (SDOH).

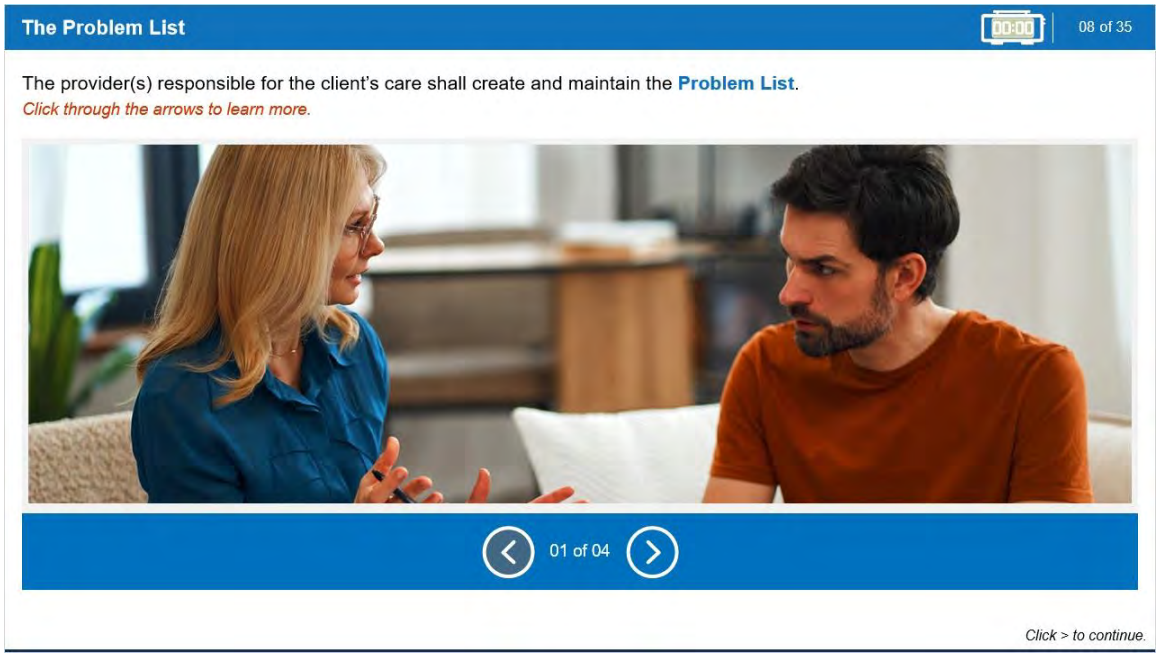
SDOH include:

- Education access and quality,
- Health care access and quality,
- Neighborhood and built environment,
- Social and community context, and
- Economic stability.

By addressing an individual's SDOH, we can provide interventions that may reduce health disparities and inequities.

This, in turn, will reduce the risk factors that negatively impact their mental health and overall functioning.

1.8 The Problem List



Notes:

The provider(s) responsible for the client's care shall create and maintain the Problem List.

The Problem List should include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) should be included with the diagnosis when applicable.
- Current International Classification of Diseases (ICD) Clinical Modification (CM) codes
- Any problems identified by a provider acting within their scope of practice, if any.
- Problems identified by the member and/or significant support person, if any.
- Include the name and title of the provider who identified, added, or removed the diagnosis/problem, along with the date when the problem was identified, added, or resolved.

The Problem List should be updated as clinically appropriate on an ongoing basis, or at least during reassessments, to reflect the current presentation of the client as the Problem List informs treatment.

Tab 01 (Slide Layer)

The Problem List 08 of 35

The provider(s) responsible for the client's care shall create and maintain the **Problem List**.

Click through the arrows to learn more.

The Problem List should include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) should be included with the diagnosis when applicable.
- Current International Classification of Diseases (ICD) Clinical Modification (CM) codes.
- Any problems identified by a provider acting within their scope of practice, if any.

02 of 04

Click > to continue.

Tab 02 (Slide Layer)

The Problem List 08 of 35

The provider(s) responsible for the client's care shall create and maintain the **Problem List**.

Click through the arrows to learn more.

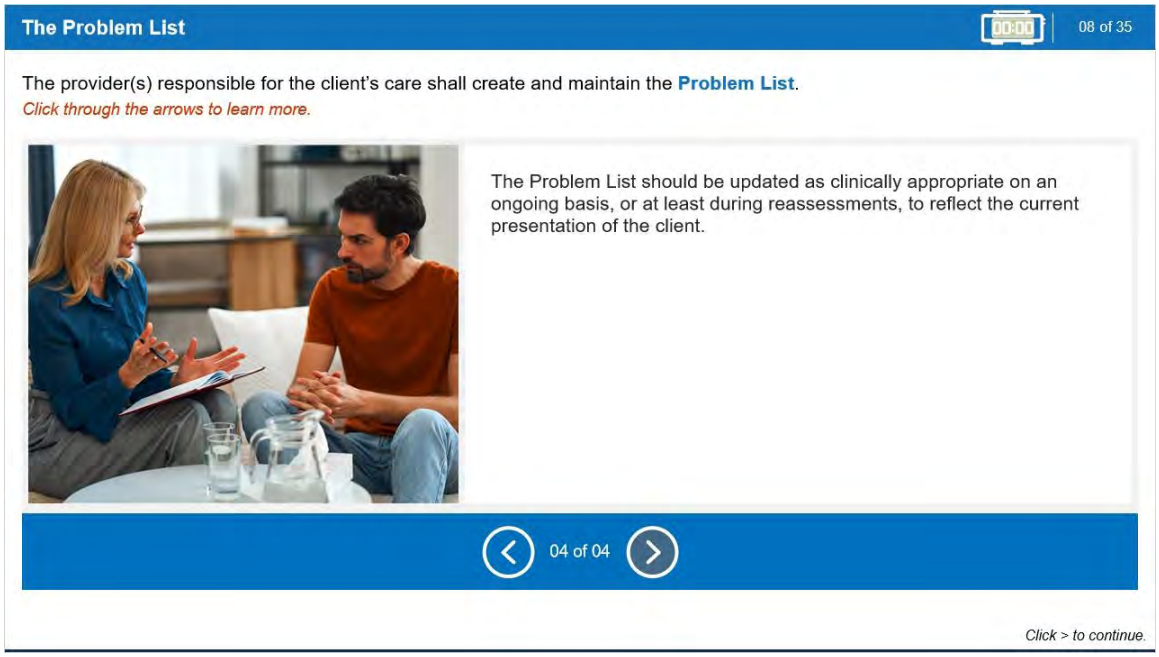
The Problem List should include, but is not limited to, the following:

- Problems identified by the member and/or significant support person, if any.
- Include the name and title of the provider who identified, added, or removed the diagnosis/problem, along with the date when the problem was identified, added, or resolved.

03 of 04

Click > to continue.

Tab 03 (Slide Layer)



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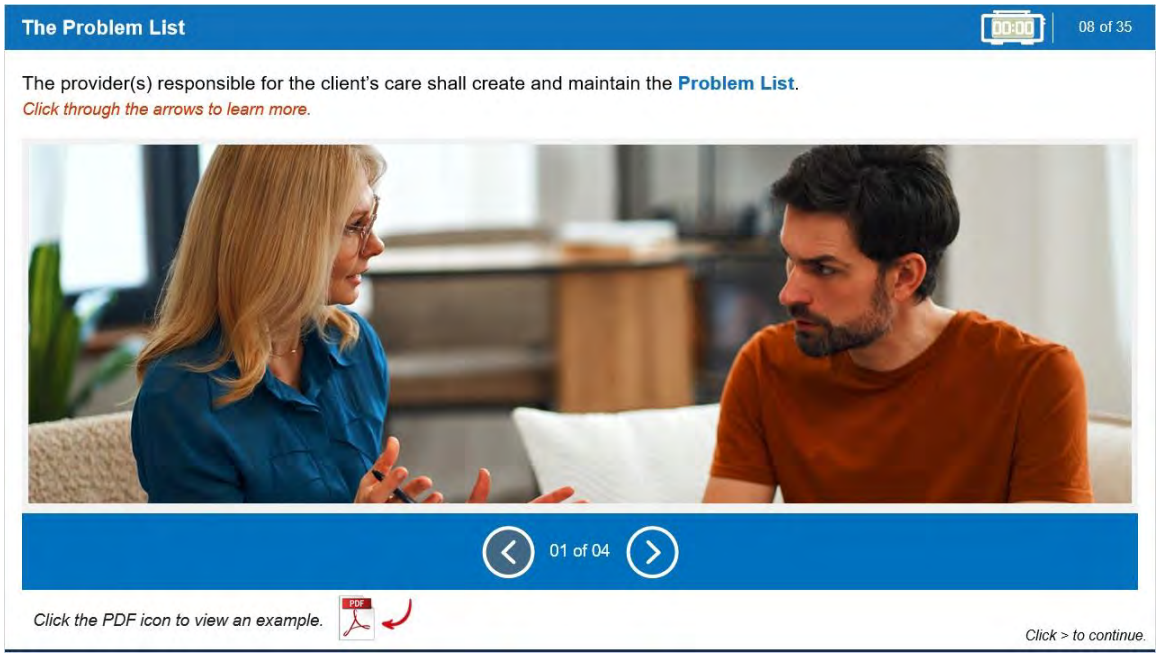
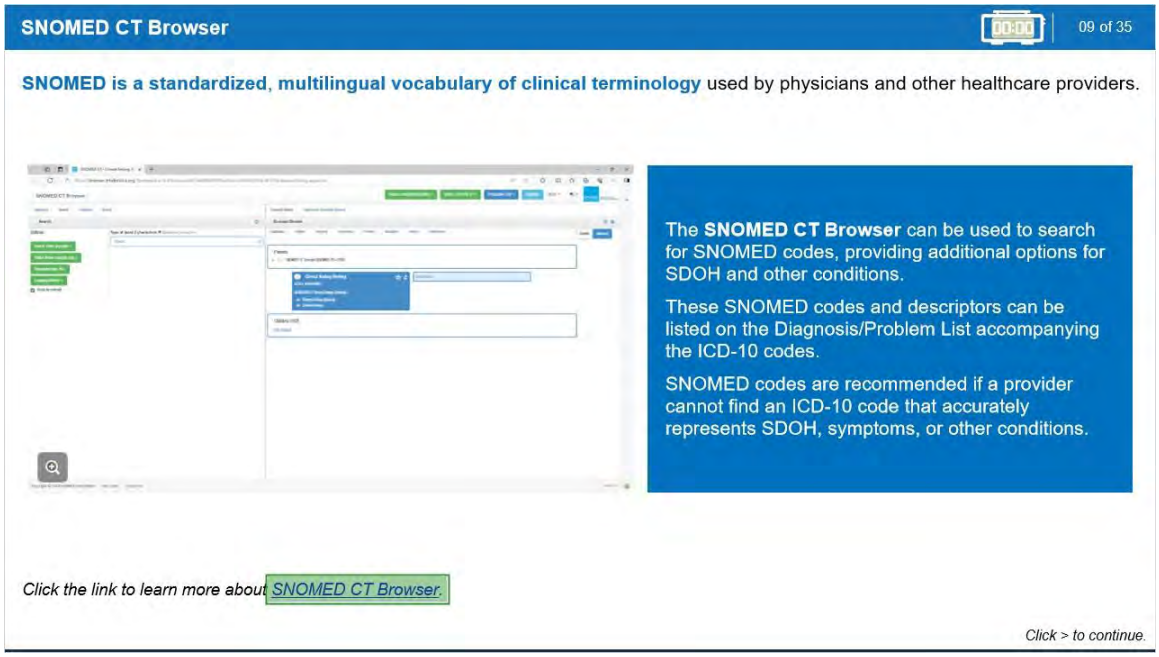


1.9 SNOMED CT Browser



Notes:

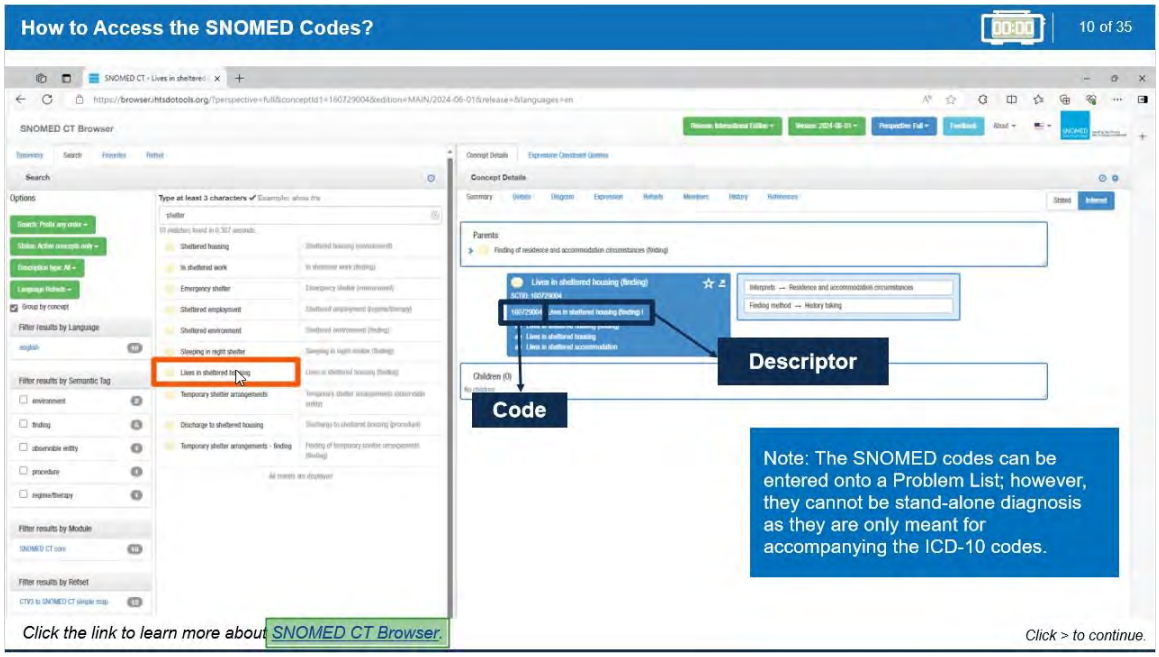
SNOMED is a standardized, multilingual vocabulary of clinical terminology used by physicians and other healthcare providers.

The SNOMED CT Browser can be used to search for SNOMED codes, providing additional options for SDOH and other conditions.

These SNOMED codes and descriptors can be listed on the Diagnosis/Problem List accompanying the ICD-10 codes.

SNOMED codes are to be used if a provider is unable to find an ICD-10 code that accurately represents SDOH, symptoms, or other conditions.

1.10 How to Access the SNOMED Codes?



Notes:

To access the SNOMED Terminology Website, the first step is to type or paste the SNOMED search engine link into the browser.

Or click the link displayed on the screen.

On the landing page of the SNOMED CT Browser, the provider can search for and choose a social determinant and/or other condition.

For example, type "shelter" in the Search field.

Based on your search data, the page is displayed here.

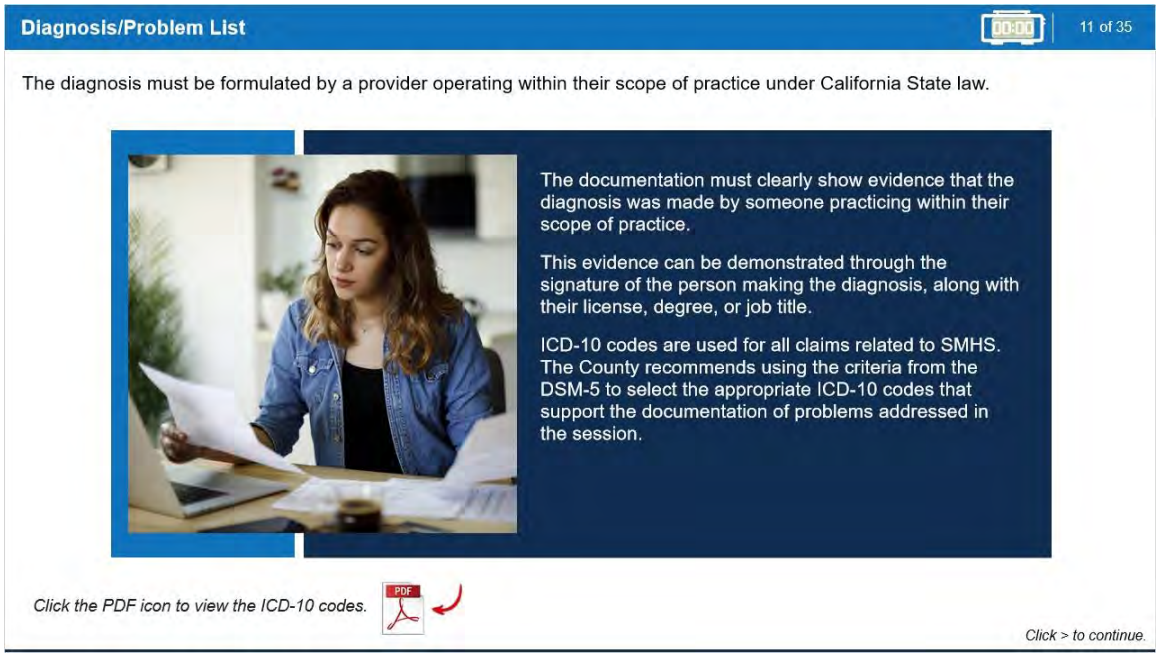
Select 'Lives in sheltered housing' from the list.

The next step is to choose the most appropriate code and type the code and descriptor onto the Diagnosis/Problem List.

Please note that SNOMED codes can be entered onto a Problem List; however, they cannot be stand-alone diagnosis as they are only meant for accompanying the ICD-10 codes.

ICD-10 codes remain the primary billing diagnosis.

1.11 Diagnosis or Problem List



Notes:

The diagnosis must be formulated by a provider operating within their scope of practice under California State law.

The documentation must clearly show evidence that the diagnosis was made by someone practicing within their scope of practice.

This evidence can be demonstrated through the signature of the person making the diagnosis, along with their license, degree, or job title.

It is important to remember that ICD-10 codes are used for all claims related to SMHS. However, the County recommends using the criteria from the DSM-5 to select the appropriate ICD-10 codes that support the documentation of problems addressed in the session.

The Problem List shall support the medical necessity of each service provided.

1.12 Care Plan

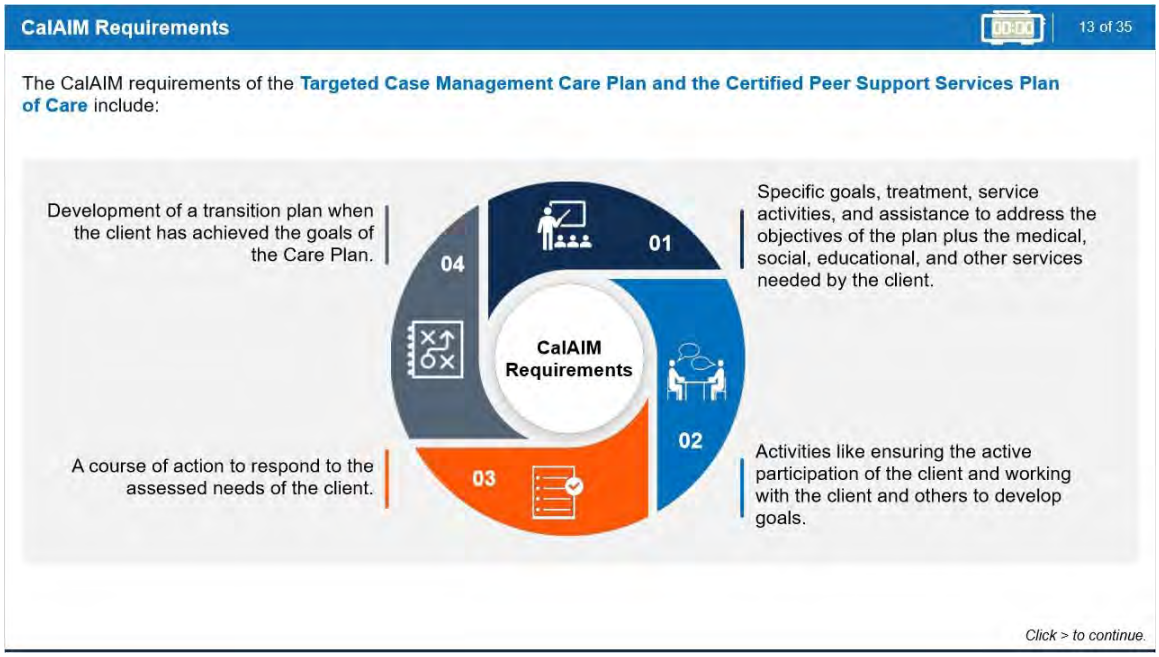
Notes:

The list of services that require a Care Plan includes:

- Targeted Case Management,
- Intensive Care Coordination (ICC),
- Therapeutic Behavioral Services,
- Short Term Residential Therapeutic Programs (STRTPs),
- Psychiatric Health Facility (PHF),
- Social Rehabilitation Services, also known as Crisis Residential Services, and
- Certified Peer Support Services.

Targeted Case Management and Certified Peer Support Services will be explained in the next slides.

1.13 CalAIM Requirements



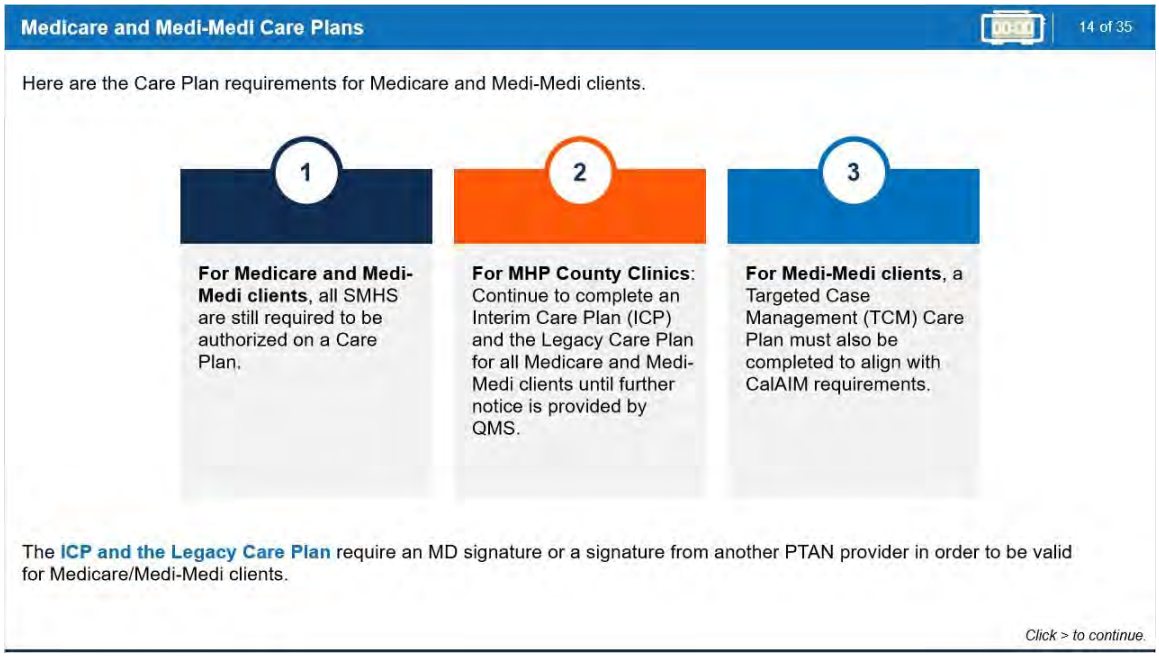
Notes:

The CalAIM requirements of the Targeted Case Management (TCM) Care Plan and the Certified Peer Support Services Plan of Care include:

- Specific goals, treatment, service activities, and assistance to address the objectives of the plan plus the medical, social, educational, and other services needed by the client,
- Activities like ensuring the active participation of the client and working with the client (or authorized health care decisionmaker) and others to develop goals,
- A course of action to respond to the assessed needs of the client, and
- Development of a transition plan when the client has achieved the goals of the Care Plan.

It is important to remember that even without a Care Plan, TCM can be provided and billed during the assessment period if justified in the progress note.

1.14 Medicare and Medi-Medi Care Plans



Notes:

Let's now look at the Care Plan requirements for Medicare and Medi-Medi clients.

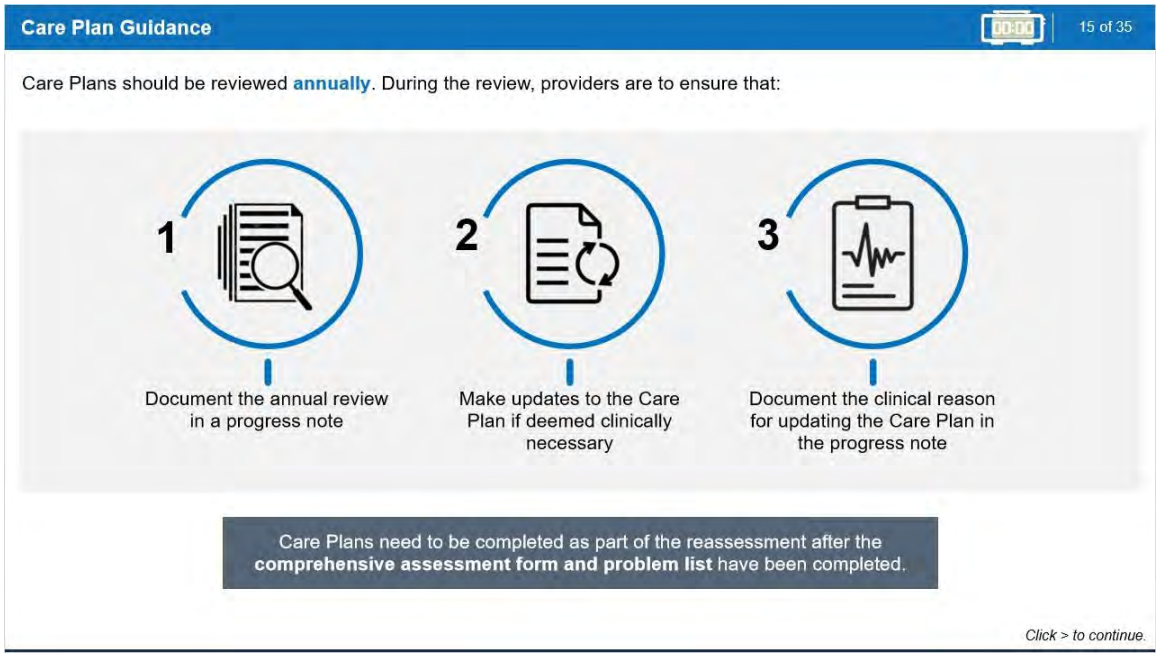
For Medicare and Medi-Medi clients, all Specialty Mental Health Services (SMHS) are still required to be authorized on a Care Plan.

For MHP County Clinics: Continue to complete an Interim Care Plan (ICP) and the Legacy Care Plan (currently in EHR) for all Medicare and Medi-Medi clients until further notice is provided by QMS.

For Medi-Medi clients, a Targeted Case Management (TCM) Care Plan must also be completed to align with CalAIM requirements.

The ICP and the Legacy Care Plan require an MD signature or a signature from another PTAN provider (e.g., psychologist, CNS, MFT, CSW, PCC, DO, or NP) in order to be valid for Medicare/Medi-Medi clients.

1.15 Care Plan Guidance



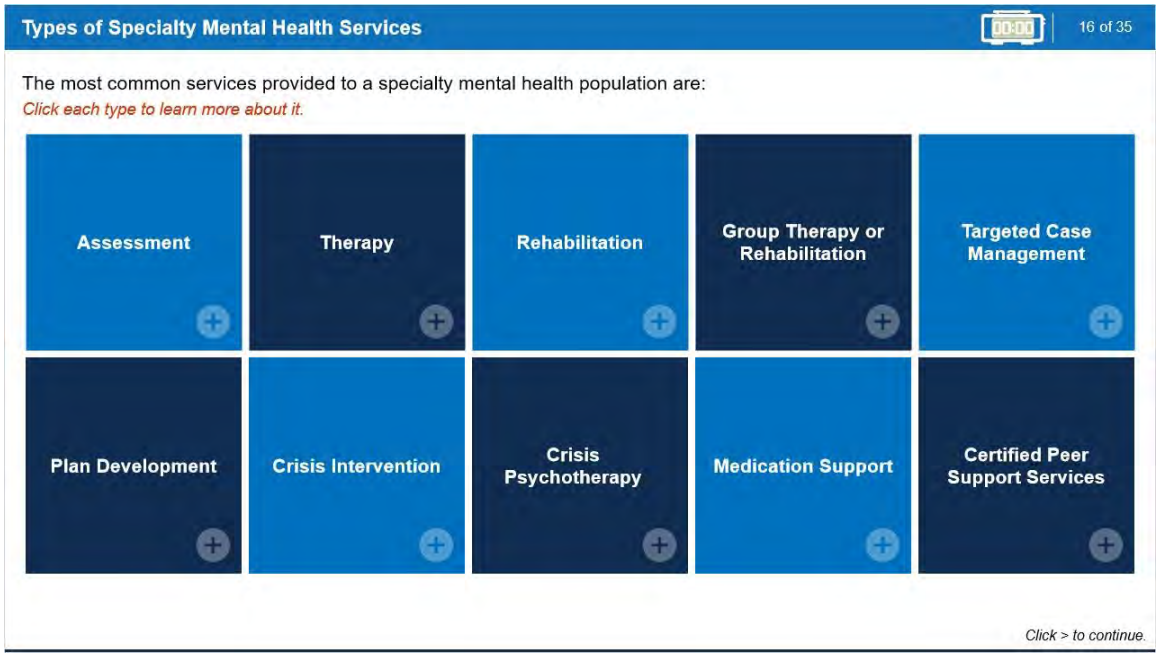
Notes:

Care Plans should be reviewed annually. During the review, providers are to ensure that:

- Document the annual review in a progress note,
- Make updates to the Care Plan if deemed clinically necessary, and
- Document the clinical reason for updating the Care Plan in the progress note.

However, Care Plans need to be completed as part of the reassessment after the comprehensive assessment form and problem list have been completed.

1.16 Types of Specialty Mental Health Services



Notes:

The most common services provided to a specialty mental health population are:

Assessment is a service activity designed to collect information and evaluate the current status of a client's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that client.

Therapy services address a client's feelings, emotions, thoughts, and behaviors.

Rehabilitation services are a recovery or resiliency focused service designed to target specific problematic behaviors resulting from a mental health condition.

Group Therapy/Rehabilitation services are used when multiple clients meet in a group setting for treatment.

Targeted Case Management services involve additional community resources, coordination of care, referrals, placements, and tracking progress as related to referrals and linkages.

Plan Development services involve a service activity that consists of one or more of the following: the development of client plans, the approval of client plans, and/or monitoring a client's treatment.

Crisis Intervention results from the need for immediate service intervention, which, if not provided, presents an imminent threat to the client or others. Services may

include, but are not limited to, assessment, evaluation, collateral, and therapy.

Crisis Psychotherapy is provided when a mental health professional is conducting a crisis evaluation and through the use of psychotherapy techniques, is able to de-escalate a crisis and avert a psychiatric hospitalization.

Medication Support services include evaluation, prescribing, administering, dispensing, and monitoring psychiatric medications, which are necessary to alleviate the symptoms of the mental illness.

Medication services may also include medical education, counseling on the risks and benefits of medication, and monitoring medication side effects.

Certified Peer Support Services are culturally appropriate services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, the development of natural supports, and the identification of strengths.

Certified Peer Support Specialist services include, but are not limited to, prevention services, support, coaching, facilitation, or education that is individualized and is conducted by a Medi-Cal Certified Peer Support Specialist.

More information about Medi-Cal Peer Support Specialists will be presented on the next slide.

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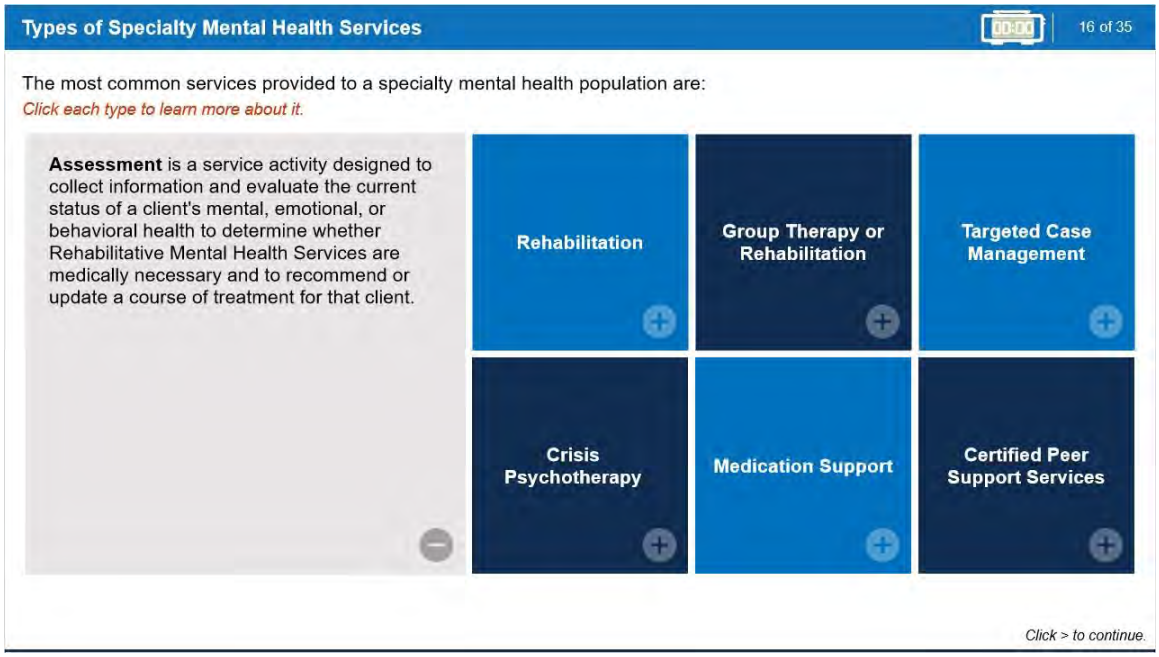

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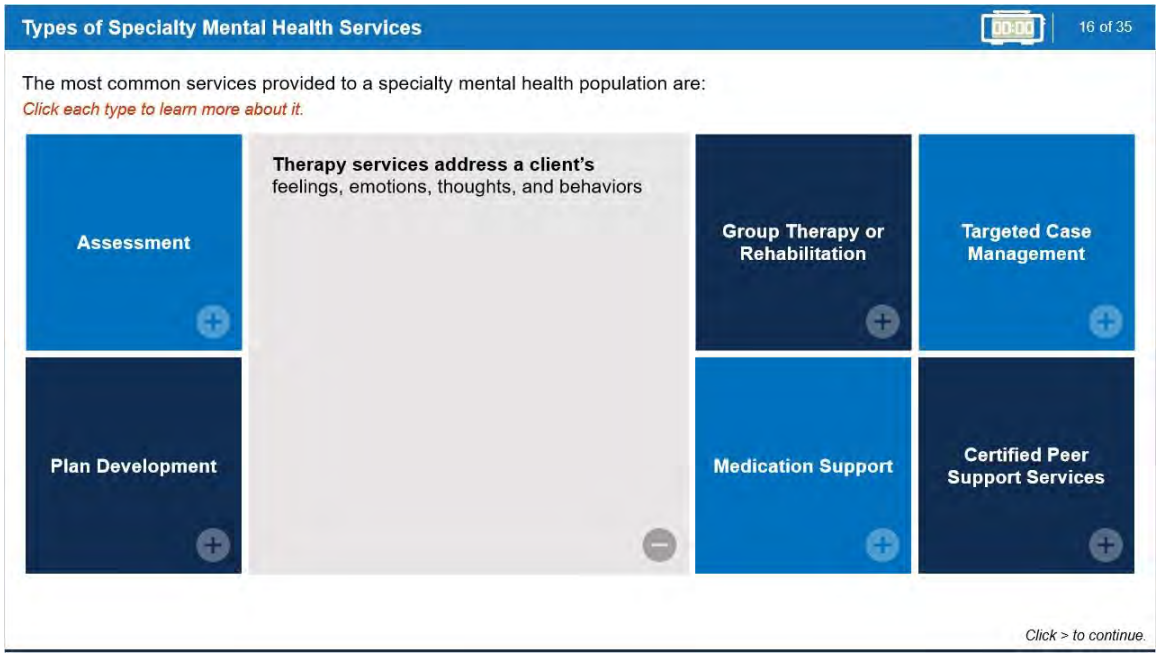

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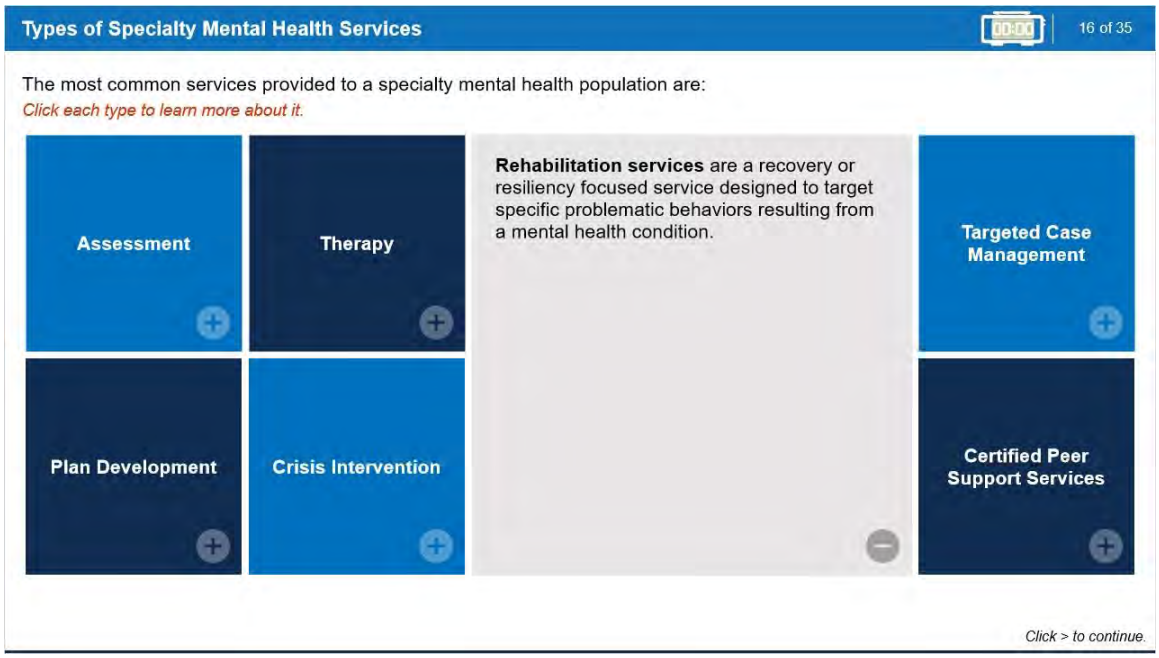

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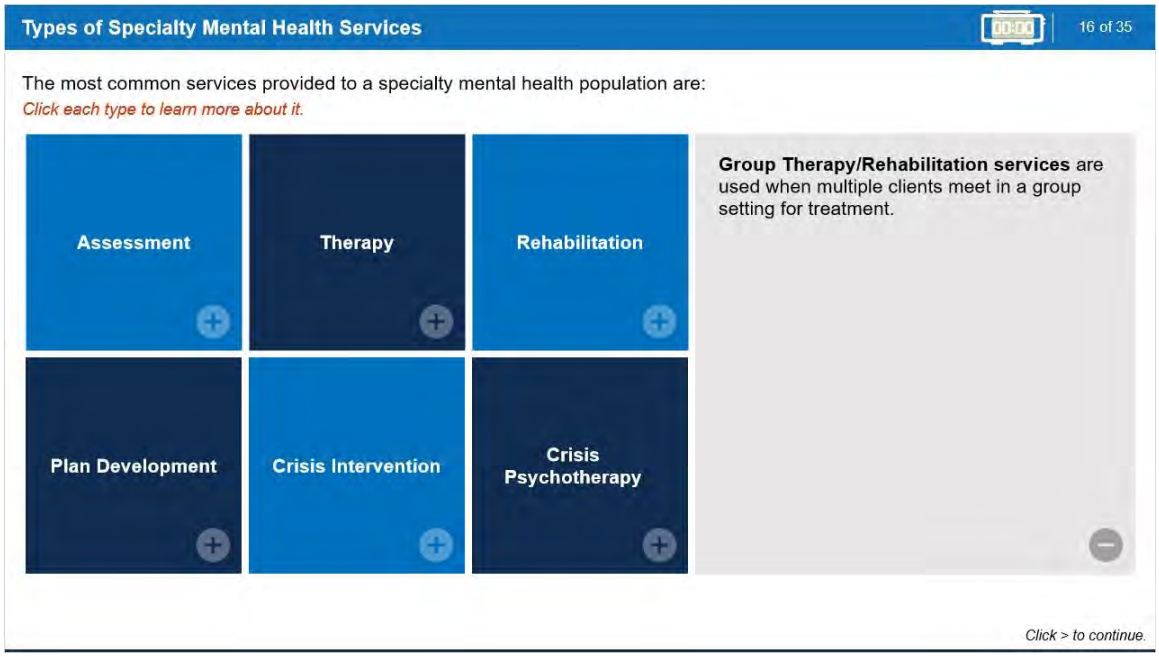

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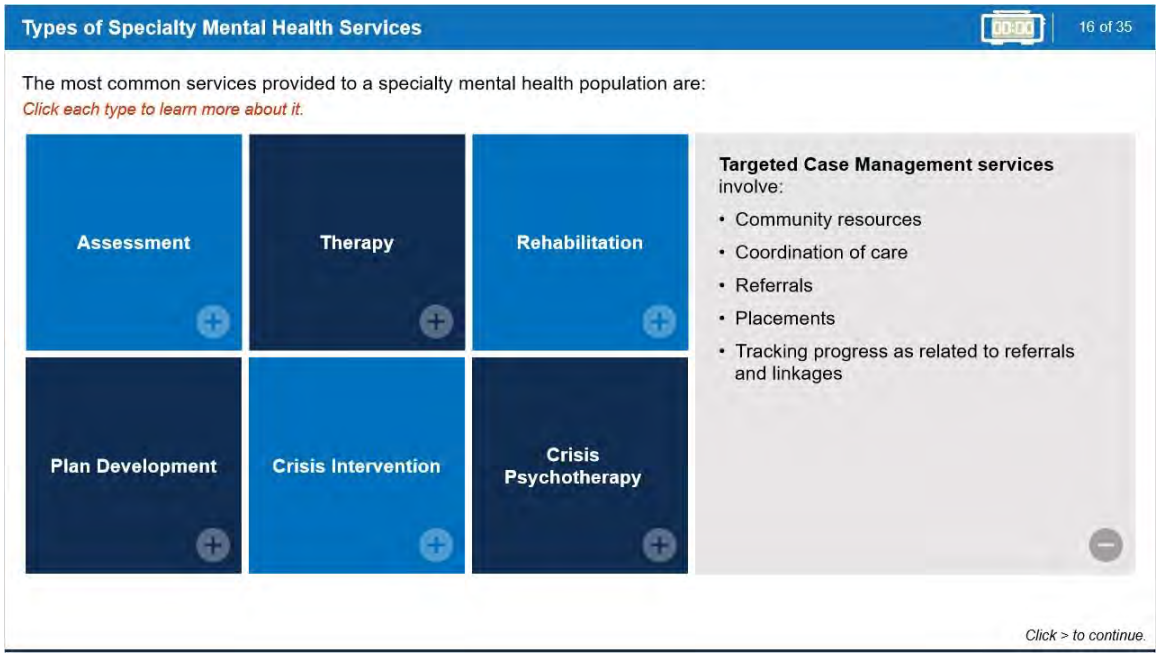


6 (Slide Layer)

Types of Specialty Mental Health Services 16 of 35

The most common services provided to a specialty mental health population are:

Click each type to learn more about it.

Plan Development services involve a service activity that consists of one or more of the following:

- Development of client plans
- Approval of client plans
- Monitoring a client's treatment

Rehabilitation

Group Therapy or Rehabilitation

Targeted Case Management

Crisis Psychotherapy

Medication Support

Certified Peer Support Services

Click > to continue.

7 (Slide Layer)

Types of Specialty Mental Health Services 16 of 35

The most common services provided to a specialty mental health population are:

Click each type to learn more about it.

Assessment

Plan Development

Crisis Intervention results from the need for immediate service intervention, which, if not provided, presents an imminent threat to the client or others.

Services may include, but are not limited to:

- Assessment
- Evaluation
- Collateral
- Therapy

Group Therapy or Rehabilitation

Targeted Case Management

Medication Support

Certified Peer Support Services

Click > to continue.

8 (Slide Layer)

Types of Specialty Mental Health Services 16 of 35

The most common services provided to a specialty mental health population are:

Click each type to learn more about it.

Assessment

Therapy

Crisis Psychotherapy is provided when a mental health professional is conducting a crisis evaluation and through the use of psychotherapy techniques, is able to de-escalate a crisis and avert a psychiatric hospitalization.

Targeted Case Management

Plan Development

Crisis Intervention

Certified Peer Support Services

Click > to continue.

9 (Slide Layer)

Types of Specialty Mental Health Services 16 of 35

The most common services provided to a specialty mental health population are:

Click each type to learn more about it.

Assessment

Therapy

Rehabilitation

Medication Support services include:

- Evaluation
- Prescribing
- Administering
- Dispensing
- Monitoring psychiatric medications
- Medical education
- Counseling on the risks and benefits of medication
- Monitoring medication side effects

Plan Development

Crisis Intervention

Crisis Psychotherapy

Click > to continue.

10 (Slide Layer)

Types of Specialty Mental Health Services 16 of 35

The most common services provided to a specialty mental health population are:
Click each type to learn more about it.

Assessment | Therapy | Rehabilitation
Plan Development | Crisis Intervention | Crisis Psychotherapy

Certified Peer Support services are culturally appropriate services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, the development of natural supports, and the identification of strengths.

Certified Peer Support Specialist services include, but are not limited to, prevention services, support, coaching, facilitation, or education that is individualized and is conducted by a Medi-Cal Certified Peer Support Specialist.

Click > to continue.

1.17 Non-Billable Services

Non-Billable Services 17 of 35

Non-billable services are defined as **services that are never paid for by Medi-Cal or Medicare**. These services include:

1. Travel time
2. Documentation time
3. Review of internal records
4. Supervision
5. Waiting
6. Clerical services (faxing, copying, and scheduling appointments)
7. Providing transportation, except for mobile crisis
8. Most letter writing and form completion
9. Any activity that is solely academic, vocational, recreational, or social in nature
10. Child, elder, or dependent adult abuse reporting
11. Home visits solely for Continuum of Care inspections

Click the more info icon for details.

Click > to continue.

Notes:

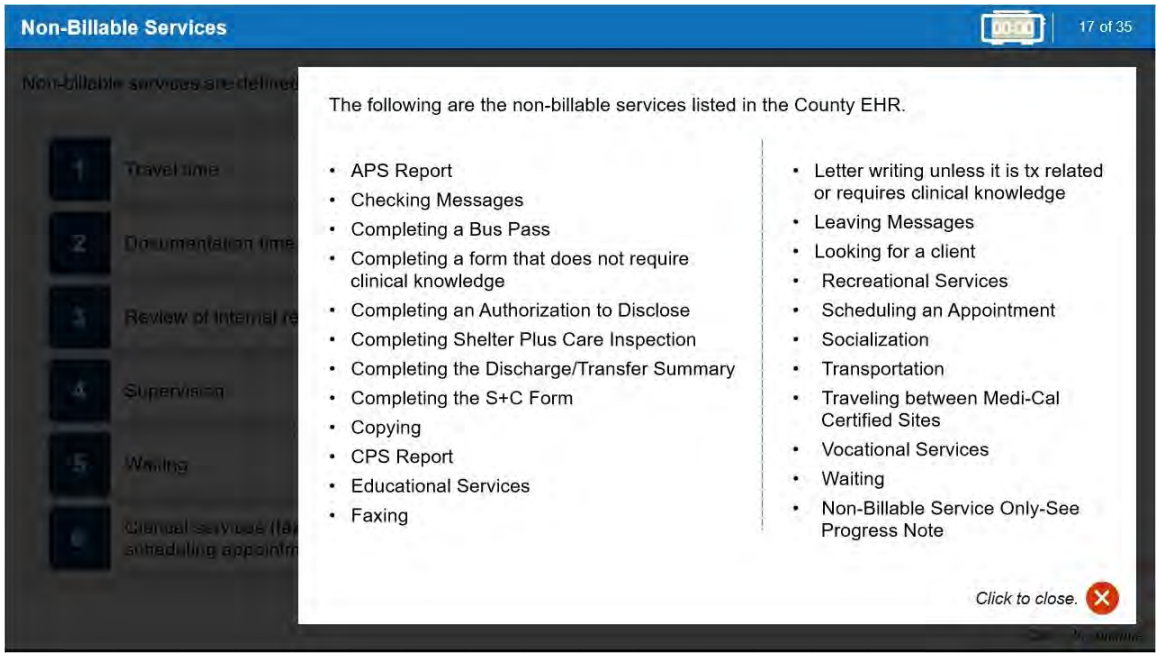
Non-billable services are defined as services that are never paid for by Medi-Cal or

Medicare. These services include:

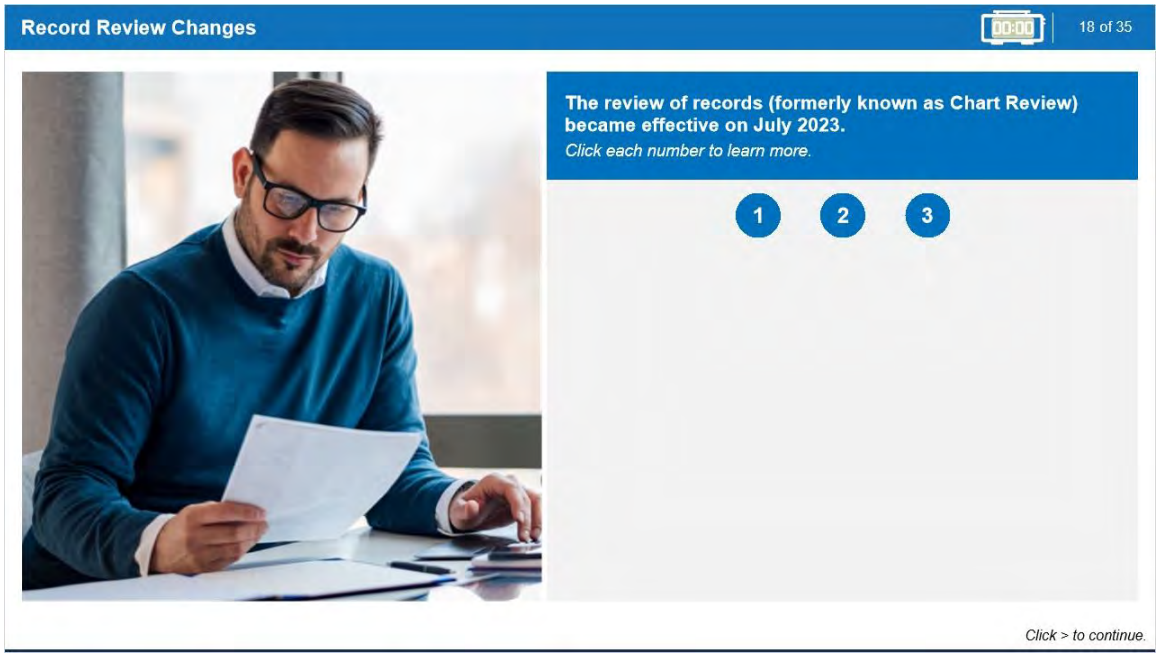
- Travel time,
- Documentation time,
- Review of internal records,
- Supervision,
- Waiting,
- Clerical services (for example, faxing, copying, and scheduling appointments),
- Providing transportation, except for mobile crisis,
- Most letter writing and form completion,
- Any activity that is solely academic, vocational, recreational, or social in nature,
- Child, elder, or dependent adult abuse reporting, and
- Home visits solely for Continuum of Care inspections.

Displayed here are the non-billable services listed in the County Electronic Health Record. Take a minute to go through it.

more_info (Slide Layer)



1.18 Record Review Changes



Notes:

The review of records (formerly known as Chart Review) became effective on July 2023.

A review of internal records is no longer billable (the only exceptions are for certain medication management codes).

A review of records is now considered an assessment service with its own billing code. It cannot be combined with any other service (the only exceptions are for certain medication management codes).

The review of records service billing code is to be billed when a provider, under their scope of practice, conducts a Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes.

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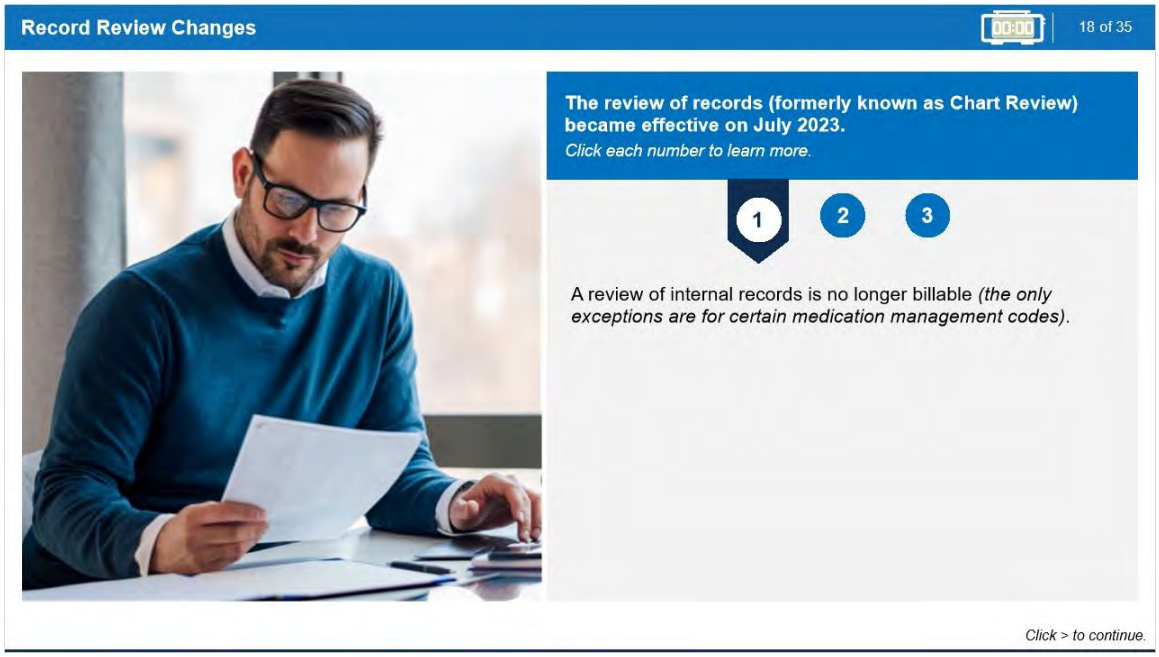

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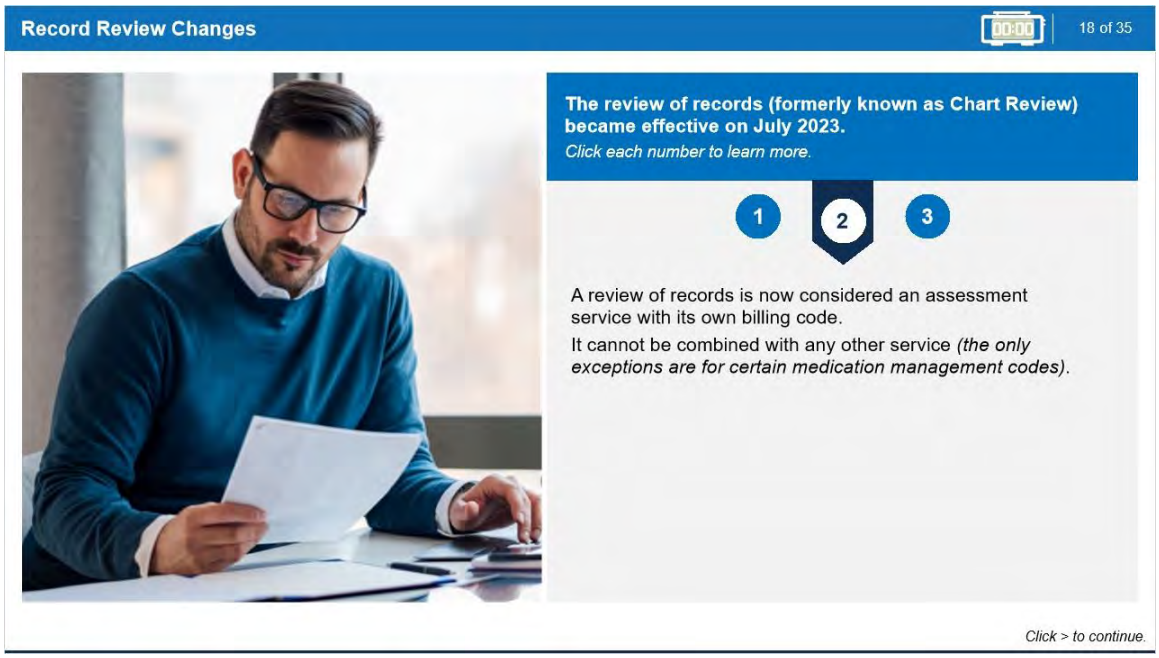

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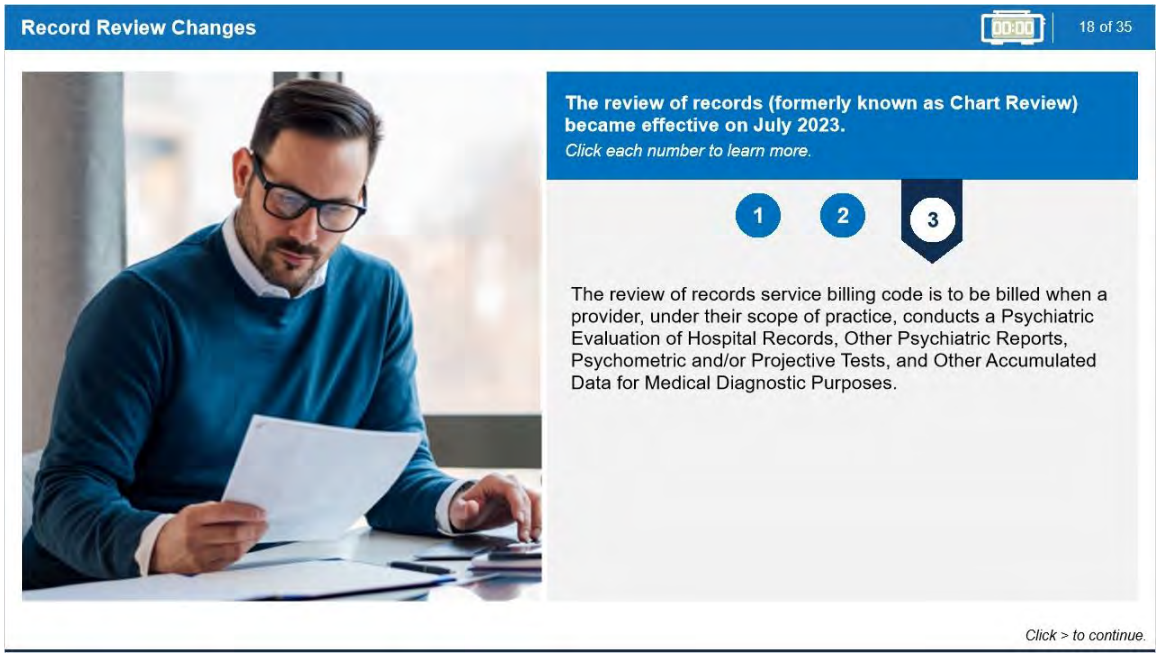
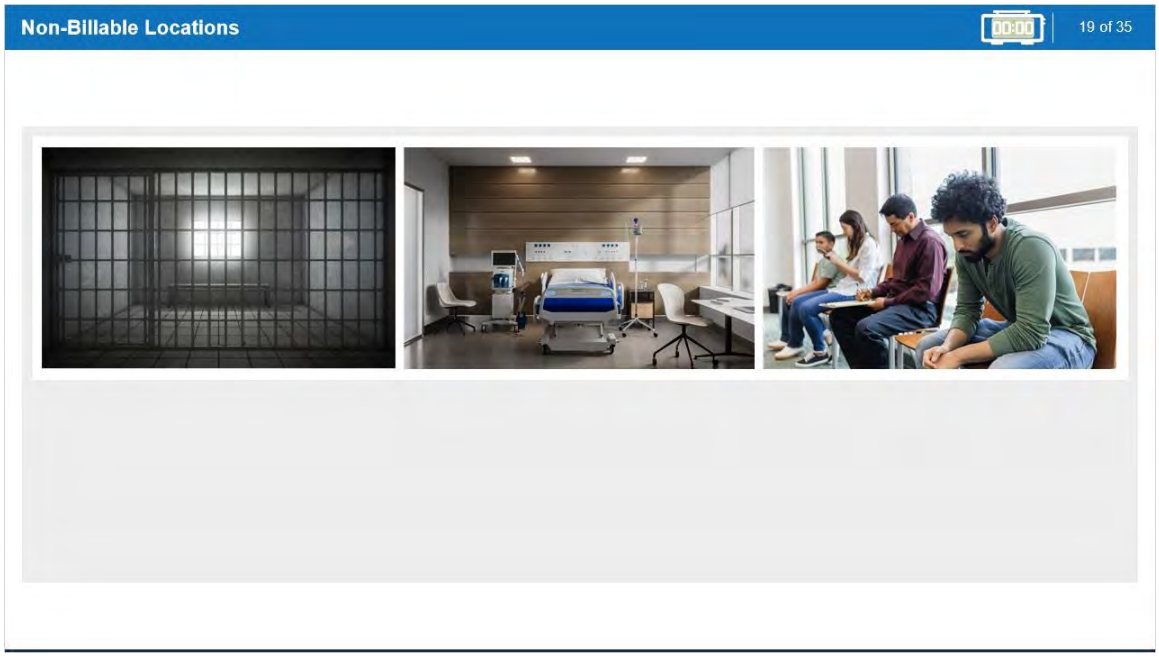


1.19 Non-Billable Locations



Notes:

Services provided at any of the locations displayed here are not billable.

If a youth in Juvenile Hall has completed court activities and is only staying in there until a living situation can be arranged, then services can be billed.

There is an exception for Juvenile Hall: services provided post-adjudication and while awaiting placement.

There is no exception for jails.

There is an exception for inpatient psychiatric hospitals.

For example, it is permissible to bill for placement services while a client is in a psychiatric unit during the 30 days prior to discharge.

However, it is important to note that while working on securing post-hospitalization placement may be considered part of discharge planning (for example, arranging follow-up care for psychiatric or medical issues), placement is the only portion of 'discharge planning' that is billable.

There is no exception for the Institutes for Mental Disease (IMD).

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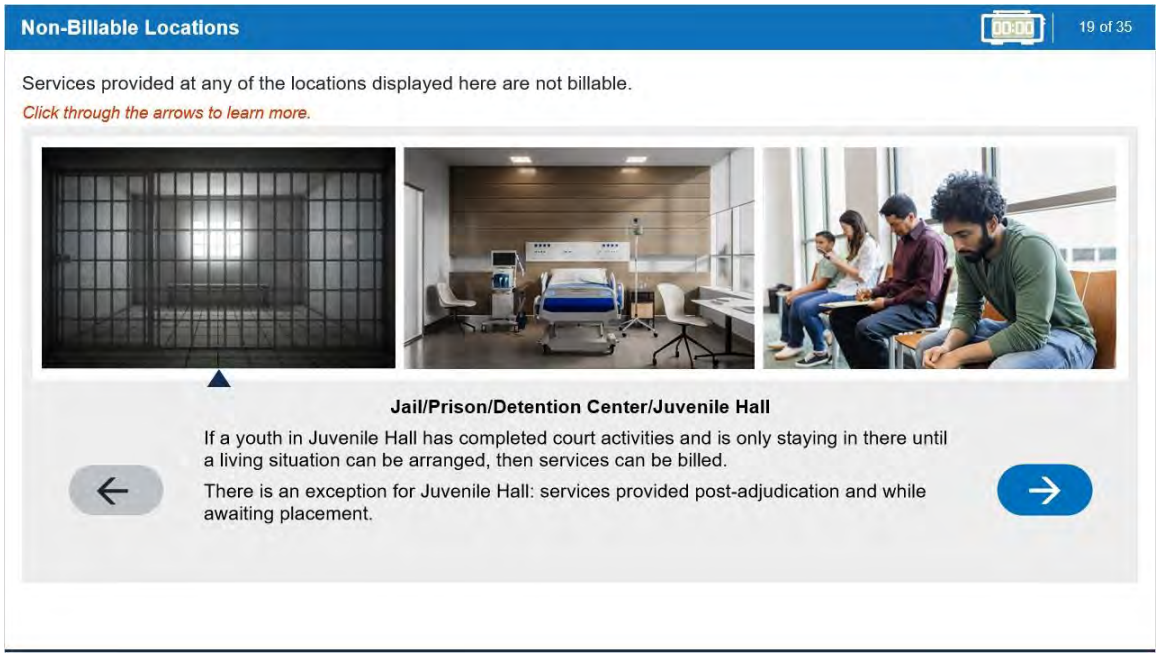

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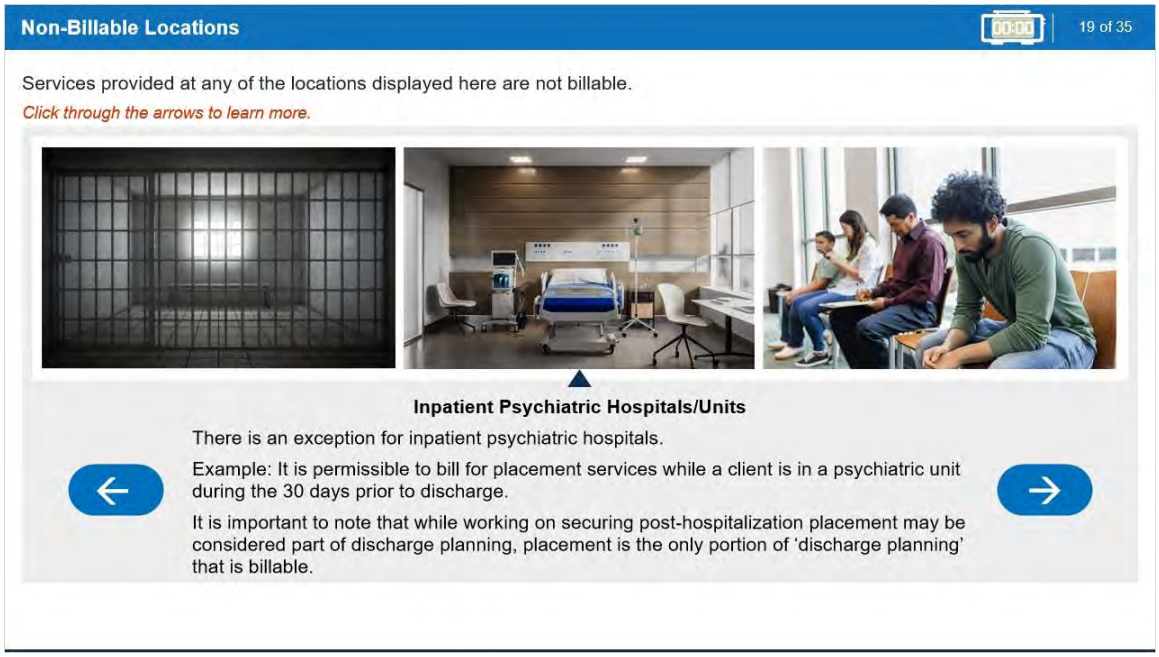

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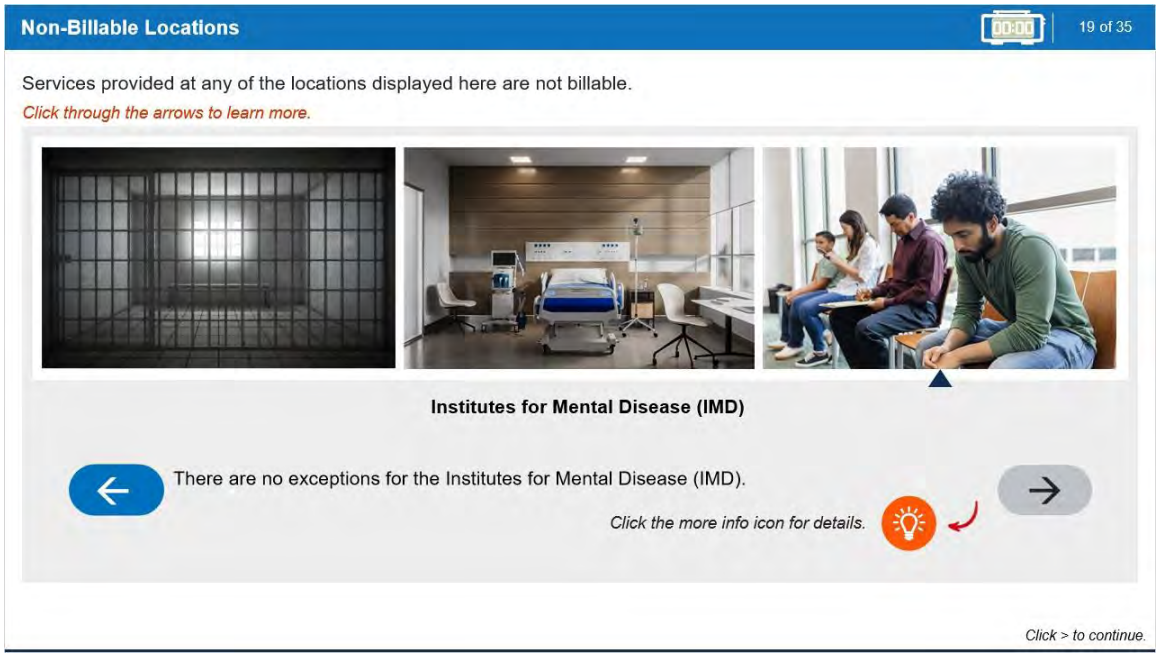

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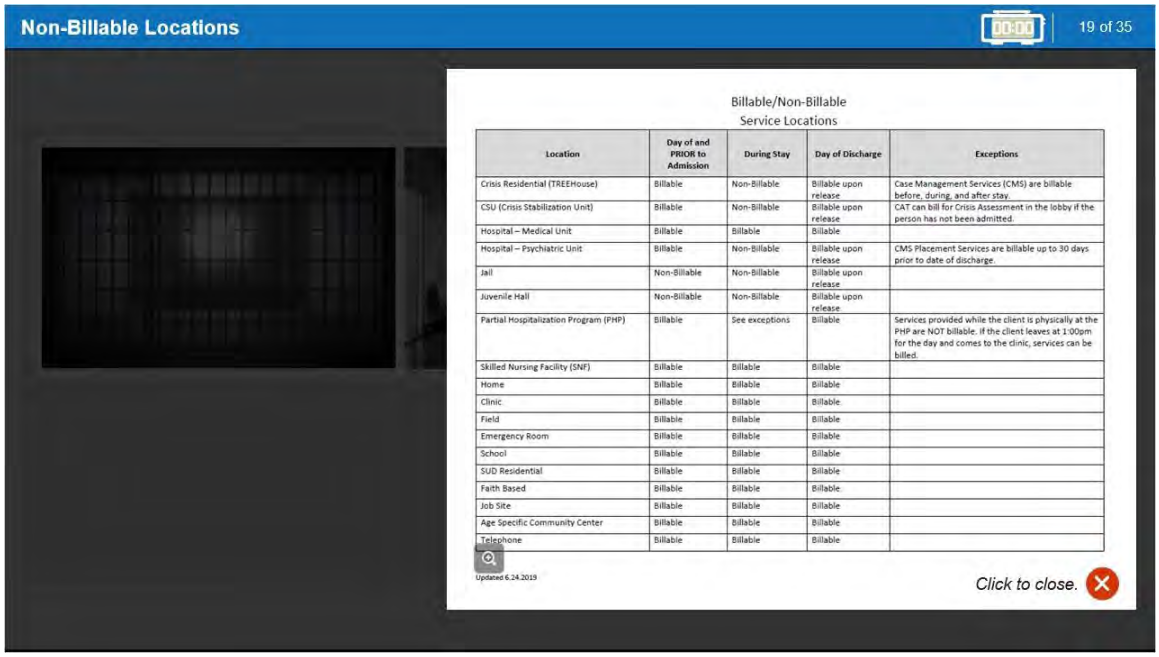

Non-Billable Locations

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Billable/Non-Billable
Service Locations

Location	Day of and PRIOR to Admission	During Stay	Day of Discharge	Exceptions
Crisis Residential (TREEHouse)	Billable	Non-Billable	Billable upon release	Case Management Services (CMS) are billable before, during, and after stay.
CSU (Crisis Stabilization Unit)	Billable	Non-Billable	Billable upon release	CAT can bill for Crisis Assessment in the lobby if the person has not been admitted.
Hospital – Medical Unit	Billable	Billable	Billable	
Hospital – Psychiatric Unit	Billable	Non-Billable	Billable upon release	CMS Placement Services are billable up to 30 days prior to date of discharge.
Jail	Non-Billable	Non-Billable	Billable upon release	
Juvenile Hall	Non-Billable	Non-Billable	Billable upon release	
Partial Hospitalization Program (PHP)	Billable	See exceptions	Billable	Services provided while the client is physically at the PHP are NOT billable. If the client leaves at 1:00pm for the day and comes to the clinic, services can be billed.
Skilled Nursing Facility (SNF)	Billable	Billable	Billable	
Home	Billable	Billable	Billable	
Clinic	Billable	Billable	Billable	
Field	Billable	Billable	Billable	
Emergency Room	Billable	Billable	Billable	
School	Billable	Billable	Billable	
SUD Residential	Billable	Billable	Billable	
Faith Based	Billable	Billable	Billable	
Job Site	Billable	Billable	Billable	
Age Specific Community Center	Billable	Billable	Billable	
Telephone	Billable	Billable	Billable	

Updated 6.24.2019

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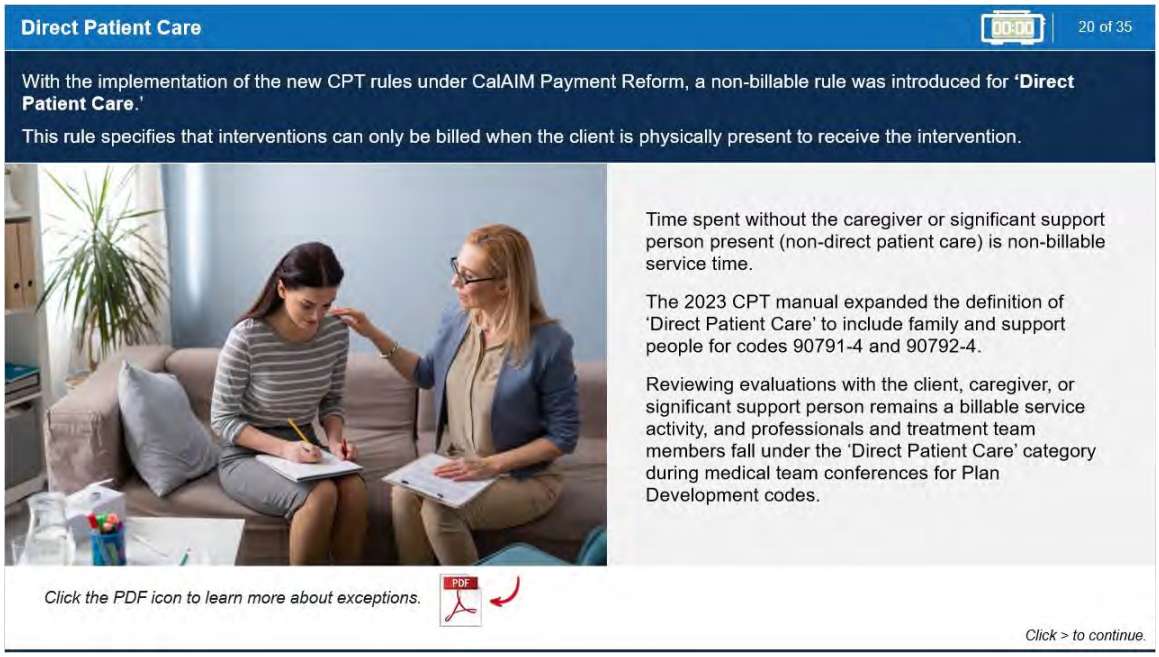
1.20 Direct Patient Care



Direct Patient Care

20 of 35

With the implementation of the new CPT rules under CalAIM Payment Reform, a non-billable rule was introduced for **'Direct Patient Care.'**

This rule specifies that interventions can only be billed when the client is physically present to receive the intervention.

Time spent without the caregiver or significant support person present (non-direct patient care) is non-billable service time.

The 2023 CPT manual expanded the definition of 'Direct Patient Care' to include family and support people for codes 90791-4 and 90792-4.

Reviewing evaluations with the client, caregiver, or significant support person remains a billable service activity, and professionals and treatment team members fall under the 'Direct Patient Care' category during medical team conferences for Plan Development codes.

Click the PDF icon to learn more about exceptions.

Click > to continue.

Notes:

With the implementation of the new CPT rules under CalAIM Payment Reform, a

non-billable rule was introduced for 'Direct Patient Care.'

This rule specifies that interventions can only be billed when the client is physically present to receive the intervention.

Additionally, family members, support personnel, and other professionals may also be present during assessment activities.

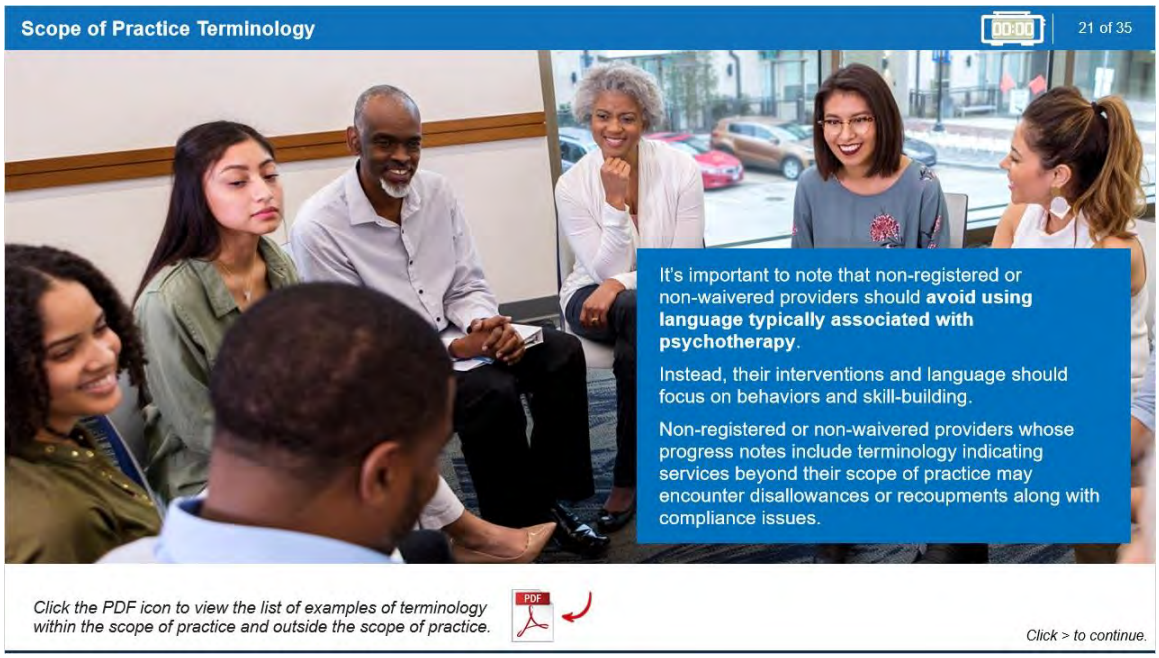
Time spent without the caregiver or significant support person present is non-billable service time.

The 2023 CPT manual expanded the definition of 'Direct Patient Care' to include family and support people for codes 90791-4 and 90792-4.

However, activities like Temporary Medication Refills (TMR) and writing up MDs' Biopsychosocial are no longer billable without the client, caregiver, or significant support person present.

Reviewing evaluations with the client, caregiver, or significant support person remains a billable service activity, and professionals and treatment team members fall under the 'Direct Patient Care' category during medical team conferences for Plan Development codes.

1.21 Scope of Practice Terminology



Notes:

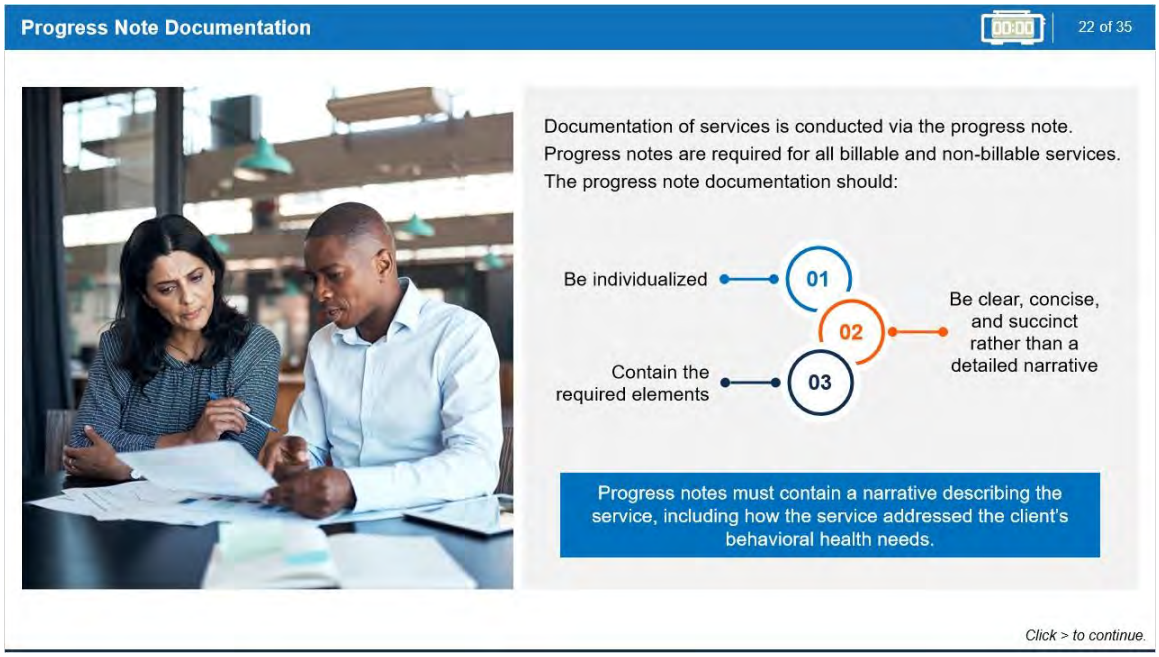
Let's learn about the scope of practice terminology.

It's important to note that non-registered or non-waivered providers should avoid using language typically associated with psychotherapy.

Instead, their interventions and language should focus on behaviors and skill-building.

Non-registered or non-waivered providers whose progress notes include terminology indicating services beyond their scope of practice may encounter disallowances or recoupments along with compliance issues.

1.22 Progress Note Documentation



Notes:

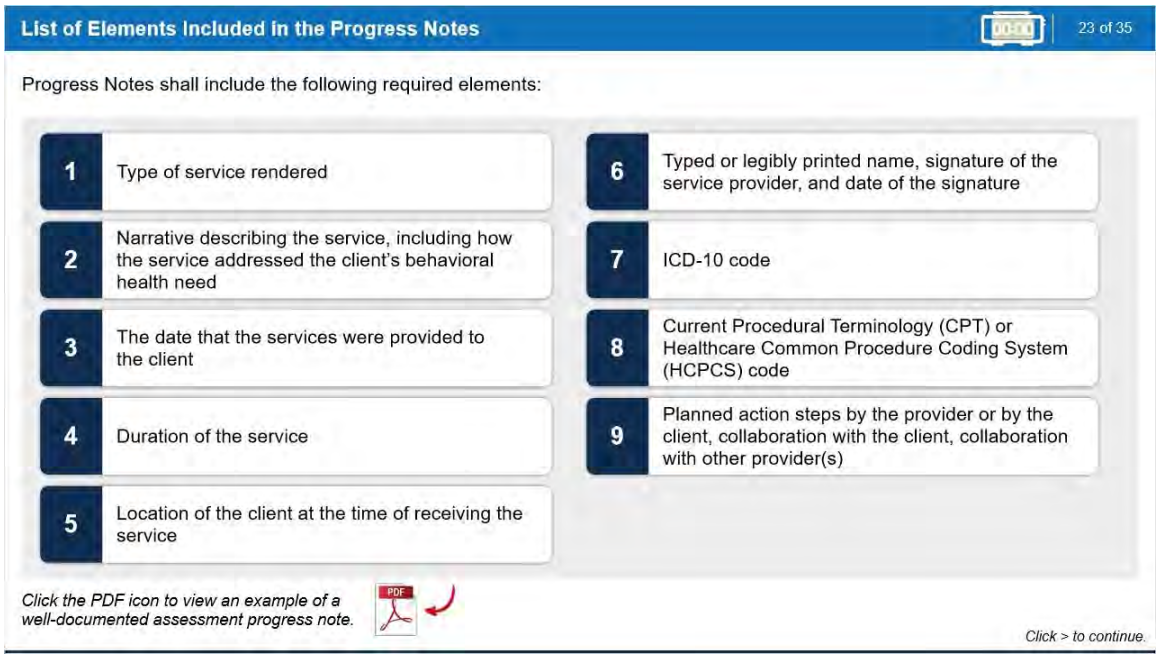
Documentation of services is conducted via the progress note. Progress notes are required for all billable and non-billable services. The progress note documentation should be individualized, clear, concise, and succinct rather than a detailed narrative and contain the required elements.

Progress notes must contain a narrative describing the service, including how the service addressed the client's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).

Regardless of the type of note, the same elements are required which are further

explained on the next slide.

1.23 List of Elements Included in the Progress Notes



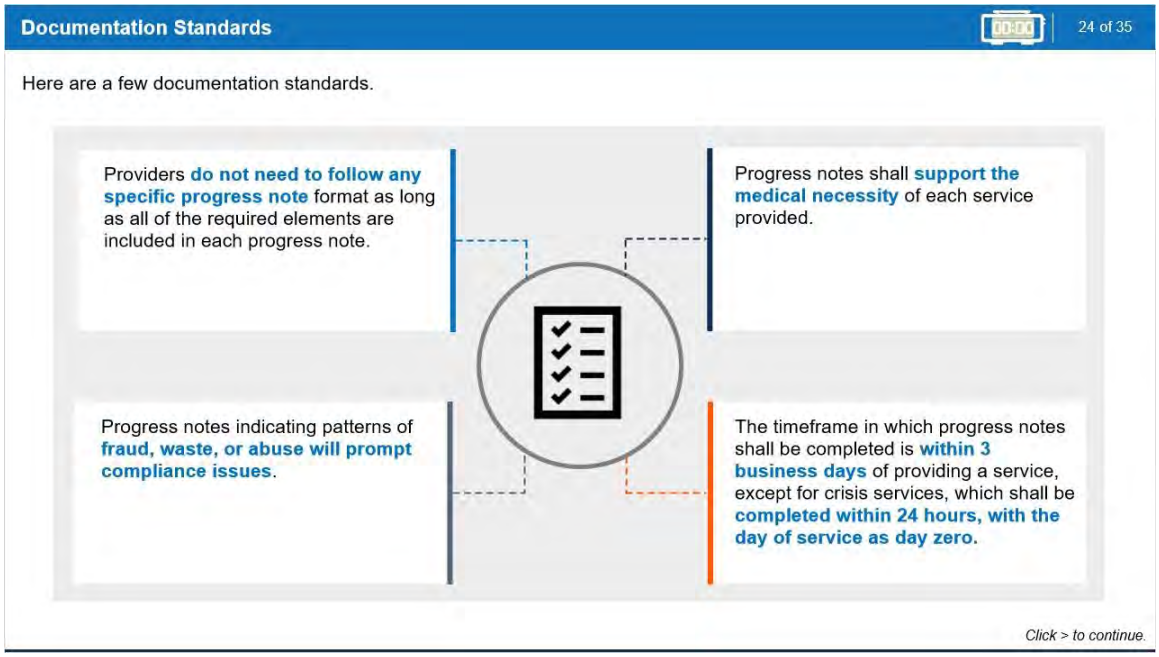
Notes:

Progress Notes shall include the following required elements:

- Type of service rendered,
- Narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors),
- The date that the services were provided to the client,
- Duration of the service,
- Location of the client at the time of receiving the service,
- Typed or legibly printed name, signature of the service provider, and date of the signature,
- ICD-10 code,
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code, and
- Next steps, including but not limited to, planned action steps by the provider or by

the client, collaboration with the client, collaboration with other provider(s), and any update to the problem list as appropriate.

1.24 Documentation Standards



Notes:

Let's now have a look at the documentation standards.

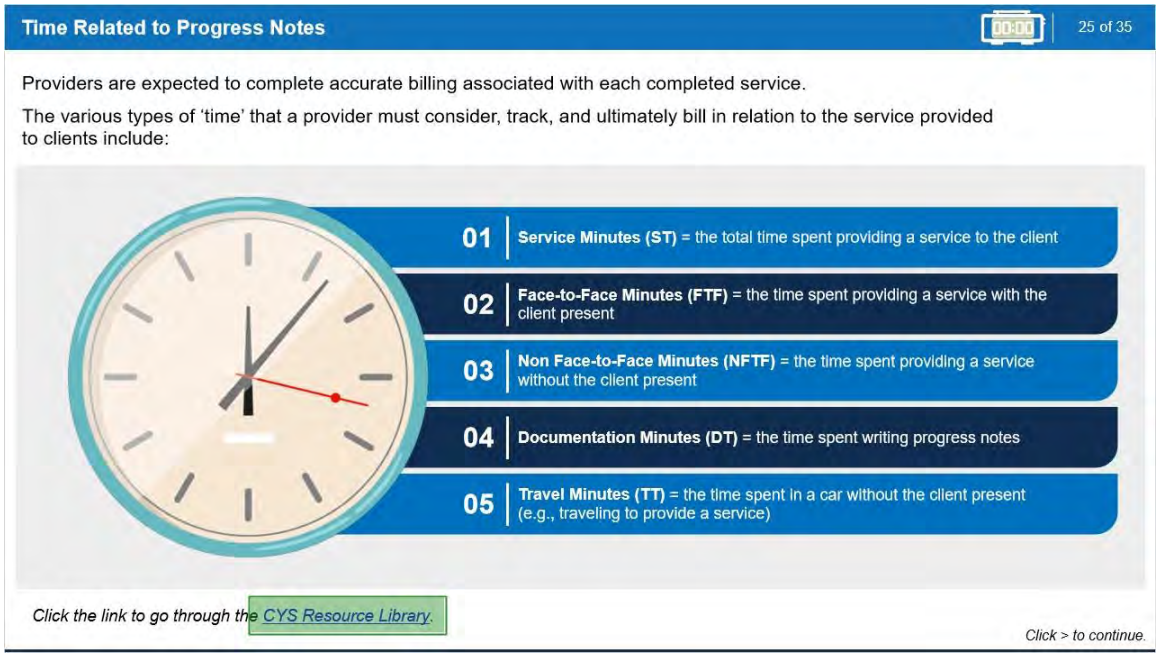
Providers do not need to follow any specific progress note format as long as all of the required elements are included in each progress note.

Progress notes shall support the medical necessity of each service provided.

The timeframe in which progress notes shall be completed is within 3 business days of providing a service, except for crisis services, which shall be completed within 24 hours, with the day of service as day zero.

Progress notes indicating patterns of fraud, waste, or abuse will prompt compliance issues.

1.25 Time Related to Progress Notes



Notes:

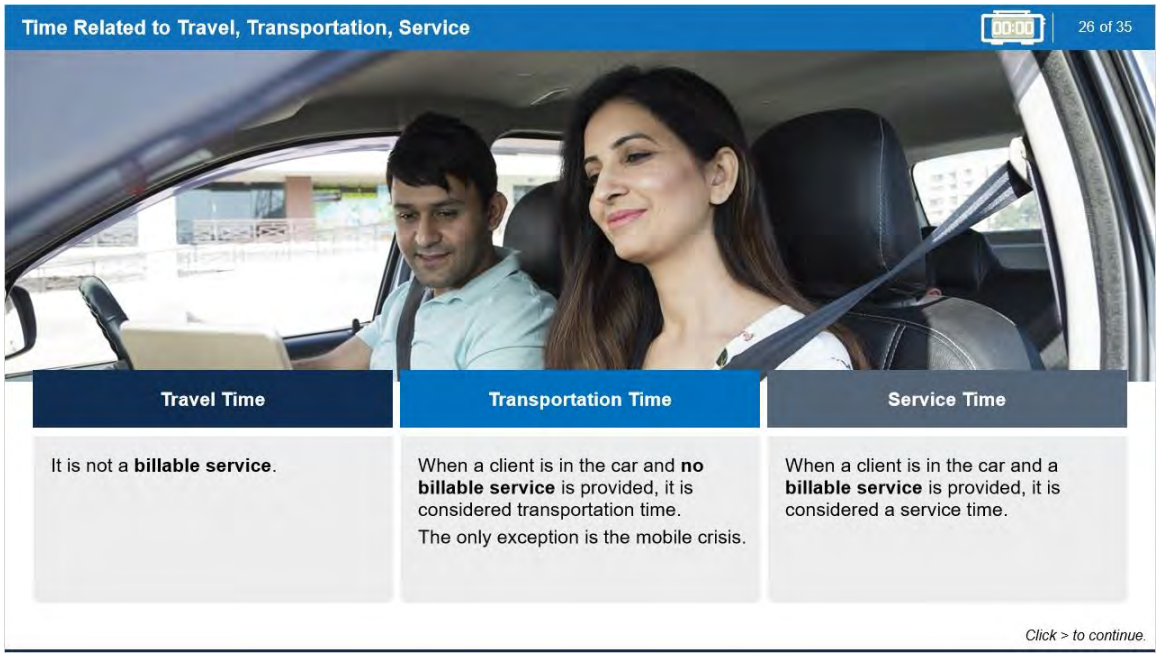
Providers are expected to complete accurate billing associated with each completed service.

Displayed here are various types of 'time' that a provider must consider, track, and ultimately bill in relation to the service provided to clients.

Take a minute to go through it.

It's important to note that group time is documented somewhat differently. Additional guidance will be posted to the CYS Resource Library soon.

1.26 Time Related to Travel, Transportation, Service



Notes:

It is important to know the difference between travel, transportation, and service when it comes to documentation.

Per CalAIM Payment Reform changes, travel time is NOT a billable service.

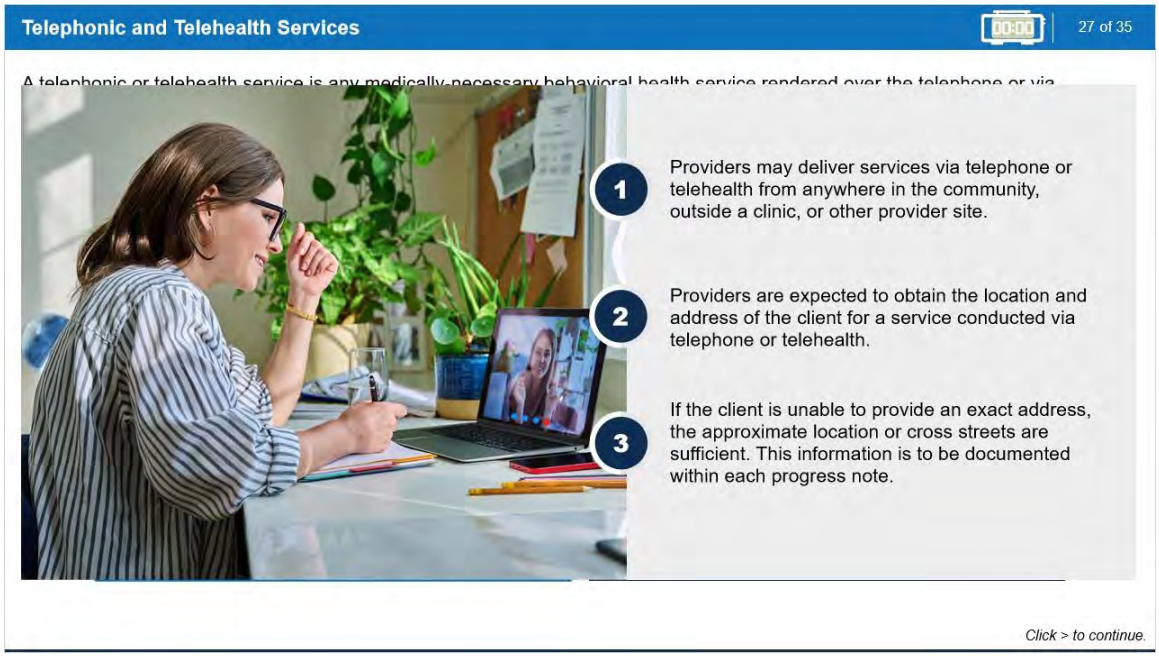
The time a provider spends in the car with the client, during which no billable service is provided, is considered transportation.

Transportation is NOT a billable service.

The only exception is when a mobile crisis team transports a client to an appropriate level of care or treatment setting.

The time a provider spends in the car with a client while also providing a billable service is considered billable service time.

1.27 Telephonic and Telehealth Services



Notes:

Let's have a look at the telephonic and telehealth services.

A telephonic or telehealth service is any medically-necessary behavioral health service rendered over the telephone or via telehealth to a client and/or their authorized representative.

Telephonic services are identified as services that occur when you speak with a client over the telephone only and are not able to see the individual.

Telehealth services occur when a service is provided over the telephone or computer and the provider is able to see the client through an audio-visual platform.

Providers may deliver services via telephone or telehealth from anywhere in the community, outside a clinic, or other provider site.

The standard of care is the same whether the client is seen in-person, by telephone, or through telehealth.

Providers are expected to obtain the location and address of the client for a service conducted via telephone or telehealth.

If the client is unable to provide an exact address, the approximate location or cross streets are sufficient. This information is to be documented within each progress note.

It is important to document telehealth services in the correct manner to ensure that documentation and billing are as accurate as possible.

1.28 Important Considerations Regarding Telehealth Services

Notes:

The General Informed Consent for telehealth and telephonic services does not replace the original General Informed Consent for Services.

All clients, whether new or existing, receiving telephone or telehealth services, must be provided both consents:

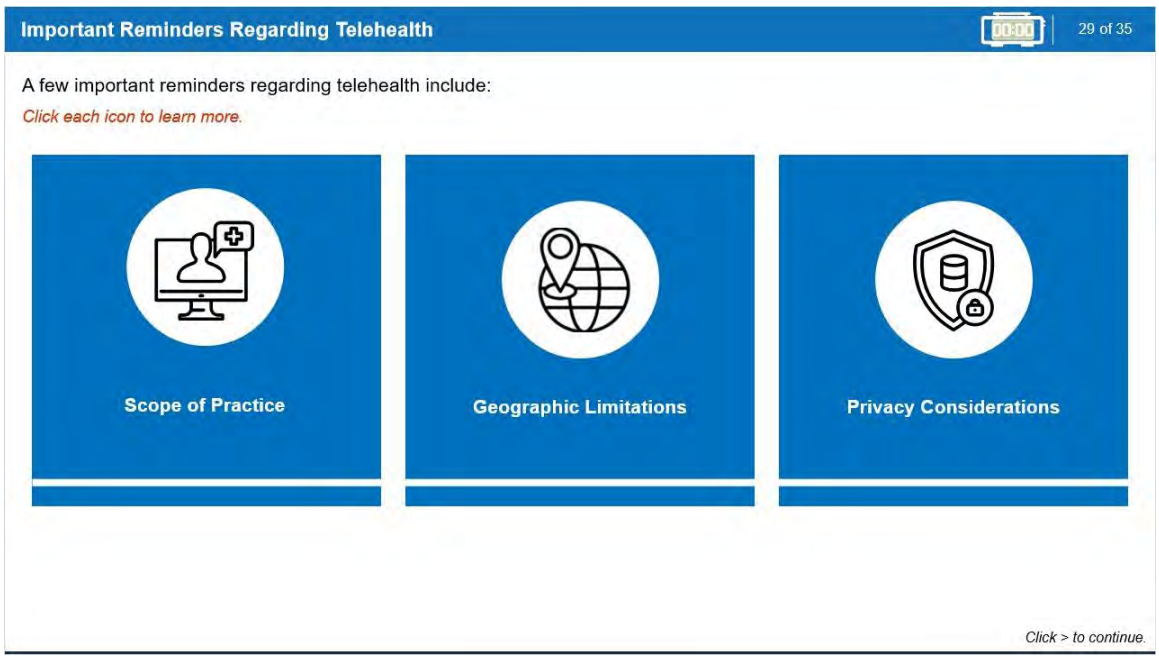
- General Informed Consent for Telehealth and Telephonic Services and
- General Informed Consent for Services.

Additionally, for those determined appropriate for and able to engage in telehealth services, the Telehealth Email Acknowledgment Form should be completed.

It is important to remember that if a client is unable or unwilling to participate in telephone or telehealth services, then they would not need to be given the General Informed Consent for Telehealth and Telephonic Services or the Email Acknowledgment Form.

Applicable consents/forms will need to be reviewed with each client and their verbal consent should be obtained and documented in the progress note.

1.29 Important Reminders Regarding Telehealth



Notes:

A few important reminders regarding telehealth include:

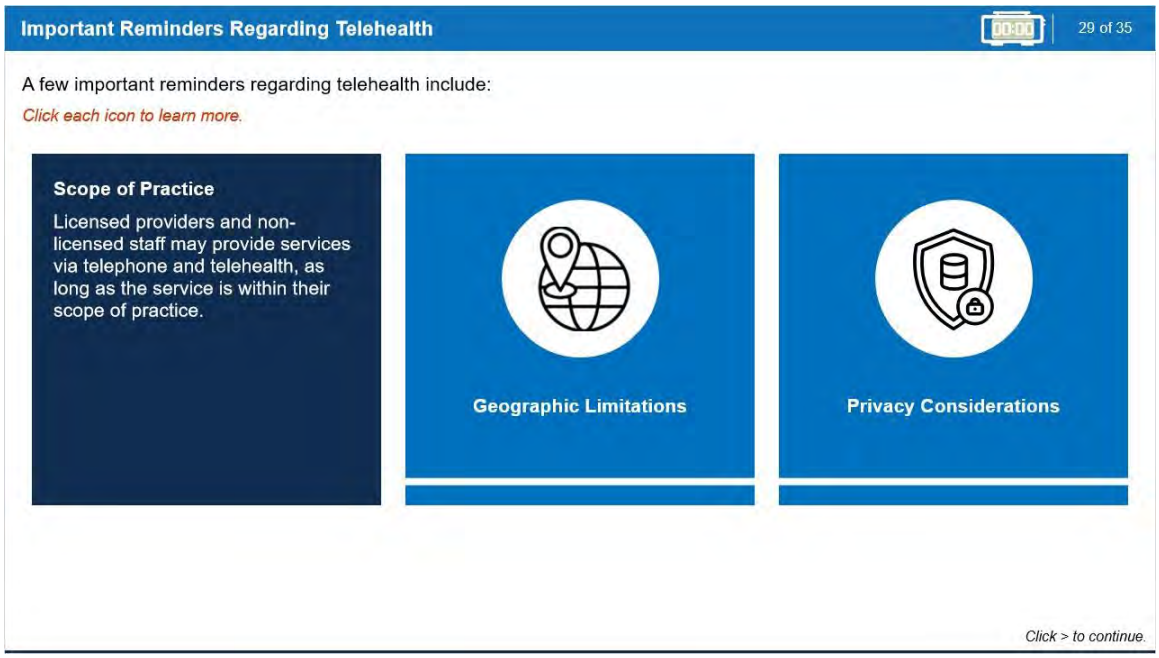
- Scope of Practice,
- Geographic Limitations, and
- Privacy Considerations.

Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.

It is critical that providers DO NOT provide or conduct telehealth and/or telephonic services to clients who are located outside of California.

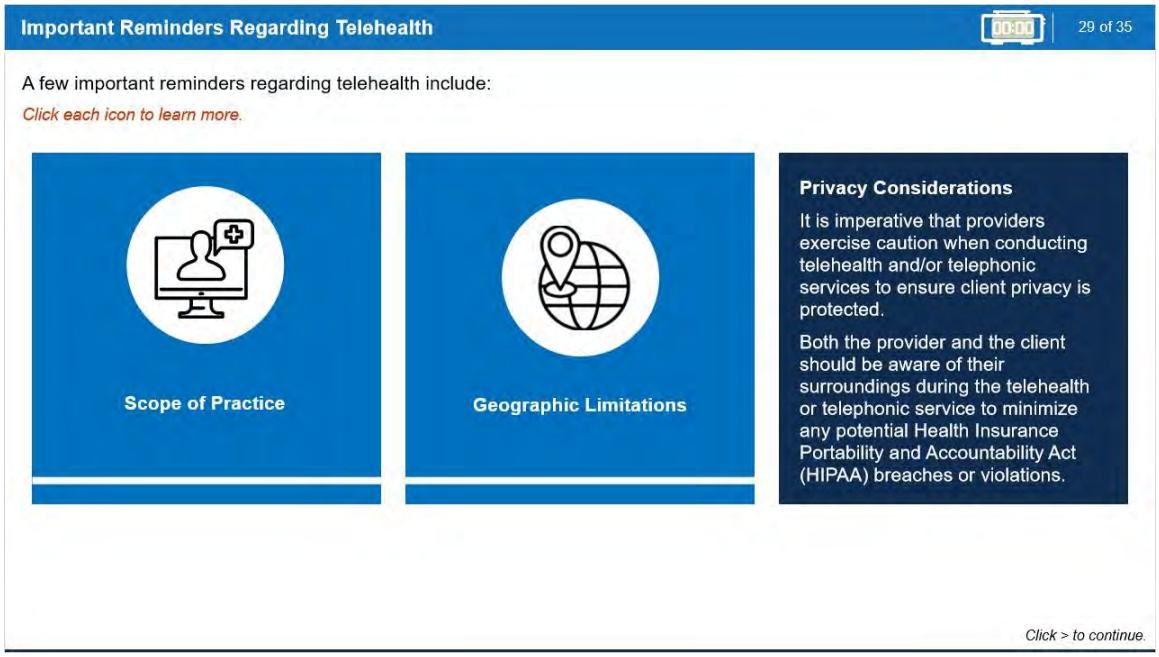
It is imperative that providers exercise caution when conducting telehealth and/or telephonic services to ensure client privacy is protected. Both the provider and the client should be aware of their surroundings during the telehealth or telephonic service to minimize any potential Health Insurance Portability and Accountability Act (HIPAA) breaches or violations.

Scope of Practice (Slide Layer)

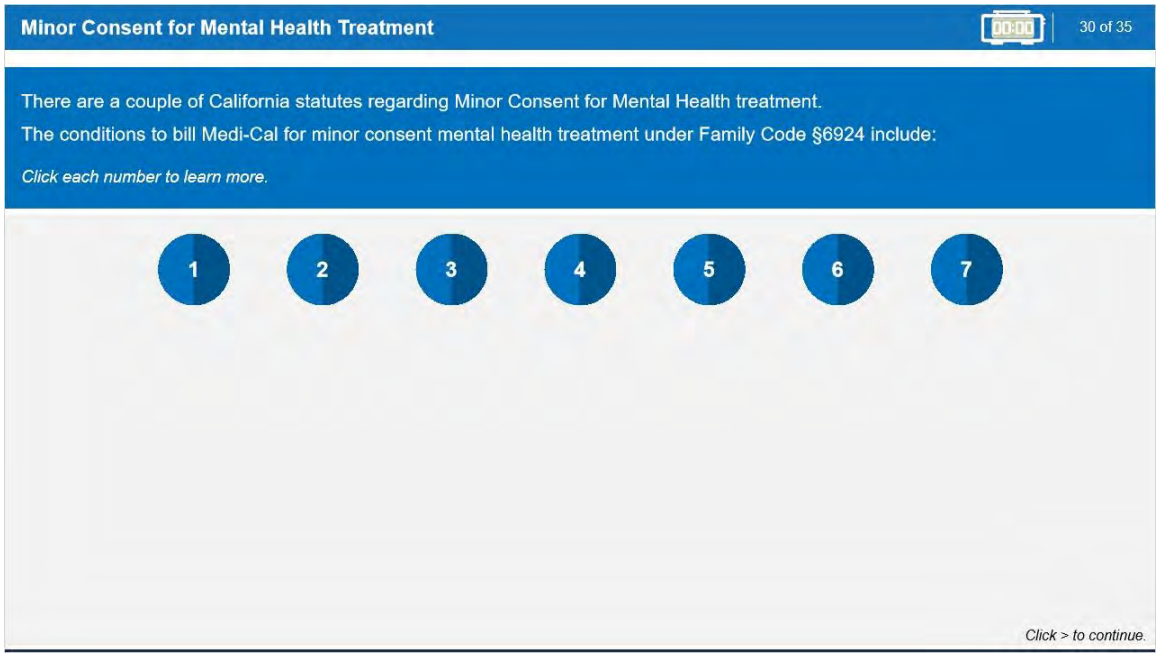


Geographic limitations (Slide Layer)

Privacy (Slide Layer)



1.30 Minor Consent for Mental Health Treatment



Notes:

There are a couple of California statutes regarding Minor Consent for Mental Health

treatment.

Let's discuss Family Code §6924, as these criteria are the only conditions that we can bill Medi-Cal for minor consent mental health treatment.

When can a minor consent to services under this statute?

A minor can consent to mental health treatment if he or she meets all of the following requirements:

- The minor must be 12 years of age or older,
- The minor is mature enough to participate intelligently in the treatment in the opinion of the attending professional person, and
- The minor would be in danger of serious physical or mental harm to him/himself or others without treatment, or the minor is the alleged victim of incest or child abuse.

What mental health services can minors consent to under this statute?

A minor can consent to outpatient mental health treatment and counseling.

What mental health services are not covered by this statute?

Minors cannot consent to any of the following services under this statute:

- Inpatient mental health treatment,
- Psychotropic drugs,
- Convulsive therapy, and
- Psychosurgery.

Do parents need to be notified when a minor consents to mental health treatment under this law?

The mental health treatment or counseling of a minor must include the involvement of the minor's parent or guardian unless the professional person who is treating or counseling the minor determines that the involvement would be inappropriate.

The professional person who is treating or counseling the minor shall state in the client record when the provider attempted to contact the minor's parent or guardian; whether the attempt was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

Involvement of parents or guardians in treatment will necessitate sharing certain confidential information; however, it does not mean that parents or guardians have a right to access confidential records.

Do parents have a right to access the mental health records regarding services

provided under this statute?

When a minor consents to treatment under this statute, the provider can only share the related mental health records with parents or guardians when the provider has written authorization from the minor.

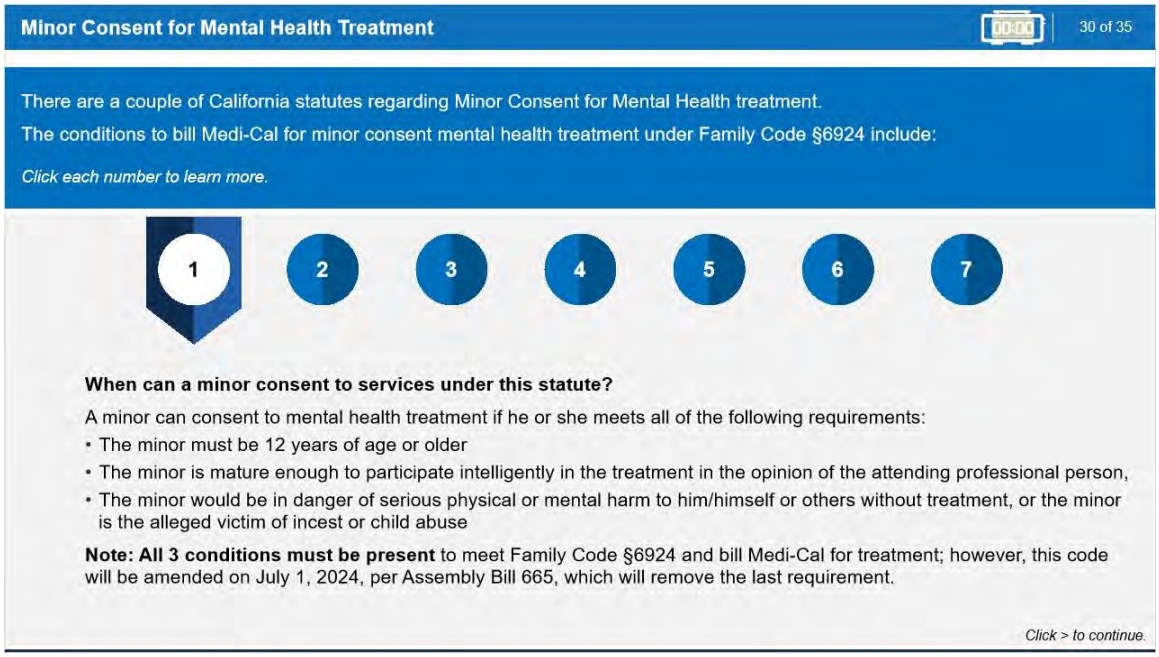
Are parents financially liable for services?

The minor's parents or guardian are not liable for payment for treatment provided under minor consent unless the parent or guardian participates in the treatment.

Are there any differences in the funding sources available for these services?

Family Code §6924 contains no insurance funding restrictions.

T1 (Slide Layer)



T2 (Slide Layer)

Minor Consent for Mental Health Treatment 30 of 35

There are a couple of California statutes regarding Minor Consent for Mental Health treatment.
The conditions to bill Medi-Cal for minor consent mental health treatment under Family Code §6924 include:

Click each number to learn more.

1 2 3 4 5 6 7

What mental health services can minors consent to under this statute?

A minor can consent to outpatient mental health treatment and counseling.

Click > to continue.

T3 (Slide Layer)

Minor Consent for Mental Health Treatment 30 of 35

There are a couple of California statutes regarding Minor Consent for Mental Health treatment.
The conditions to bill Medi-Cal for minor consent mental health treatment under Family Code §6924 include:

Click each number to learn more.

1 2 3 4 5 6 7

What mental health services are not covered by this statute?

Minors *cannot* consent to any of the following services under this statute:

- Inpatient mental health treatment
- Psychotropic drugs
- Convulsive therapy
- Psychosurgery

Click > to continue.

T4 (Slide Layer)

Minor Consent for Mental Health Treatment 30 of 35

There are a couple of California statutes regarding Minor Consent for Mental Health treatment.

The conditions to bill Medi-Cal for minor consent mental health treatment under Family Code §6924 include:

Click each number to learn more.

1 2 3 4 5 6 7

Do parents need to be notified when a minor consents to mental health treatment under this law?

Parents or guardians must be involved in the minor's treatment unless the provider determines that their involvement would be inappropriate.

The professional person who is treating or counseling the minor shall state in the client record when the provider attempted to contact the minor's parent or guardian.

Involving parents or guardians in treatment will necessitate **sharing certain confidential information**; however, having them participate does not mean parents have a **right to access confidential records**.

Click > to continue.

T5 (Slide Layer)

Minor Consent for Mental Health Treatment 30 of 35

There are a couple of California statutes regarding Minor Consent for Mental Health treatment.

The conditions to bill Medi-Cal for minor consent mental health treatment under Family Code §6924 include:

Click each number to learn more.

1 2 3 4 5 6 7

Do parents have a right to access the mental health records regarding services provided under this statute?

When a minor consents to treatment under this statute, the provider can only share the related mental health records with parents or guardians when the provider has written authorization from the minor.

Click > to continue.

T6 (Slide Layer)

Minor Consent for Mental Health Treatment 30 of 35

There are a couple of California statutes regarding Minor Consent for Mental Health treatment.
The conditions to bill Medi-Cal for minor consent mental health treatment under Family Code §6924 include:

Click each number to learn more.

1 2 3 4 5 6 7

Are parents financially liable for services?

The minor's parents or guardian are not liable for payment for treatment provided under minor consent unless the parent or guardian participates in the treatment.

Click > to continue.

T7 (Slide Layer)

Minor Consent for Mental Health Treatment 30 of 35

There are a couple of California statutes regarding Minor Consent for Mental Health treatment.
The conditions to bill Medi-Cal for minor consent mental health treatment under Family Code §6924 include:

Click each number to learn more.

1 2 3 4 5 6 7

Are there any differences in the funding sources available for these services?

Family Code §6924 contains no insurance funding restrictions.

Click > to continue.

1.31 Summary

Notes:

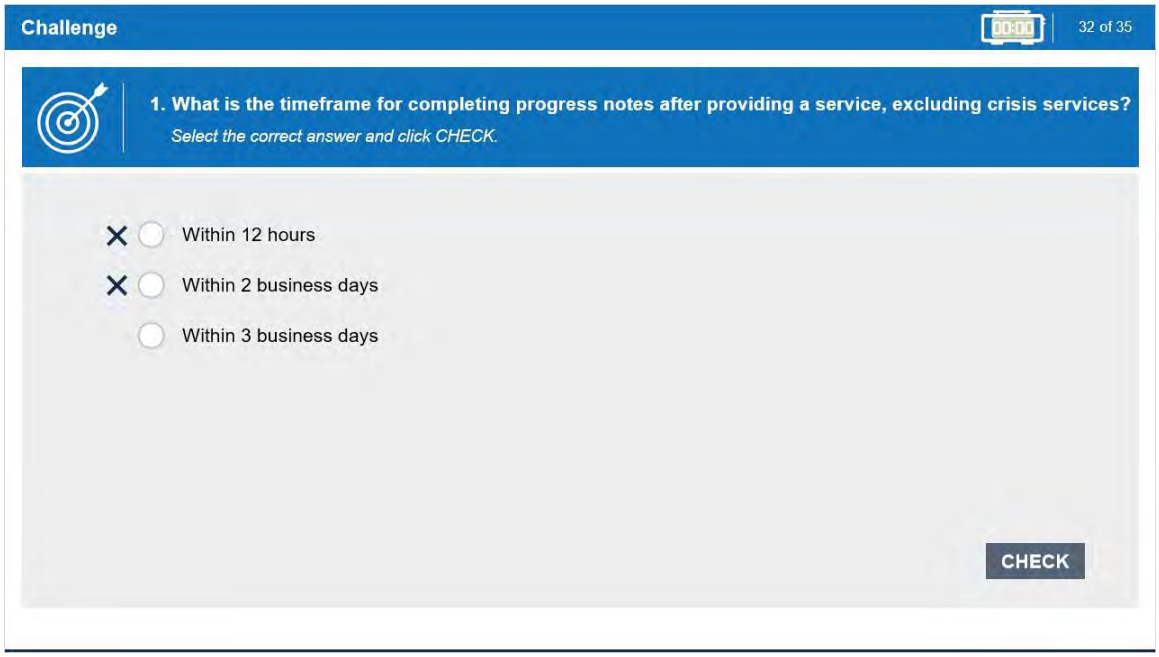
We have come to the end of this module, let's summarize.

- A key aspect of documentation standards as it relates to providing services is that providers must operate within their scope of practice.
- Non-registered or non-waivered providers should avoid using language typically associated with psychotherapy.
- Social Drivers of Health can provide interventions for the purpose of providing mental health care.
- ICD-10 codes are used for all claims related to SMHS.
- Care Plans should be reviewed annually. During the review, you need to:
    - Document the annual review on the corresponding progress note,
    - Make updates to the Care Plan if deemed clinically necessary, and
    - Document the clinical reason for updating the Care Plan in the progress note.
- Progress notes are required for all billable and non-billable services. The progress note documentation should be individualized, clear, concise, and succinct rather than a detailed narrative and contain the required elements.
- The timeframe in which most progress notes are to be completed is within 3 business days of service. Crisis services are to be documented within 24 hours of rendering the service.

- Direct patient care refers to the time spent directly with a client for the purpose of providing healthcare.
- Telephonic services are identified as services that occur when you speak with a client over the telephone only and are not able to see the individual.
- Telehealth services occur when a service is provided over the telephone or computer and the provider is able to see the client through an audio-visual platform.

1.32 Challenge

(Pick One, 10 points, 1 attempt permitted)



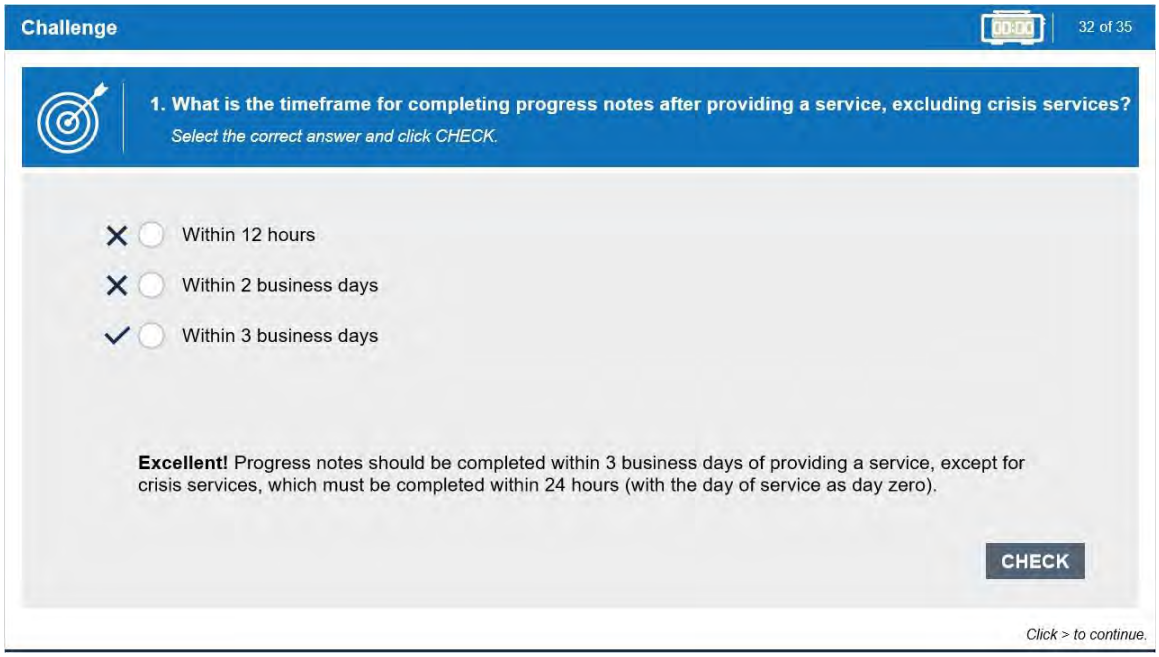
Correct	Choice
	Within 12 hours
	Within 2 business days
X	Within 3 business days

Notes:

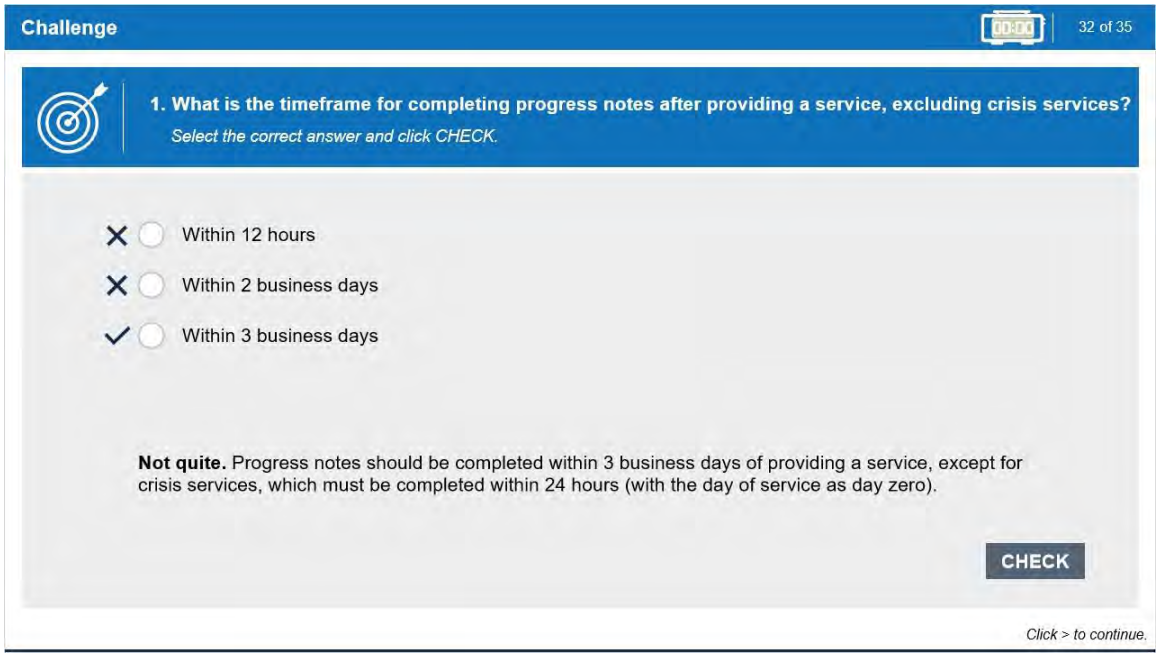
It's time for an activity.

What is the timeframe for completing progress notes after providing a service, excluding crisis services?

Correct (Slide Layer)

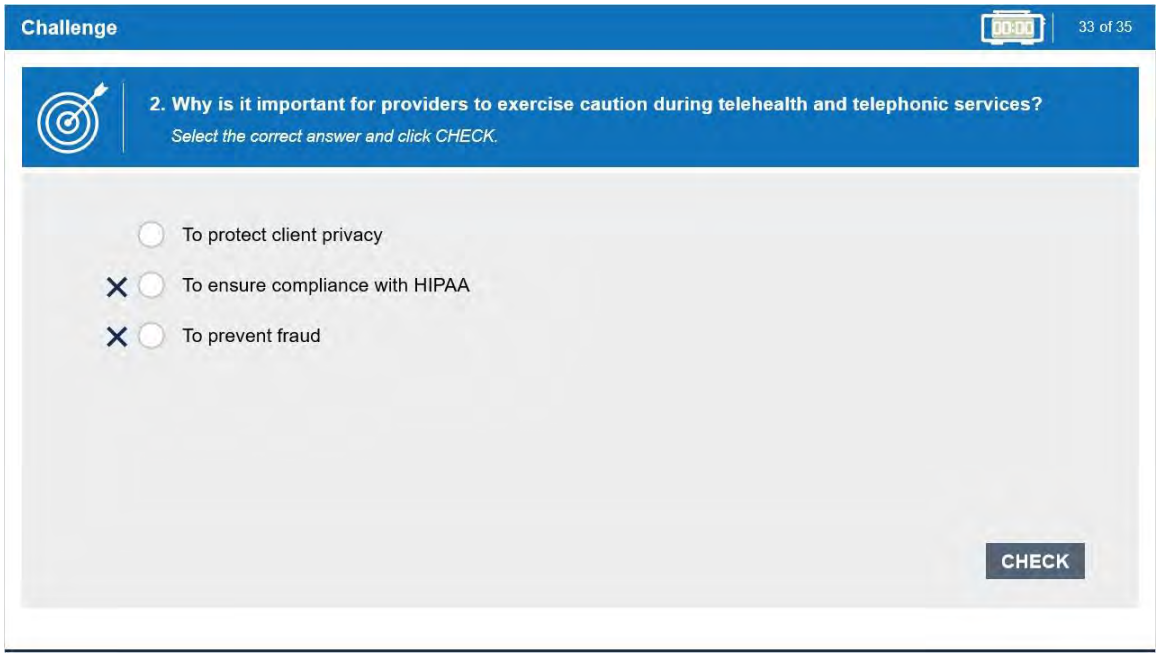


Incorrect (Slide Layer)



1.33 Challenge

(Pick One, 10 points, 1 attempt permitted)

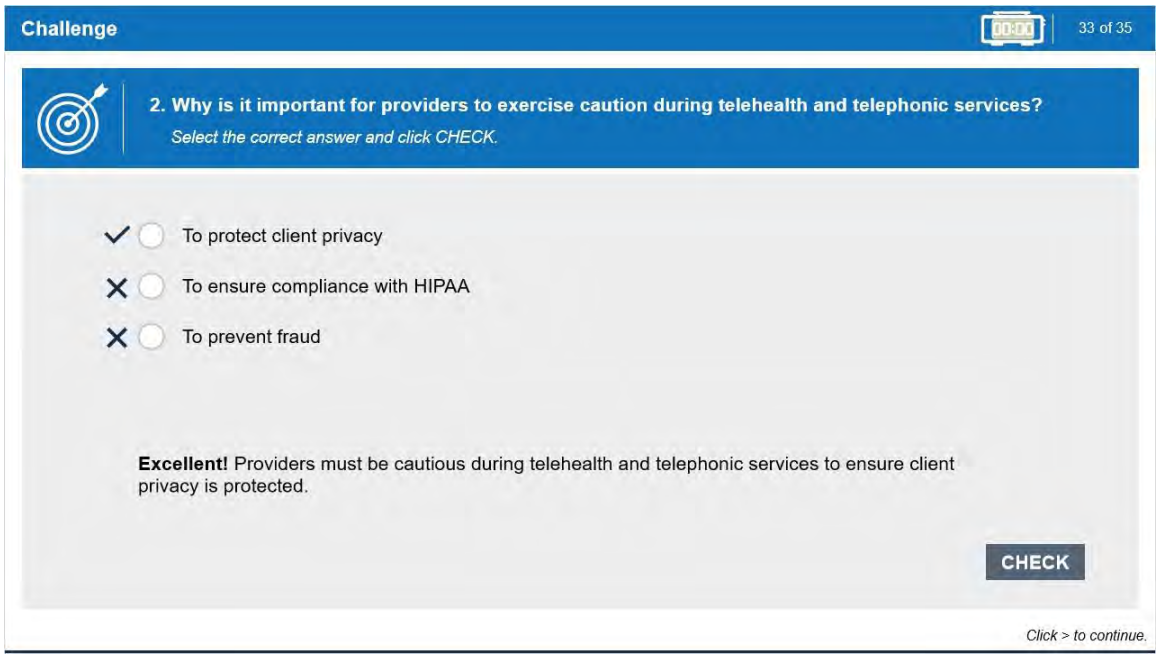


Correct	Choice
X	To protect client privacy
	To ensure compliance with HIPAA
	To prevent fraud

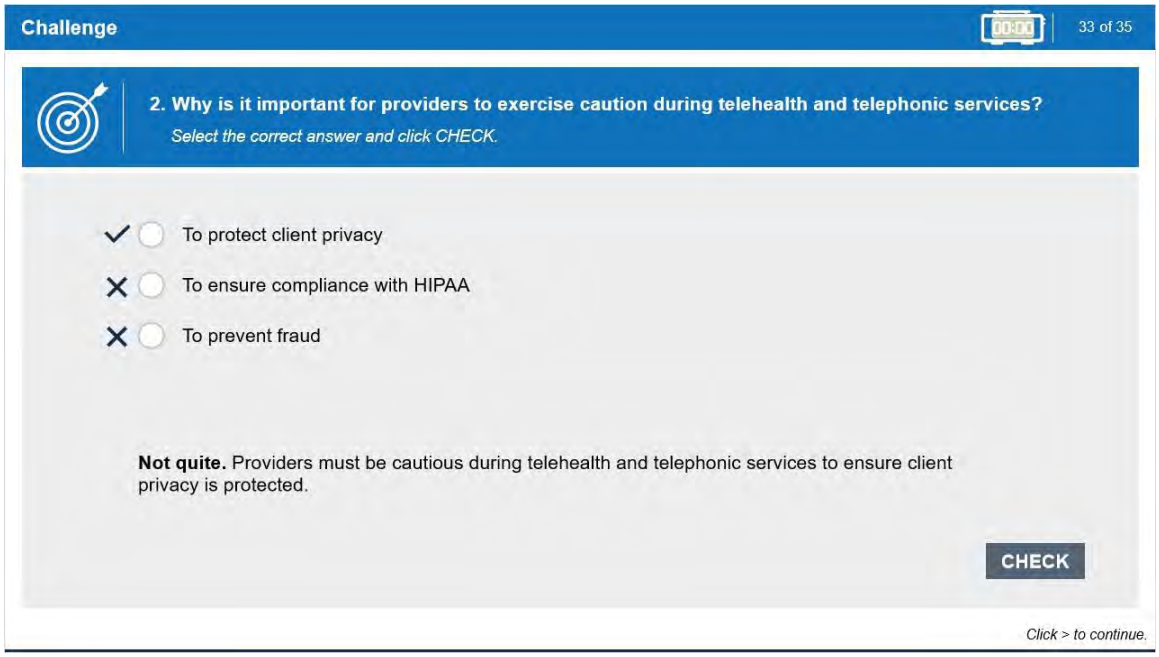
Notes:

Why is it important for providers to exercise caution during telehealth and telephonic services?

Correct (Slide Layer)

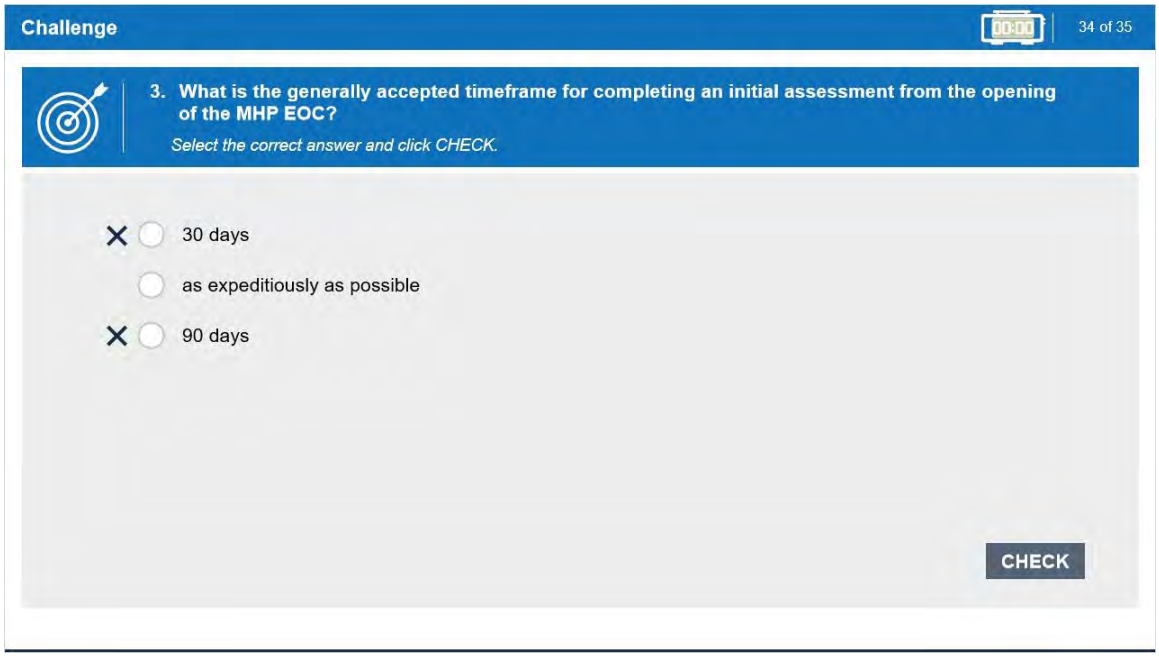


Incorrect (Slide Layer)



1.34 Challenge

(Pick One, 10 points, 1 attempt permitted)

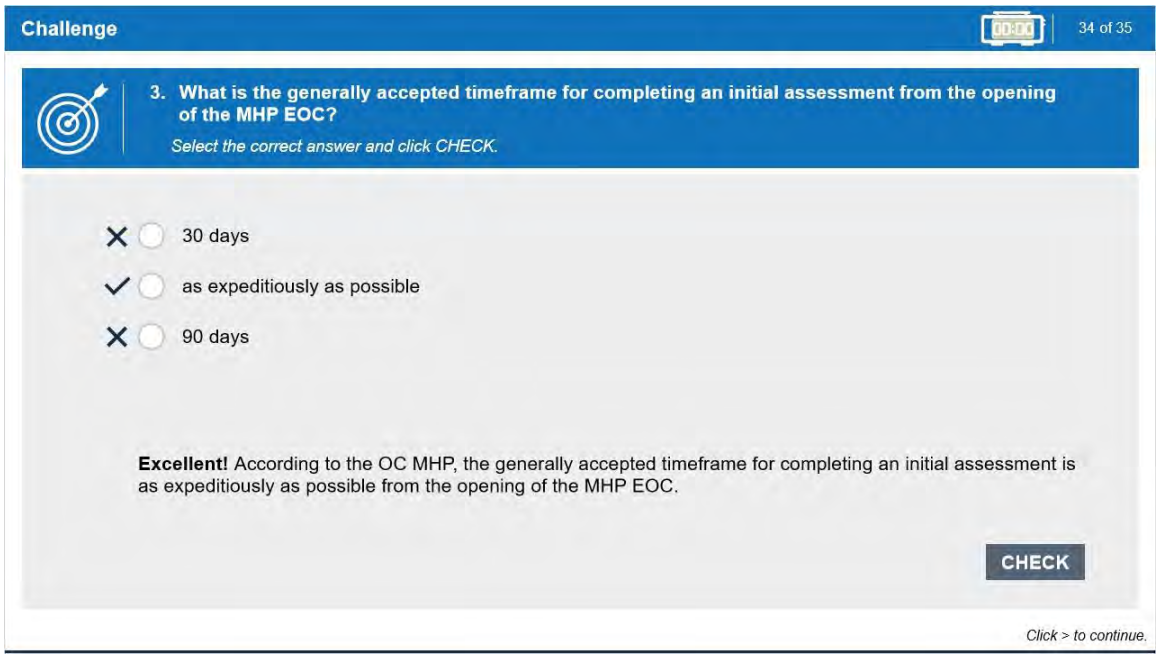


Correct	Choice
	30 days
X	as expeditiously as possible
	90 days

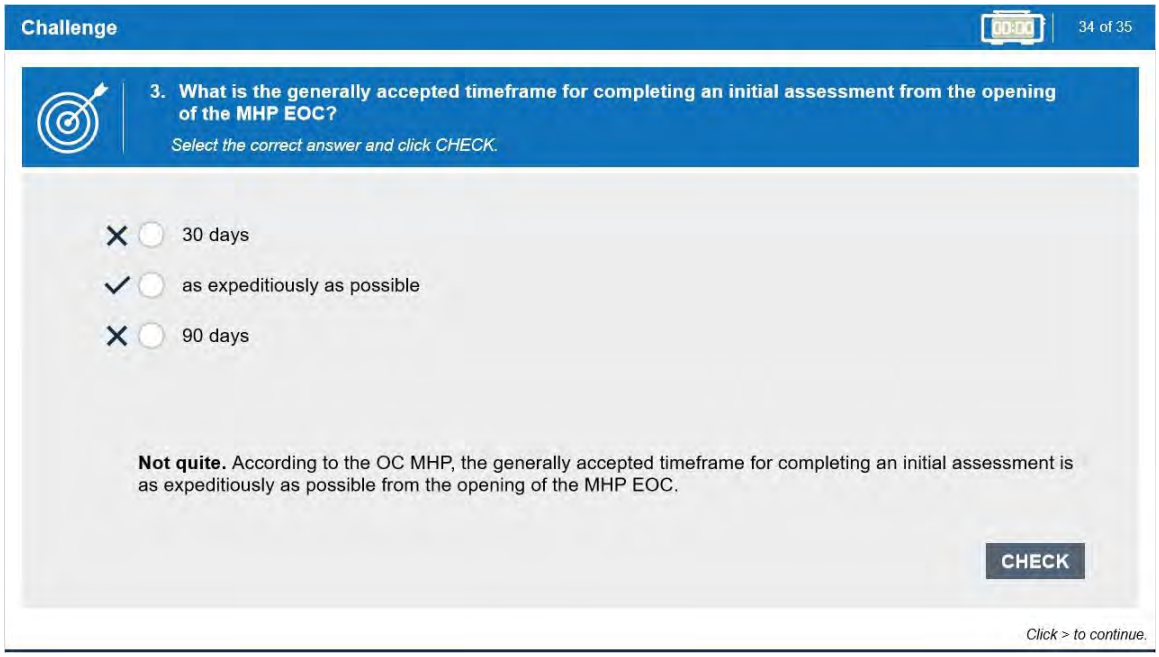
Notes:

What is the generally accepted timeframe for completing an initial assessment from the opening of the MHP EOC?

Correct (Slide Layer)



Incorrect (Slide Layer)



1.35 Thank you

Notes:

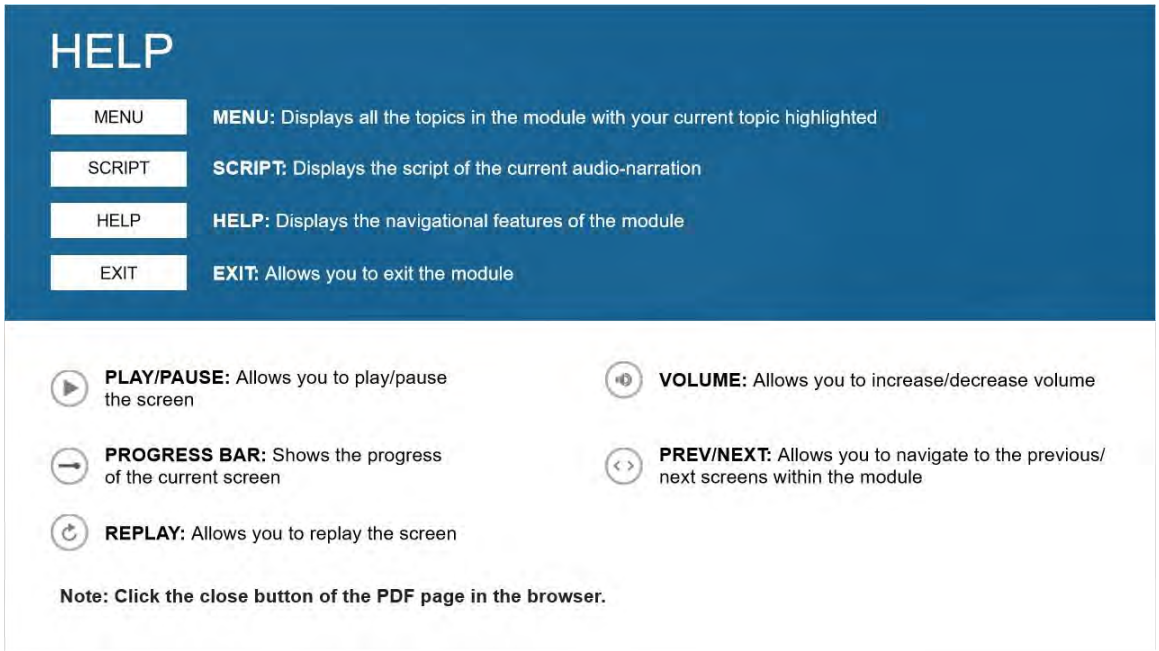
Thank you for completing the 'Children & Youth Services Documentation Standards'

module.

Click the link to start with the next module 'Children & Youth Services Additional State Requirements'.

2. Help

2.1 Help

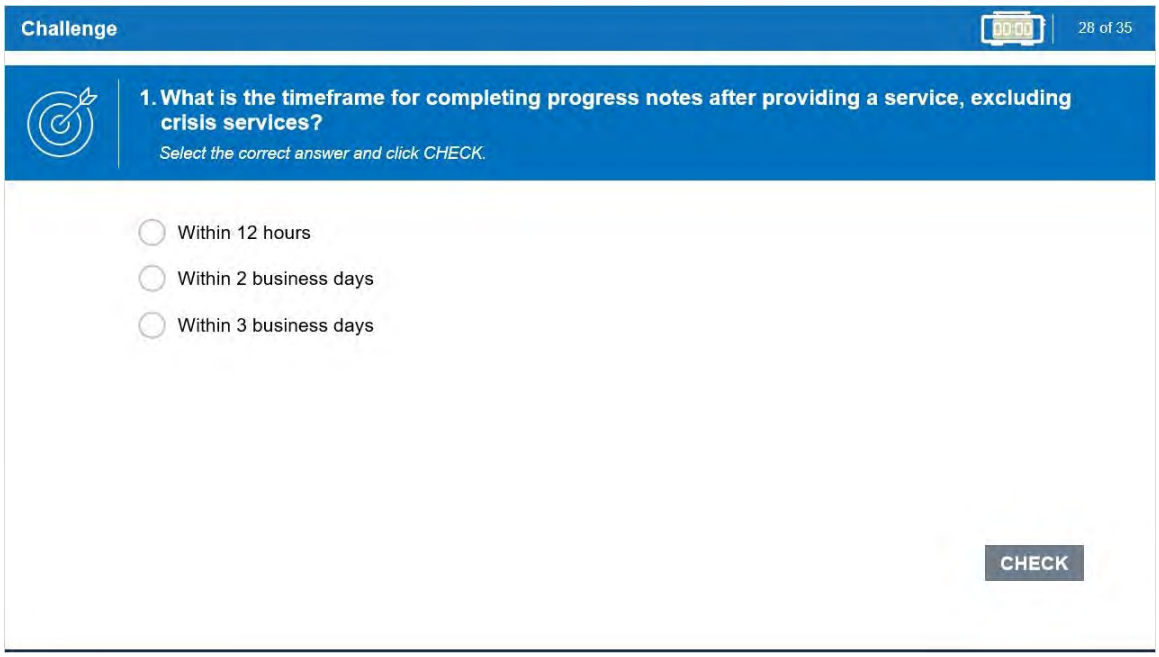


Notes:

1. Quiz

Q1.1 Challenge

(Pick One, 10 points, 1 attempt permitted)

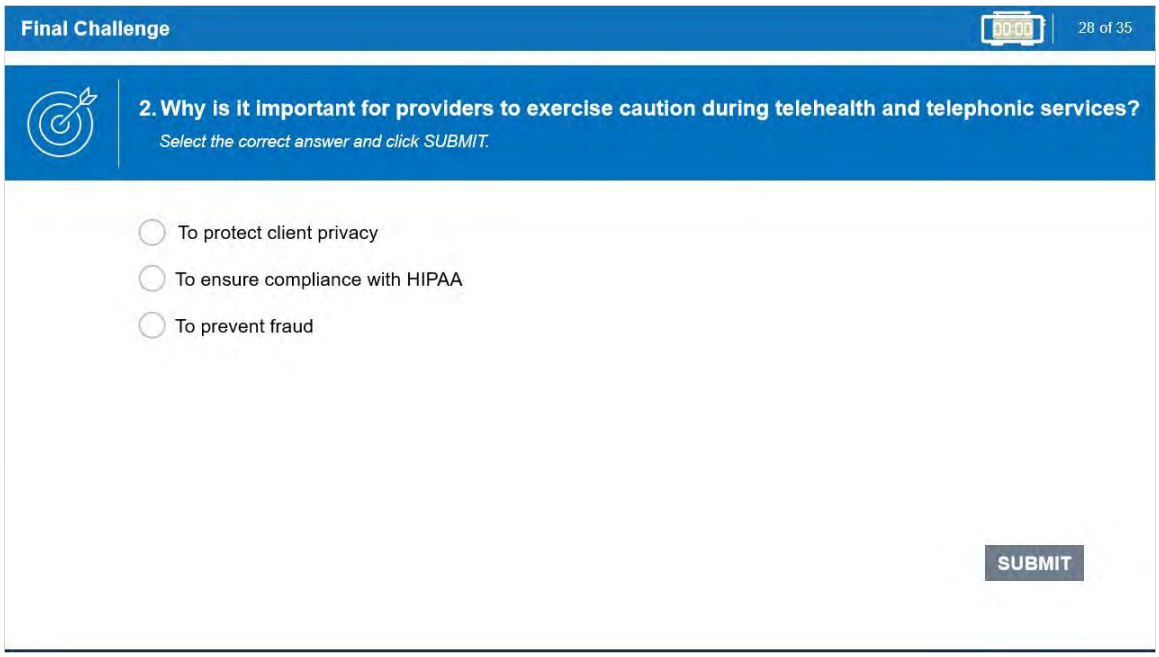


Correct	Choice
	Within 12 hours
	Within 2 business days
X	Within 3 business days

Notes:

Q1.2 Final Challenge

(Pick One, 10 points, 1 attempt permitted)

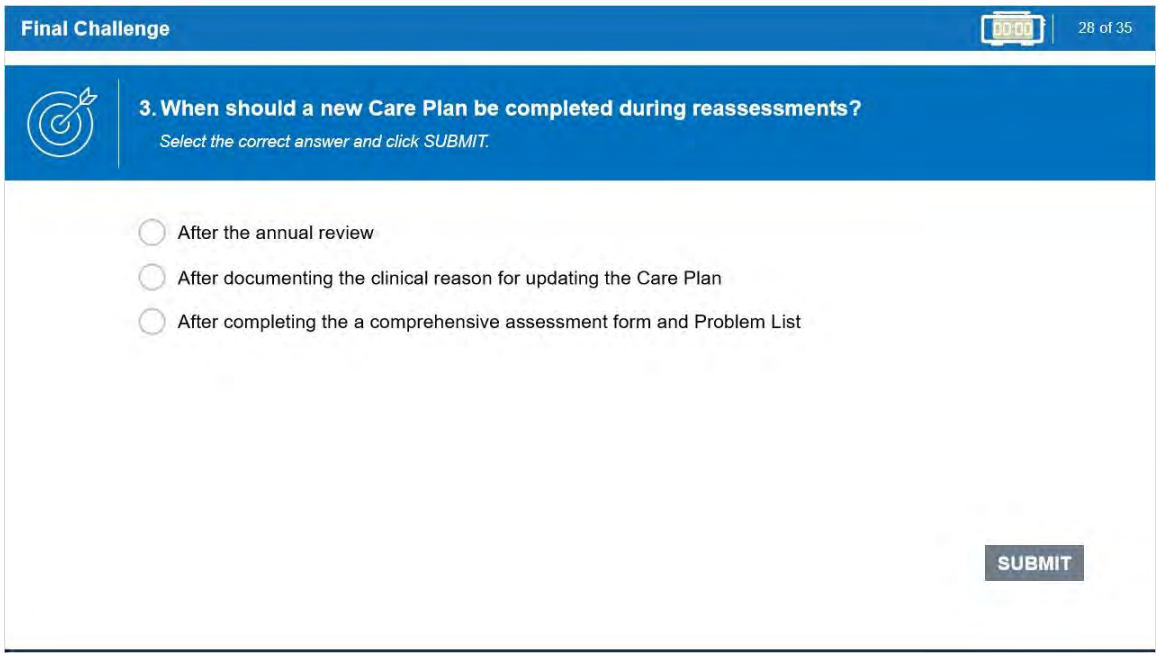


Correct	Choice
X	To protect client privacy
	To ensure compliance with HIPAA
	To prevent fraud

Notes:

Q1.3 Final Challenge

(Pick One, 10 points, 1 attempt permitted)

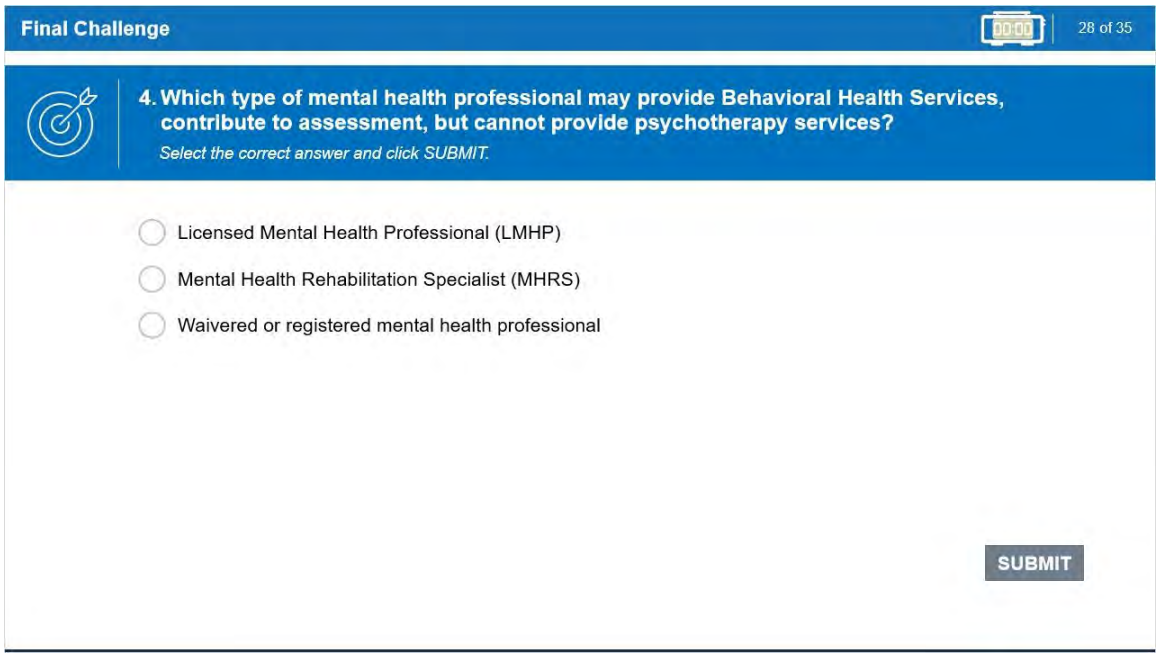


Correct	Choice
	After the annual review
	After documenting the clinical reason for updating the Care Plan
X	After completing the a comprehensive assessment form and Problem List

Notes:

Q1.4 Final Challenge

(Pick One, 10 points, 1 attempt permitted)

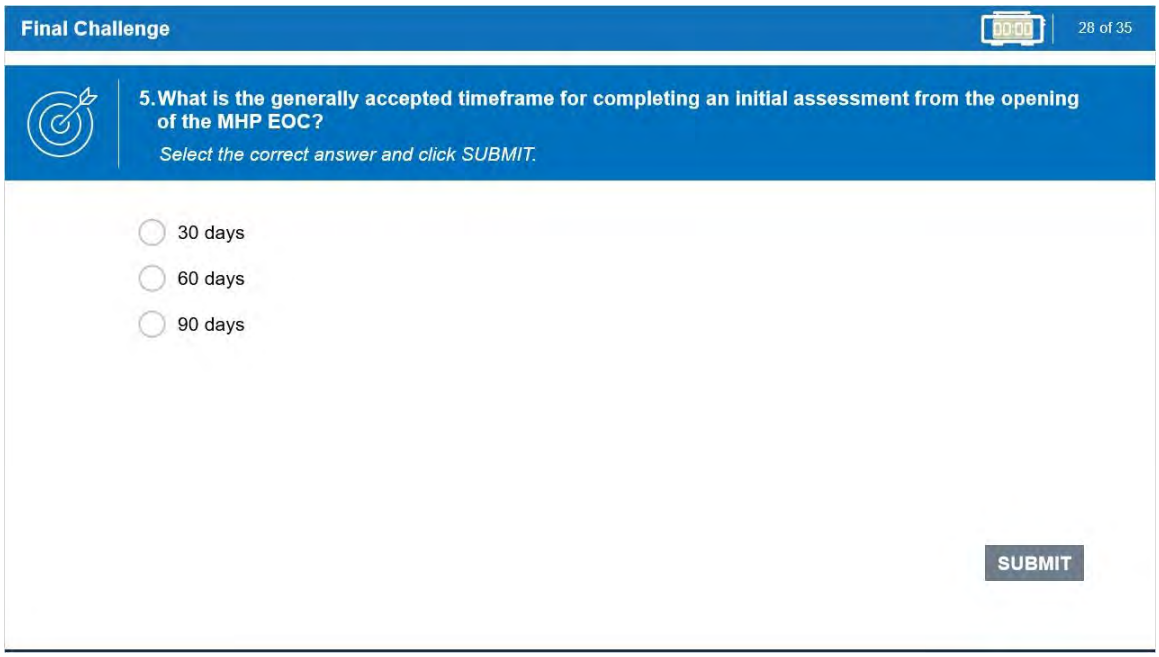


Correct	Choice
	Licensed Mental Health Professional (LMHP)
X	Mental Health Rehabilitation Specialist (MHRS)
	Waivered or registered mental health professional

Notes:

Q1.5 Final Challenge

(Pick One, 10 points, 1 attempt permitted)



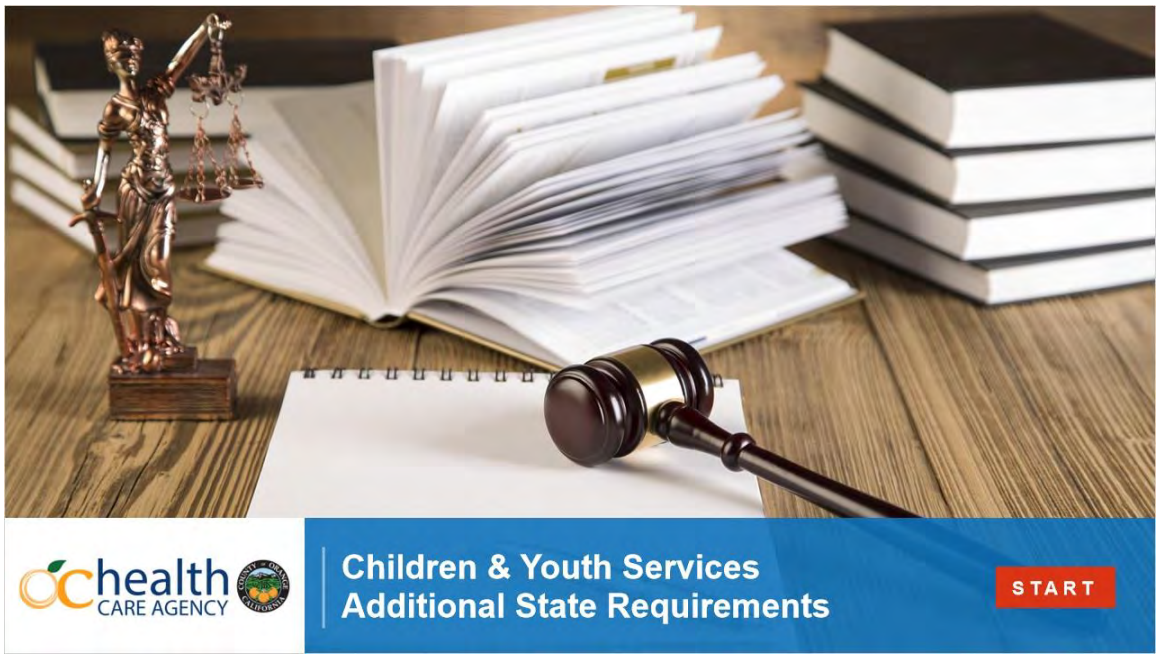
Correct	Choice
	30 days
X	60 days
	90 days

Notes:

Children & Youth Services Additional State Requirements

1. Welcome

1.1 Welcome

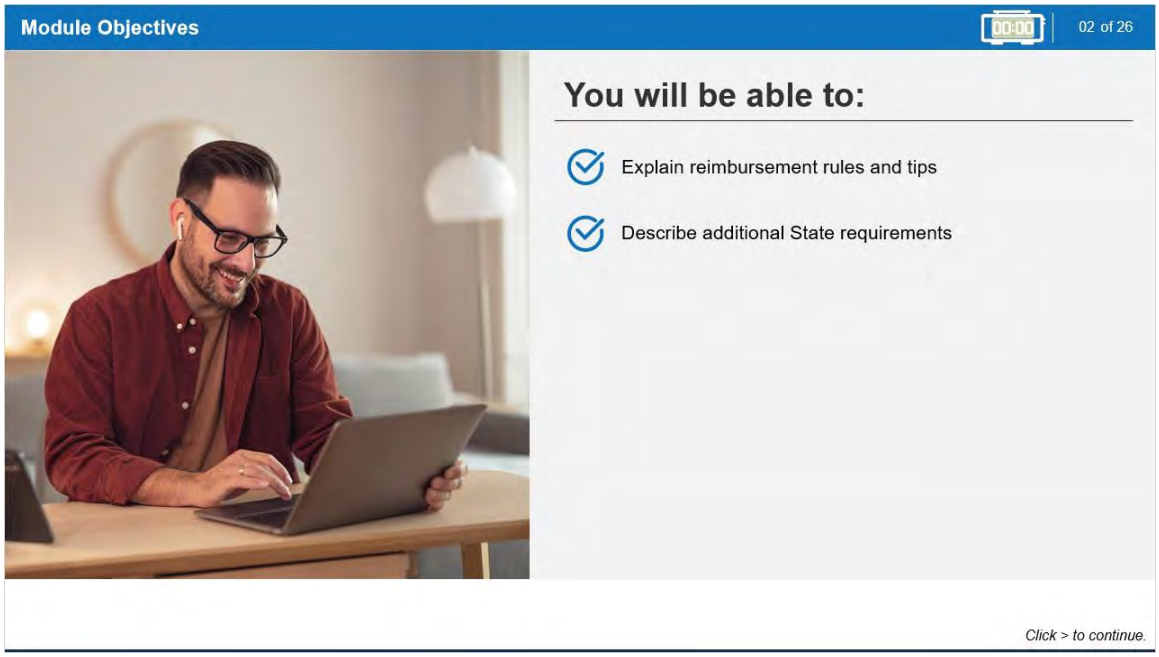


Notes:

Welcome to the module 'Children & Youth Services Additional State Requirements'.

Click the 'Help' on the top right of your screen to learn how to navigate through this module. You can proceed directly if you've been here before.

1.2 Module Objectives

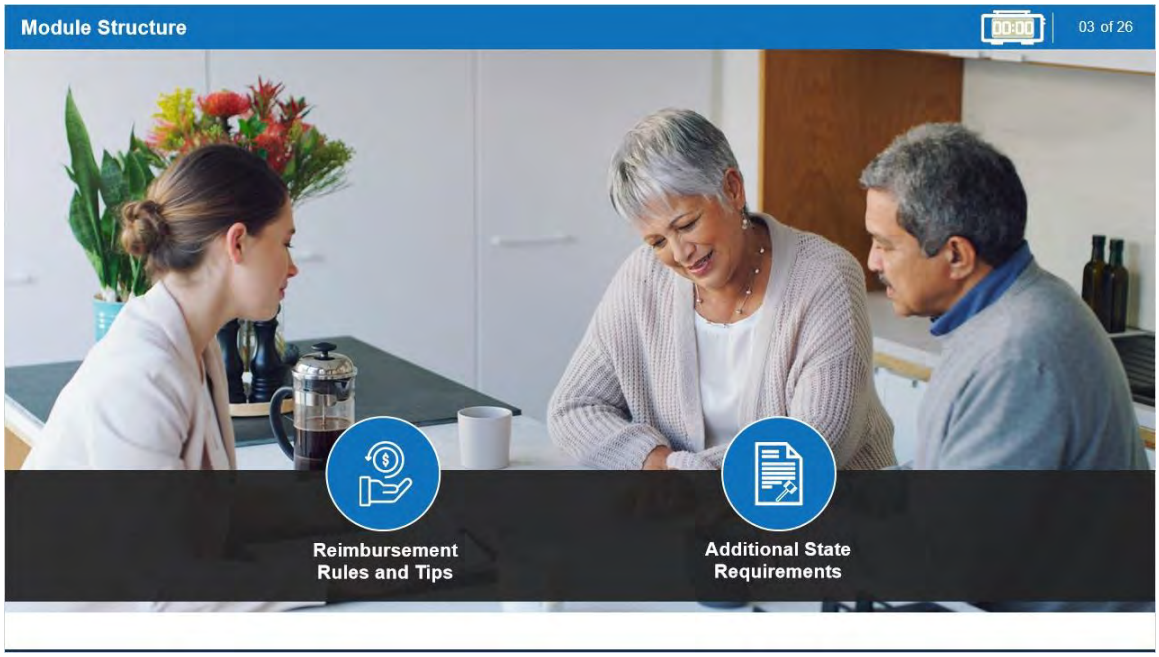


Notes:

So…what can you expect out of this module?

By the end of this module, you will be able to explain reimbursement rules and tips, and describe additional State requirements.

1.3 Module Structure



Notes:

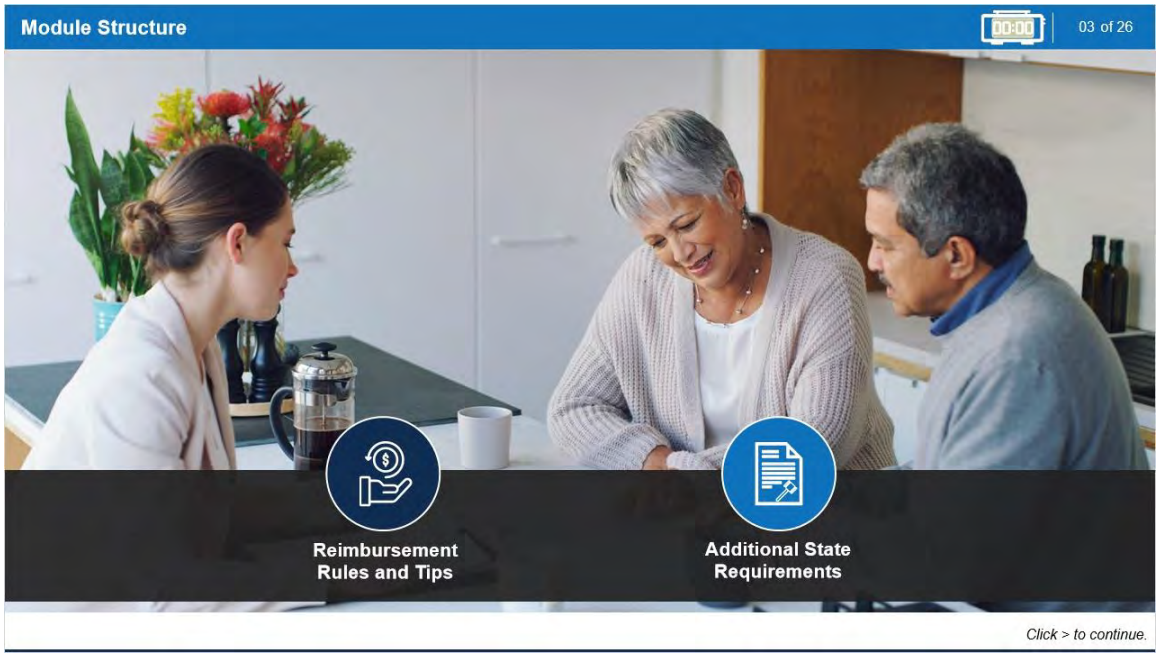
This module is divided into two units.

- Reimbursement Rules and Tips
- Additional State Requirements.

At the end, we will wrap up with a summary.

2. Unit 1: Reimbursement Rules and Tips

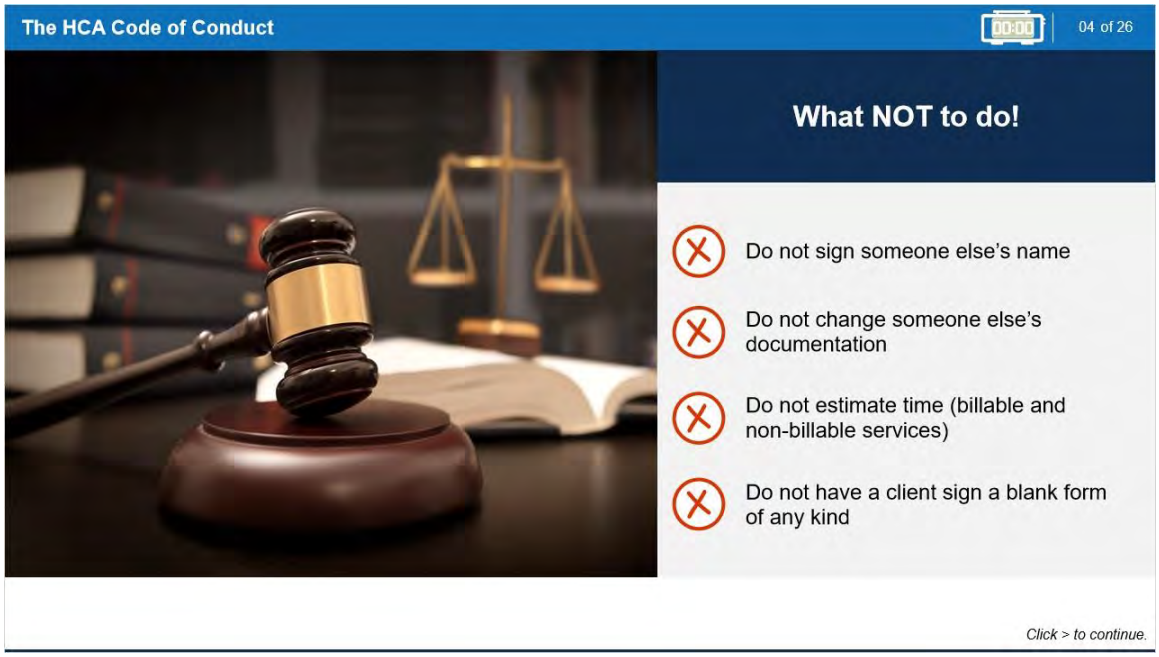
2.1 Reimbursement Rules and Tips



Notes:

Let's start with Reimbursement Rules and Tips.

2.2 The HCA Code of Conduct



Notes:

Signing another person's signature is a violation of the HCA Code of Conduct and is illegal as well.

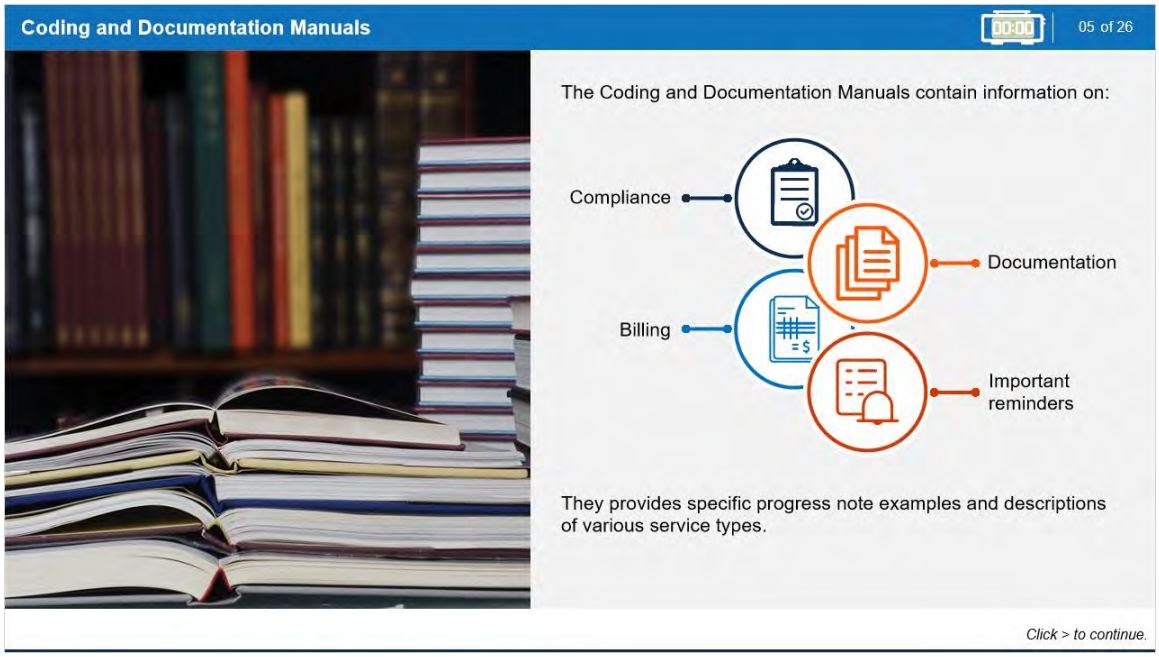
If someone writes a progress note, no one else should alter it. Remember that it is the provider who provided the service who knows what happened.

There are a few highly defined situations in which a Service Chief or Manager can amend chart documentation. These situations are specified in Policies and Procedures (P&Ps).

Estimating the time spent on any service, billable or non-billable, is a violation of the HCA Code of Conduct. Billing must be based on exact minutes.

Lastly, do not have clients sign a blank form of any kind.

2.3 Coding and Documentation Manuals



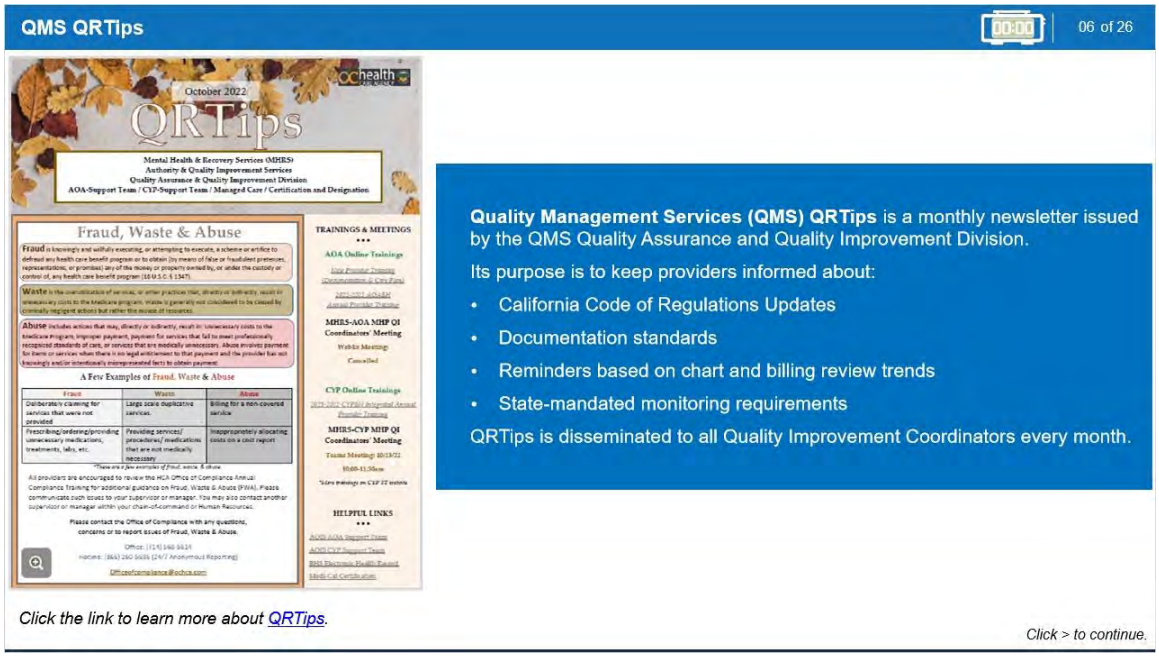
Notes:

The Coding and Documentation Manuals contain information on compliance, documentation, billing, and important reminders.

They provides specific progress note examples and descriptions of various service types.

The manuals are critical reference tools for providers to code and document according to Mental Health Plan (MHP) standards.

2.4 QMS QRTips



Notes:

Quality Management Services (QMS) QRTips is a monthly newsletter issued by the QMS Quality Assurance and Quality Improvement Division.

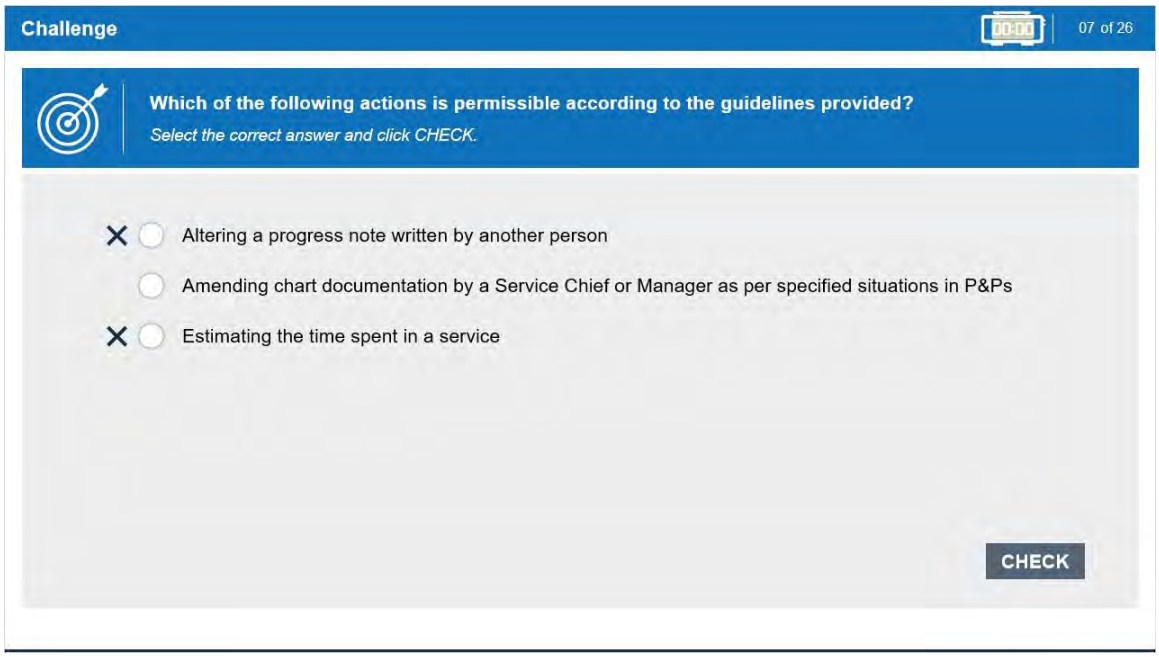
Its purpose is to keep providers informed about California Code of Regulations Updates, documentation standards, reminders based on chart and billing review trends and State-mandated monitoring requirements.

QRTips is disseminated to all Quality Improvement Coordinators every month. These coordinators are responsible for sharing and discussing QRTips with their providers.

It is encouraged to be shared with all providers via email and discussed in staff meetings.

2.5 Challenge

(Pick One, 10 points, 1 attempt permitted)



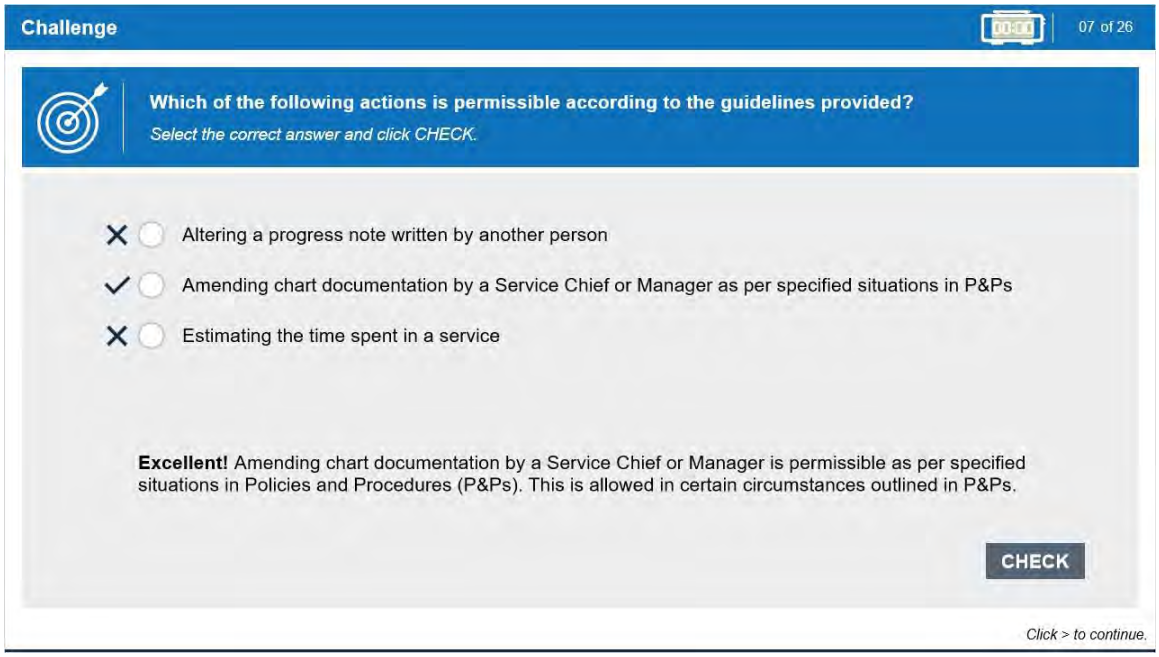
Correct	Choice
	Altering a progress note written by another person
X	Amending chart documentation by a Service Chief or Manager as per specified situations in P&Ps
	Estimating the time spent in a service

Notes:

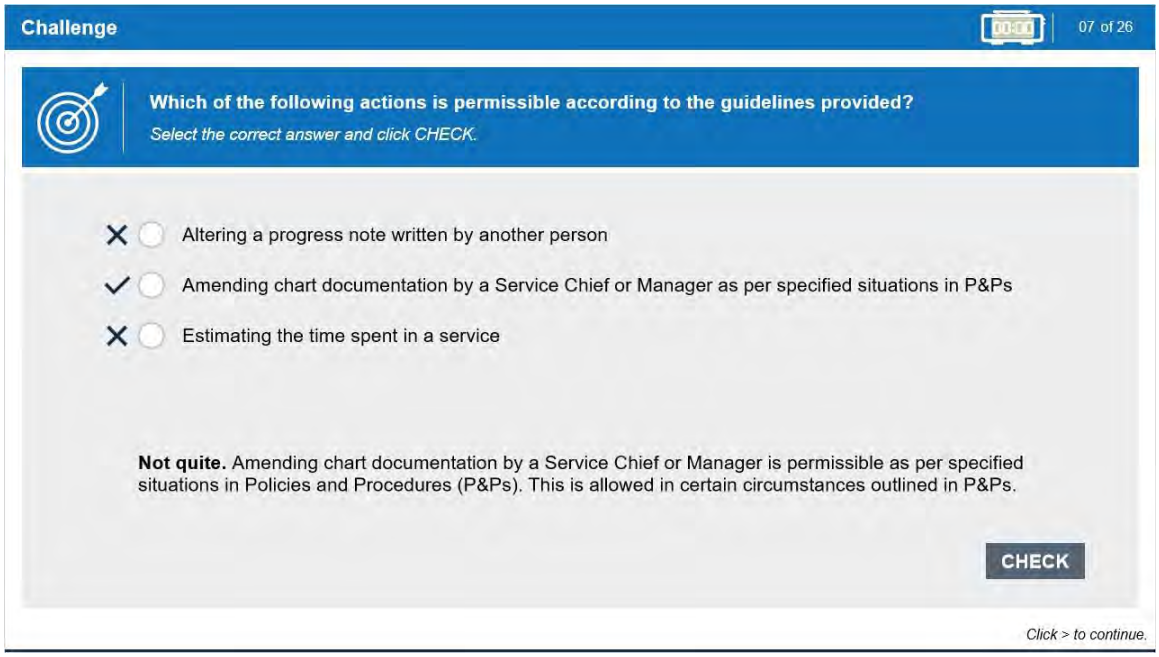
It's time for an activity.

Which of the following actions is permissible according to the guidelines provided?

Correct (Slide Layer)

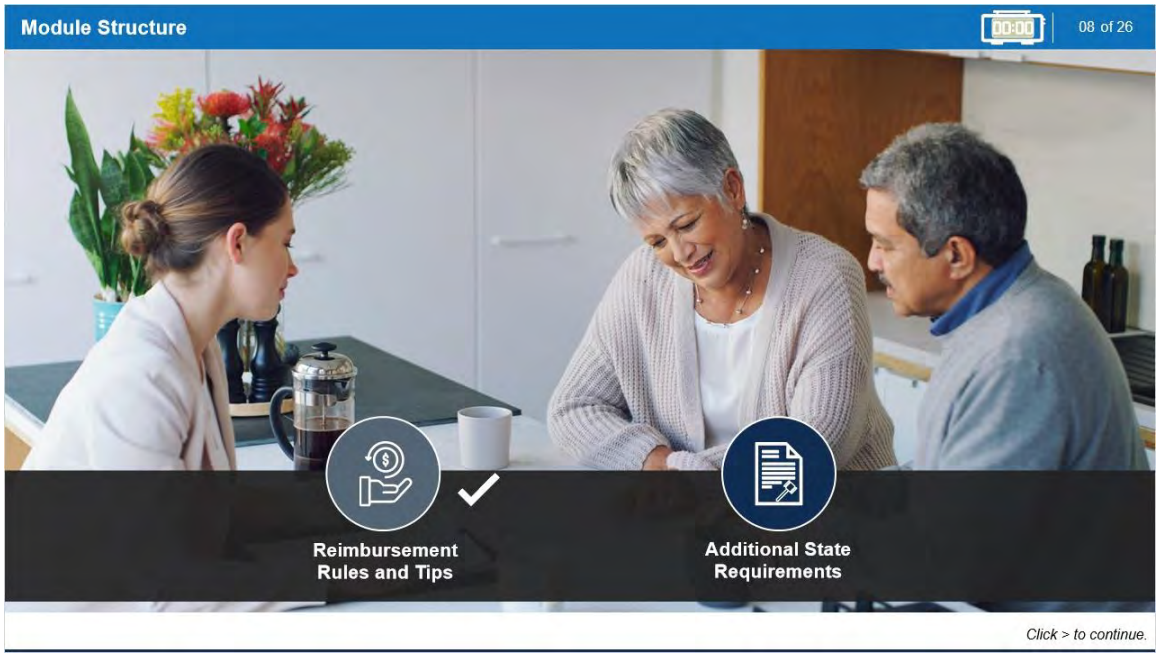


Incorrect (Slide Layer)



3. Unit 2: Additional State Requirements

3.1 Additional State Requirements



Notes:

Now that we've gone through Reimbursement Rules and Tips, let's move on to Additional State Requirements.

3.2 Pathways to Well-Being and Intensive Services

Notes:

DHCS released BH Info Notice 21-058, which outlines expectations for Pathways to Well-Being (PWB) and Intensive Services (IS).

Expanded eligibility for ICC/IHBS or TFC services for PWB subclass member and those that meet medical necessity for Intensive Services is an important reminder in our practice.

Qualified healthcare professionals with clinical expertise shall make the decision to authorize or deny services based on medical necessity and must clearly document it.

Additionally, MHP and providers of ICC/IHBS services must submit the correct HCPC codes with the HK modifier.

Ensure timely access for routine referrals within 10 days and urgent referrals within 48 hours.

No authorization is needed for ICC services, but IHBS/TFC services require authorization.

Clients must be under 21 years of age to receive ICC and IHBS services.

Additionally, the PWB/IS eligibility form must be in the chart, and individuals must meet medical necessity criteria to be eligible for PWB/IS.

Assessment codes can be used for any assessment service, as long as the assessment activity is not part of the CFT meeting.

Lastly, there should be a reassessment every 90 days to evaluate the child's strengths and needs.

ICC codes will be used for all ICC-related activities, including developing the ICC care plan and consultations.

Tab 01 (Slide Layer)

Tab 02 (Slide Layer)

Pathways to Well-Being and Intensive Services 09 of 26

DHCS released BH Info Notice 21-058, which outlines expectations for **Pathways to Well-Being (PWB) and Intensive Services (IS)**.

Click each number to learn more.

1 2 3 4

Here are a few important remainders.

- MHP and providers of ICC/IHBS services must submit (billing) the correct HCPC codes with the HK modifier.
- Ensure timely access for routine referrals within 10 days and urgent referrals within 48 hours.
- No authorization is needed for ICC services, but IHBS/TFC services require authorization.

Click > to continue.

Tab 03 (Slide Layer)

Pathways to Well-Being and Intensive Services 09 of 26

DHCS released BH Info Notice 21-058, which outlines expectations for **Pathways to Well-Being (PWB) and Intensive Services (IS)**.

Click each number to learn more.

1 2 3 4

Here are a few important remainders.

- Clients must be under 21 years of age to receive ICC and IHBS services.
- The PWB/IS eligibility form must be in the chart, and individuals must meet medical necessity criteria to be eligible for PWB/IS.
- Assessment codes can be used for any assessment service, as long as the assessment activity is not part of the CFT meeting.

Click > to continue.

Tab 04 (Slide Layer)

Pathways to Well-Being and Intensive Services 09 of 26

DHCS released BH Info Notice 21-058, which outlines expectations for **Pathways to Well-Being (PWB) and Intensive Services (IS)**.

Click each number to learn more.

1 2 3 4

Here are a few important remainders.

- There should be a reassessment every 90 days to evaluate the child's strengths and needs.
- ICC codes will be used for all ICC-related activities, including developing the ICC care plan and consultations.

Click > to continue.

PDF (Slide Layer)

Pathways to Well-Being and Intensive Services 09 of 26

DHCS released BH Info Notice 21-058, which outlines expectations for **Pathways to Well-Being (PWB) and Intensive Services (IS)**.

Click each number to learn more.

1 2 3 4

Click the PDF icon to learn more about the important reminders in detail.

Click > to continue.

3.3 CalAIM Changes: ICC and IHBS Guidelines

CalAIM Changes: ICC and IHBS Guidelines 10 of 26

As a result of CalAIM changes:

1. ICC and IHBS can be provided upon completion of the 7-Domain Assessment.
2. Both the ICC Care Plan and the PWB/IS eligibility form are completed, and the PWB/IS cohort is registered in IRIS.
3. If the client is transferred with an open PWB/IS cohort registration in IRIS, the new program can provide ICC/IHBS if prior authorization exists.
4. The ICC Care Plan must be reviewed at least once annually.
5. When the client turns 21 years of age, they are no longer eligible for ICC/IHBS and require a TCM CP progress note to continue with targeted case management.

Click the PDF icon to learn more.

Click > to continue.

Notes:

As a result of CalAIM changes, ICC and IHBS (if clinically indicated) can be provided upon completion of the 7-Domain Assessment to establish medical necessity.

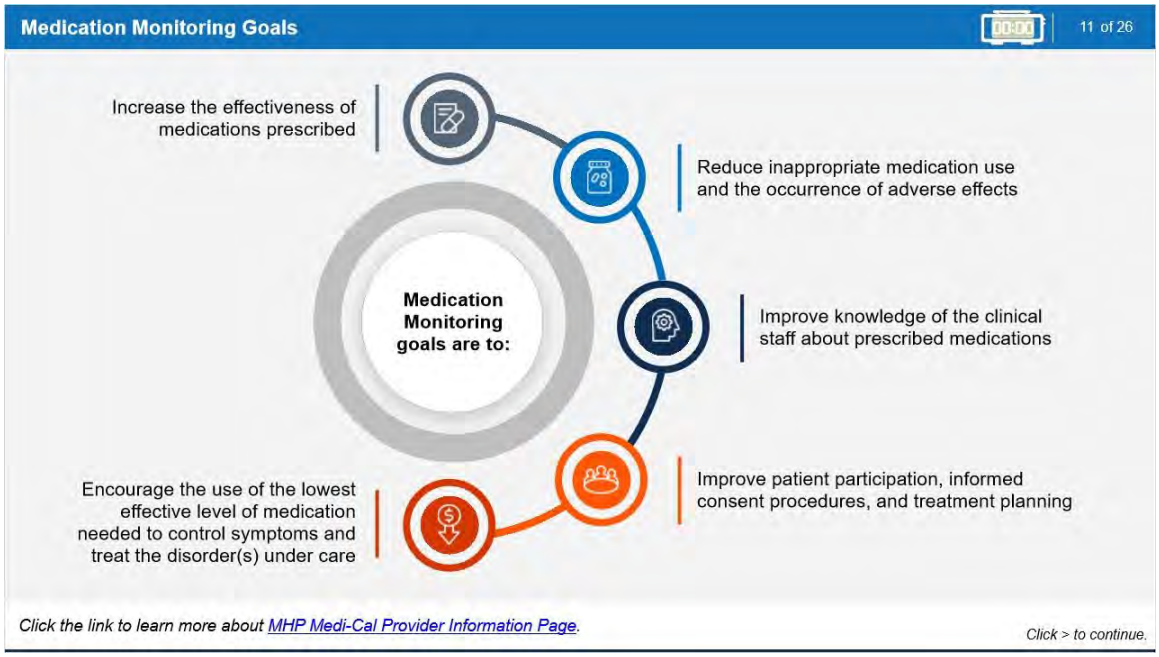
Both the ICC care plan and the PWB/IS eligibility form are completed, and the PWB/IS cohort is registered in IRIS.

If the client is transferred to your program and has an open PWB/IS cohort registration in IRIS, the new program can provide ICC and/or IHBS if the previous clinic's/provider's assessment, ICC Care Plan, and IHBS authorization form have already authorized IHBS.

Additionally, the ICC Care Plan must be reviewed at least once annually.

When the client turns 21 years of age, they are no longer eligible for ICC/IHBS and therefore would require a TCM CP progress note to continue with targeted case management.

3.4 Medication Monitoring Goals

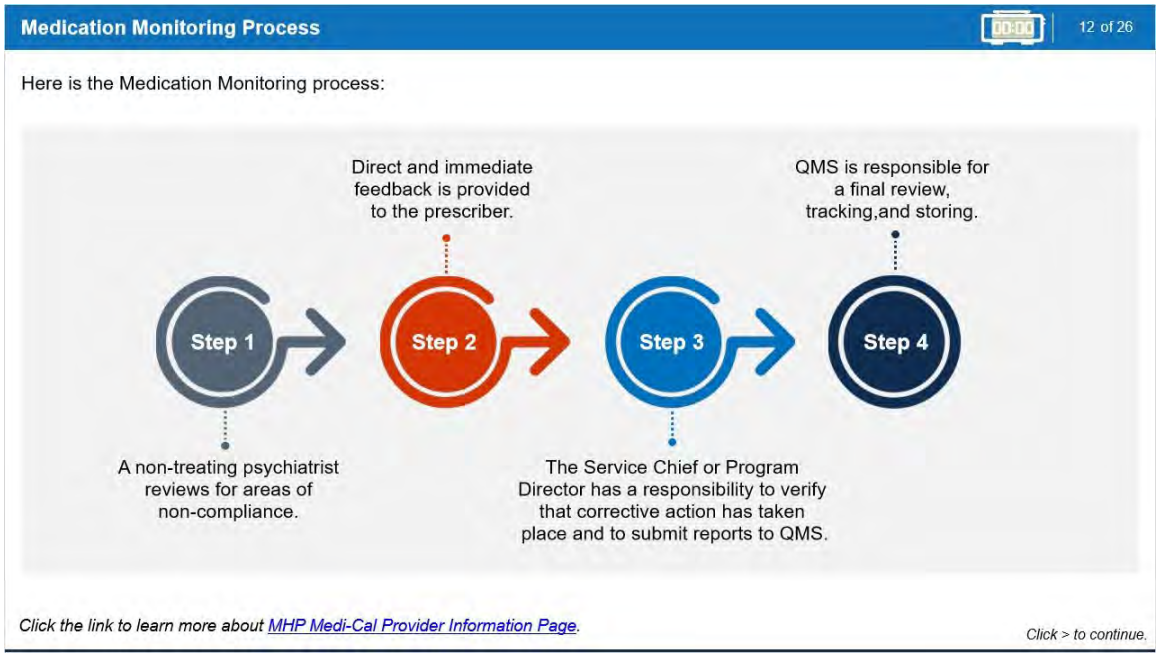


Notes:

Medication Monitoring goals are:

- Increase the effectiveness of medications prescribed
- Reduce inappropriate medication use and the occurrence of adverse effects
- Improve knowledge of the clinical staff about prescribed medications
- Improve patient participation, informed consent procedures, and treatment planning
- Encourage the use of the lowest effective level of medication needed to control symptoms and treat the disorder(s) under care

3.5 Medication Monitoring Process



Notes:

Let's have a look at the Medication Monitoring process.

The State requires an independent review by a non-treating psychiatrist who reviews for areas of non-compliance.

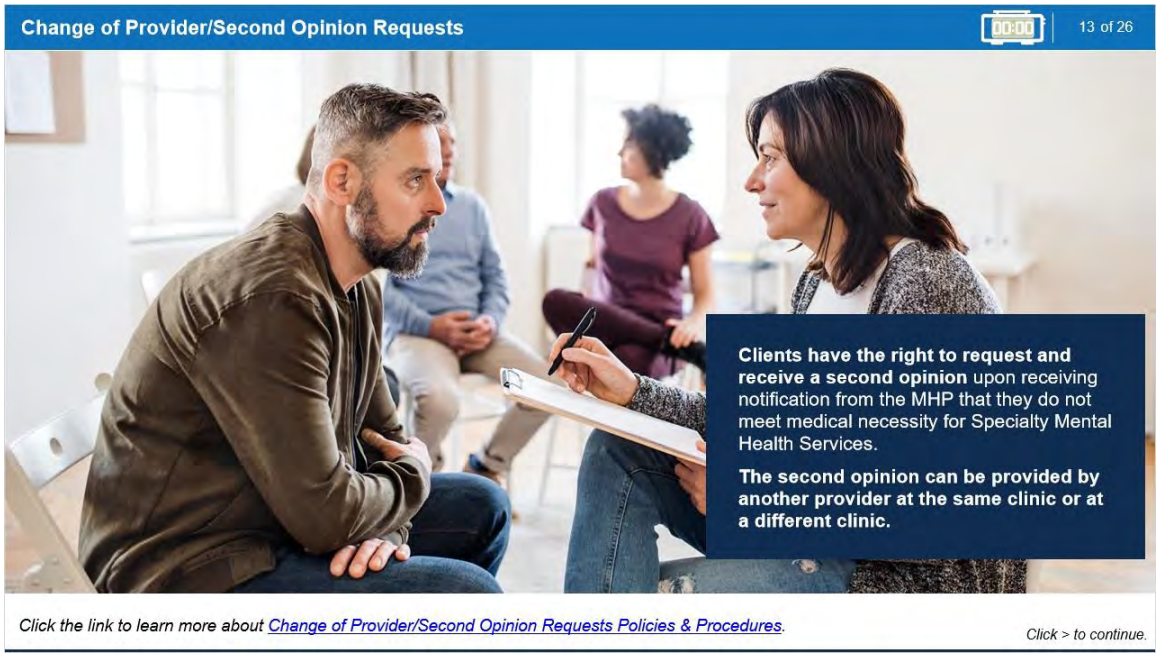
Direct and immediate feedback is required between the independent reviewer and the prescriber regarding issues of non-compliance and corrective actions.

The Service Chief or Program Director has a responsibility to verify that corrective action has taken place and to submit reports to QMS.

QMS is responsible for a final review, tracking, and storing. At the end of each fiscal year, QMS submits a summary report to the State.

•

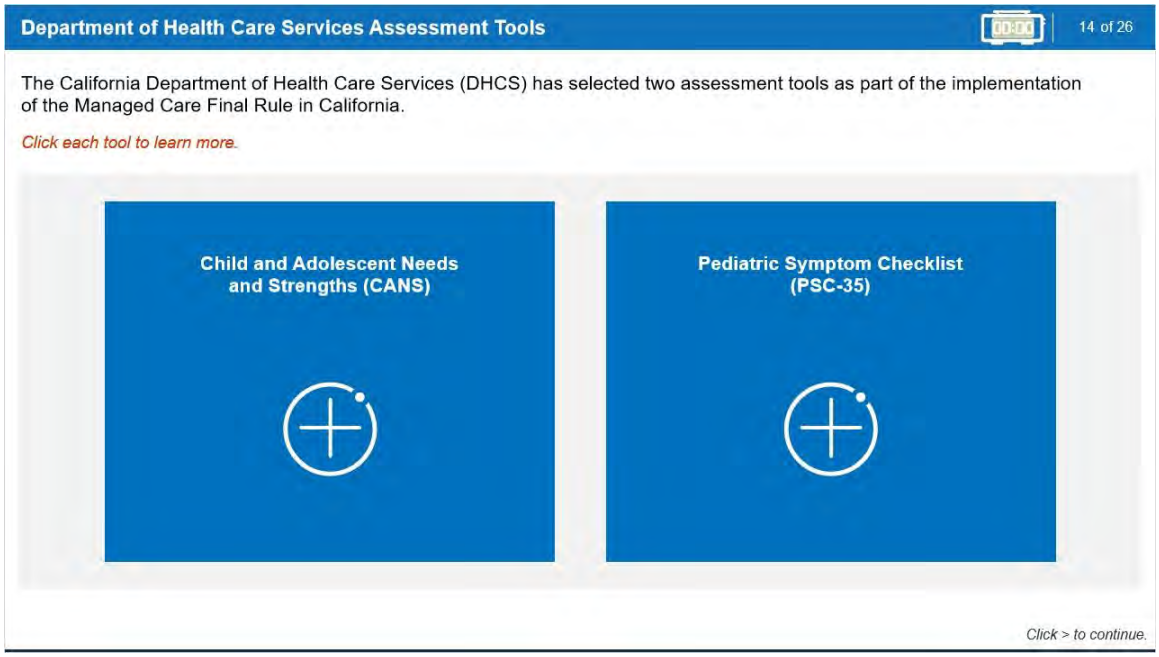
3.6 Change of Provider/Second Opinion Requests



Notes:

Change of Provider/Second Opinion Requests are also tracked as part of the State contract.
The 'Request for Change of Provider/Second Opinion Log,' which is used to monitor all requests, must be maintained in a timely manner.
Client requests for a change of provider are directed to the Supervisor/Program Director, or Provider Representative.
They oversee the timeliness and accuracy of the log, ensuring that requests are tracked, reviewed, and monitored.
The QMS Managed Care Support Team reviews the logs quarterly, and they are also discussed at the BHS Community Quality Improvement Committee (CQIC) meeting.
Instances of three or more requests to change from a particular provider within a quarter are brought to the attention of the Supervisor and Program Manager for follow-up.
Clients have the right to request and receive a second opinion upon receiving notification from the MHP that they do not meet medical necessity for Specialty Mental Health Services.
The second opinion can be provided by another provider at the same clinic or at a different clinic.

3.7 Department of Health Care Services Assessment Tools



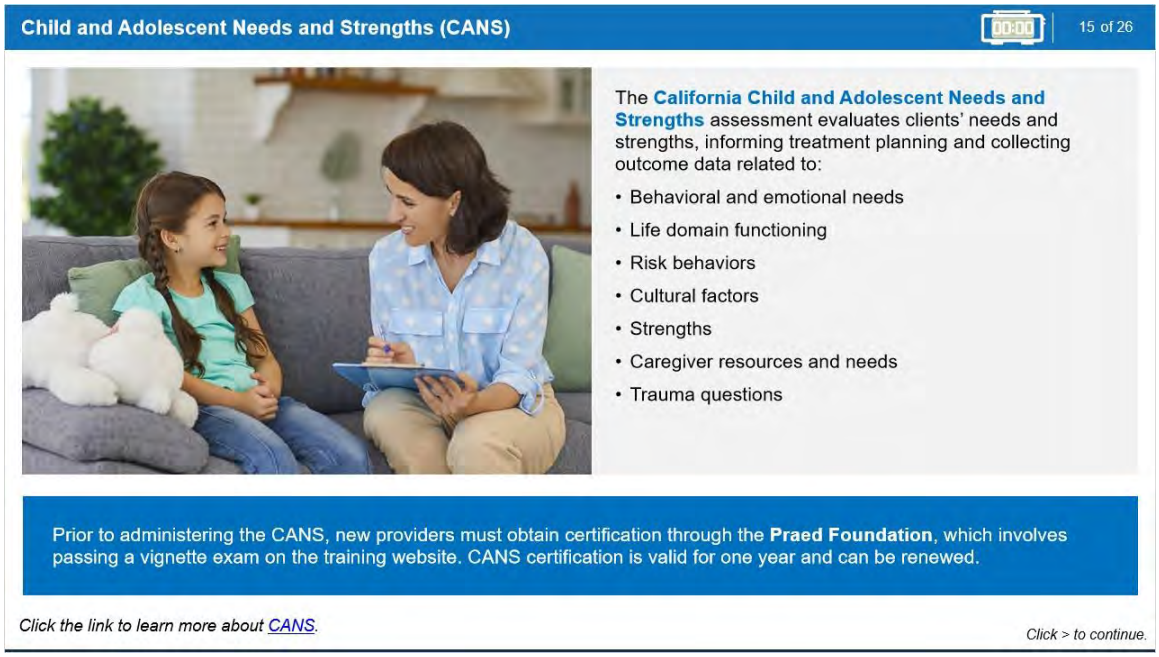
Notes:

The California Department of Health Care Services (DHCS) has selected two assessment tools as part of the implementation of the Managed Care Final Rule in California.

These tools include:

- Child and Adolescent Needs and Strengths (CANS)
- Pediatric Symptom Checklist (PSC-35)

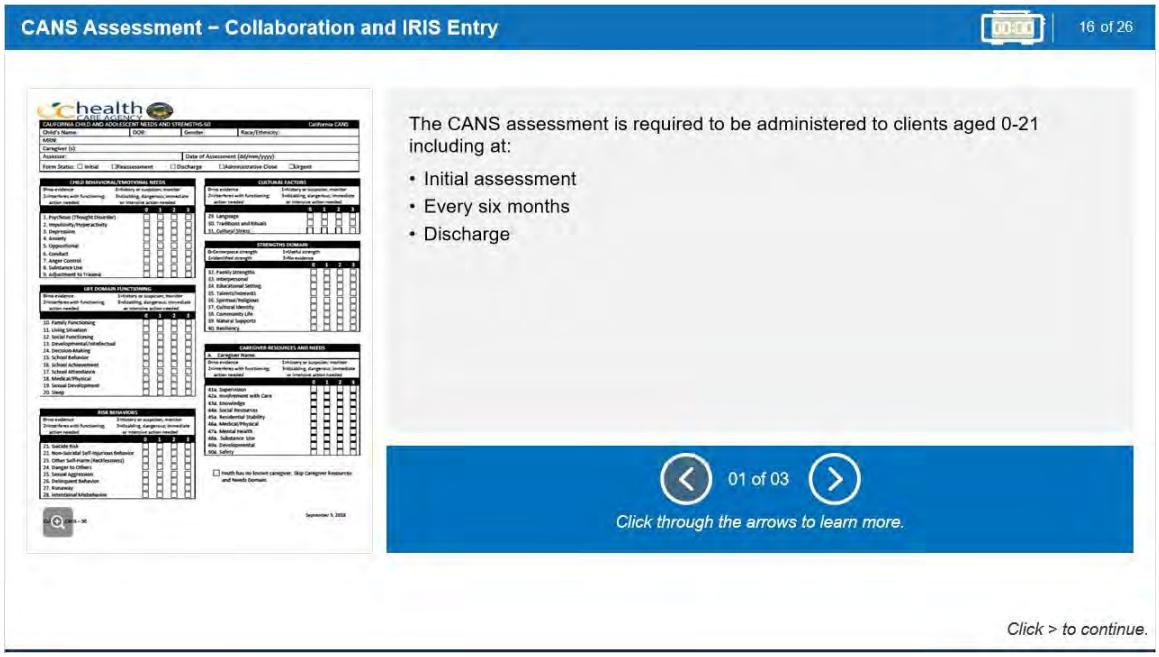
3.8 Child and Adolescent Needs and Strengths (CANS)



Notes:

The California Child and Adolescent Needs and Strengths assessment evaluates clients' needs and strengths, informing treatment planning and collecting outcome data related to behavioral and emotional needs, life domain functioning, risk behaviors, cultural factors, strengths, caregiver resources and needs, and trauma questions.
Researchers from both DHCS and the County of Orange will analyze the data collected through the CANS, examining individual items and the correlations between them.
Prior to administering the CANS, new providers must obtain certification through the Praed Foundation, which involves passing a vignette exam on the training website. CANS certification is valid for one year and can be renewed. Additionally, both County and Contract Provider employees have been designated as Certified Trainers to assist in training new and existing staff.

3.9 CANS Assessment – Collaboration and IRIS Entry



Notes:

The CANS assessment is required to be administered to clients aged 0–21, including at the initial assessment, every six months, and at discharge.

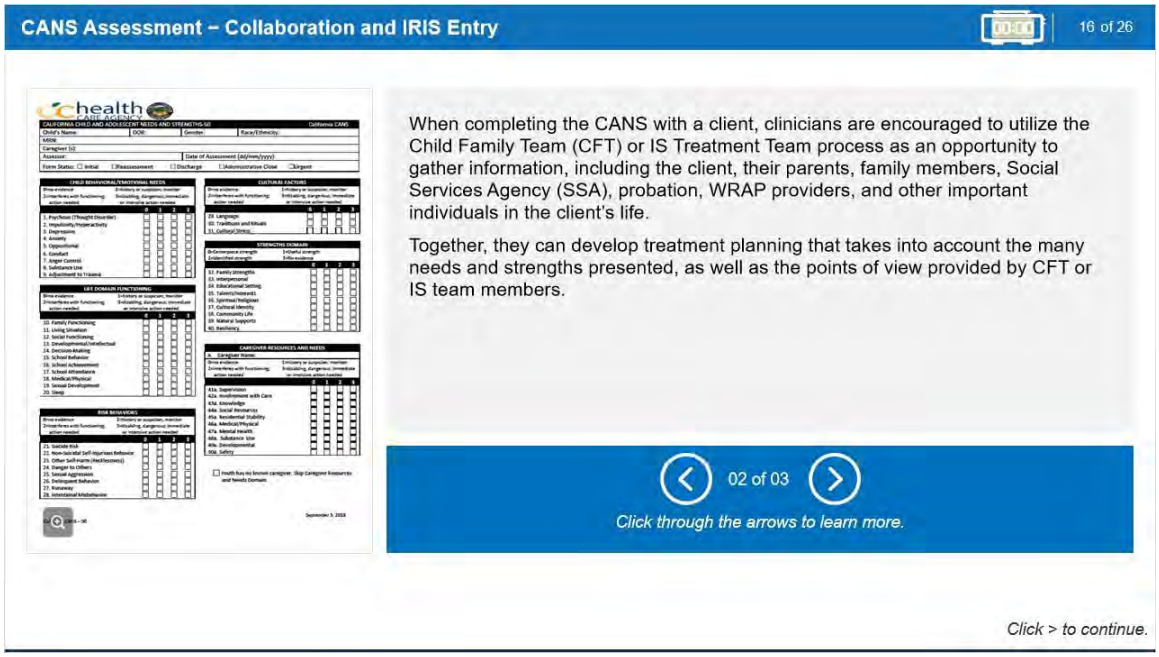
When completing the CANS with a client, clinicians are encouraged to utilize the Child Family Team (CFT) or IS Treatment Team process as an opportunity to gather information, including the client, their parents, family members, Social Services Agency (SSA), probation, WRAP providers, and other important individuals in the client's life.

Together, they can develop treatment planning that takes into account the many needs and strengths presented, as well as the points of view provided by CFT or IS team members.

Similar to our other outcome measures, the CANS data is entered into IRIS.

In County-operated programs, the CANS is entered into IRIS by the Plan Coordinator, while in Contract programs, Front Office Support staff enter the CANS data into IRIS on behalf of the clinician.

Tab 01 (Slide Layer)



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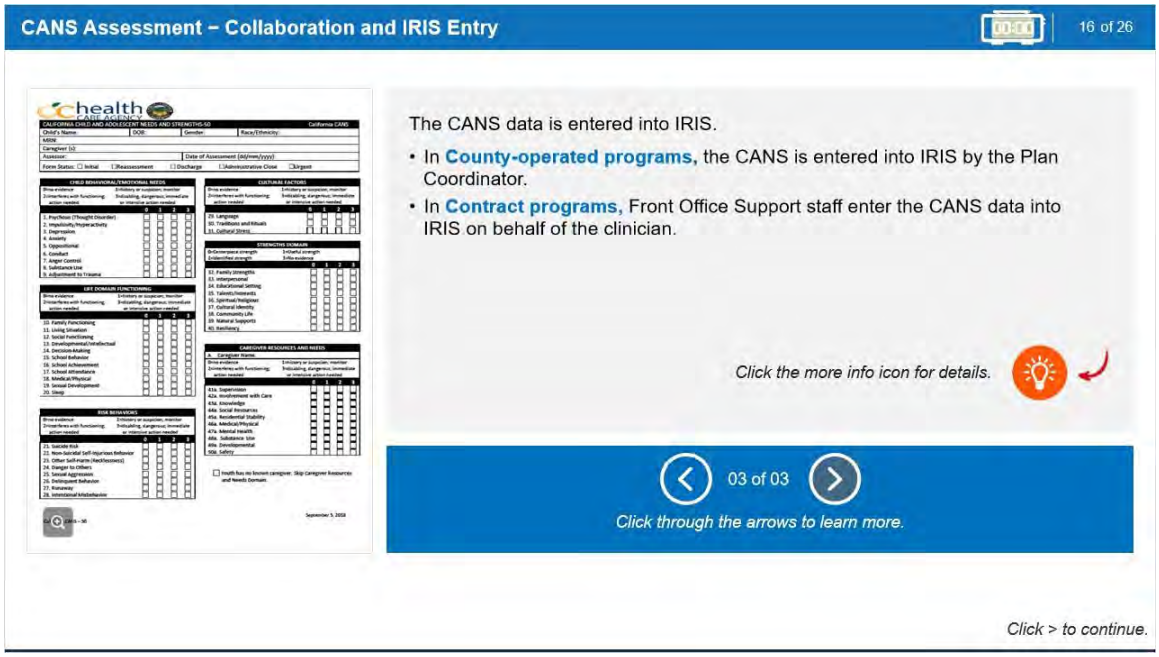
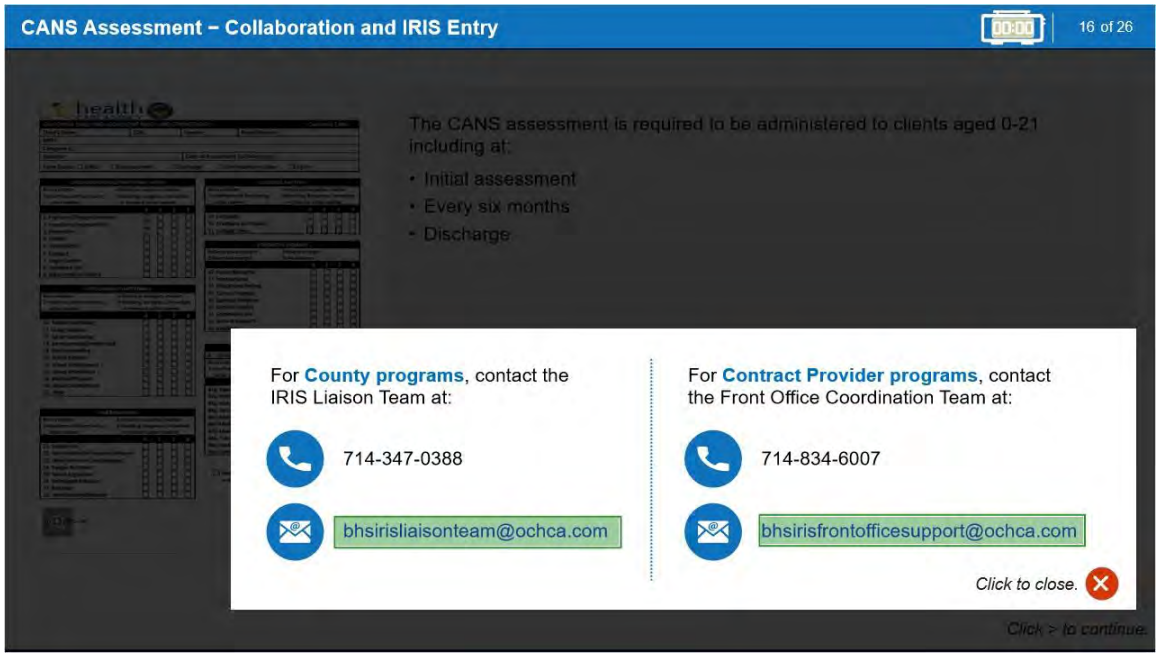
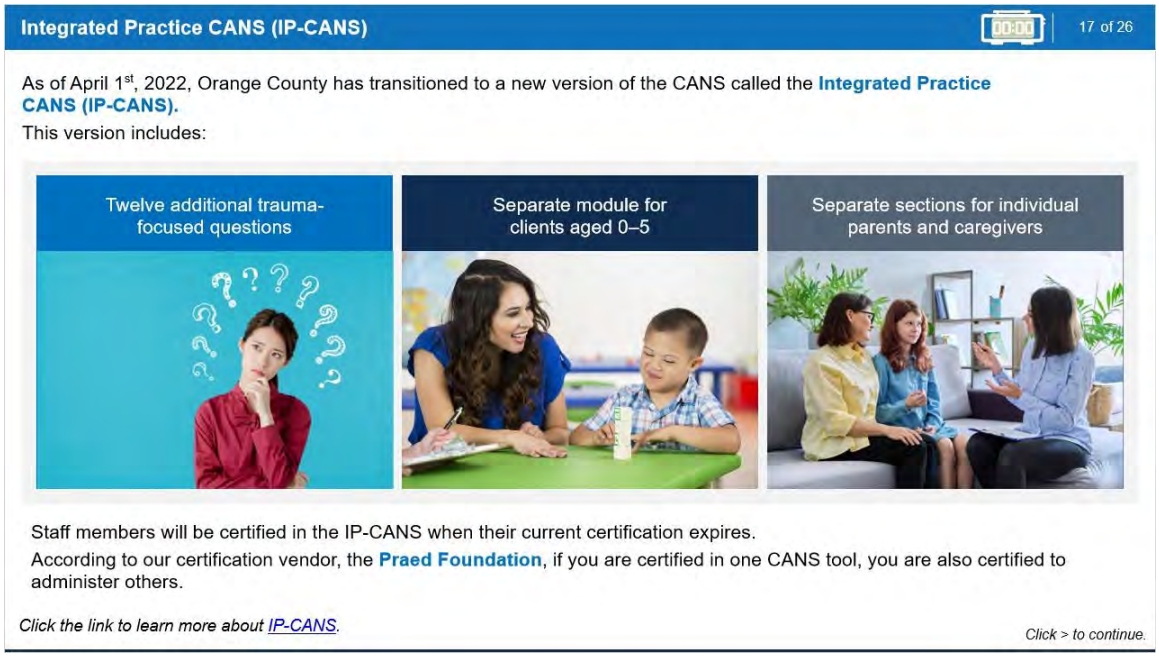


More Info (Slide Layer)



3.10 Integrated Practice CANS (IP-CANS)



Notes:

As of April 1st, 2022, Orange County has transitioned to a new version of the CANS

called the Integrated Practice CANS (IP-CANS).

This version includes twelve additional trauma-focused questions, a separate module for clients aged 0–5 (known as the Early Childhood Module), and separate sections for individual parents and caregivers.

Staff members will be certified in the IP-CANS when their current certification expires. According to our certification vendor, the Praed Foundation, if you are certified in one CANS tool, you are also certified to administer others.

3.11 Implementing the CANS Assessment Tool

Notes:

The implementation of the CANS assessment tool is important for our Child Welfare partners at the Social Services Agency (SSA).

SSA has already integrated the CANS into their programs since April 2022.

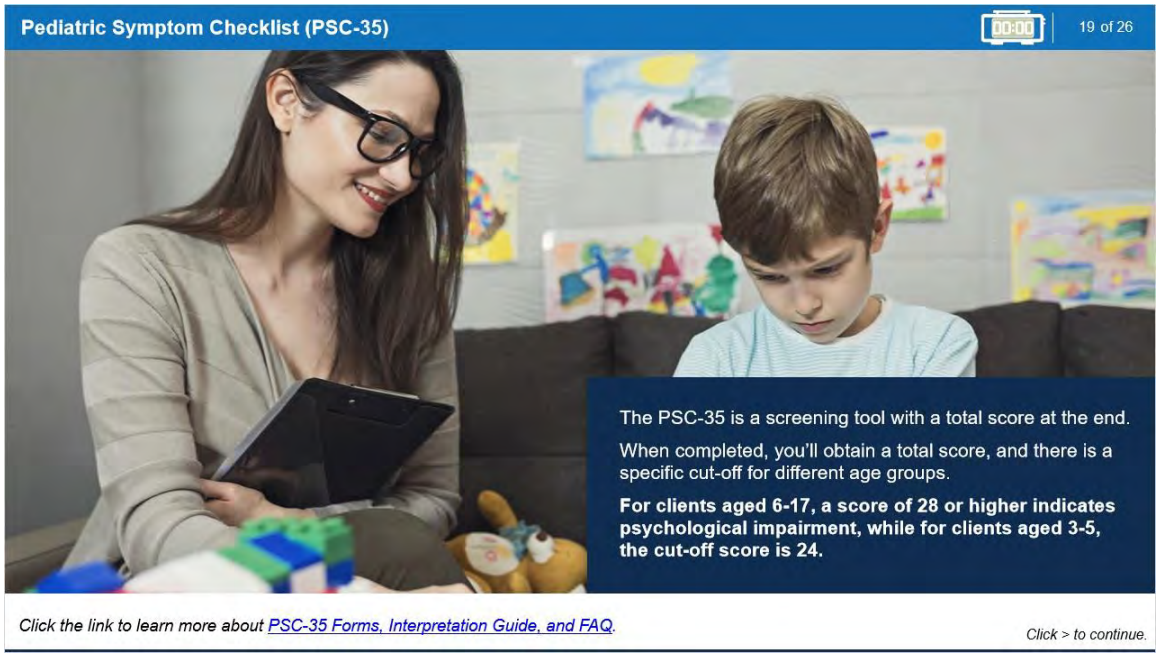
Effective coordination with SSA is essential, as the CANS will be jointly completed and submitted by both SSA and the County or Contract Providers to the State.

As SSA continues to implement the CANS, further guidance and workflow adjustments will be provided. It's important to note that sharing CANS scores with SSA for a mutual client requires a valid ATD.

Additionally, to facilitate the certification process for the CANS, the Quality Management System and the Praed Foundation have developed resources to assist with signing up for the training website as well as passing the certification exam.

This exam can be daunting, as it requires a thorough understanding of each item as well as the ability to extract information from a complex vignette.

3.12 Pediatric Symptom Checklist (PSC-35)



Notes:

The Department of Health Care Services has selected the Pediatric Symptom Checklist (PSC-35) as a secondary outcome measure for MHP's to administer to clients aged 3 to 18, alongside the CANS.

The PSC-35 is completed with the same frequency as the CANS and was introduced in 2018.

In order to facilitate data gathering, QMS requests that the PSC-35 be entered into IRIS, similar to the CANS. However, there's a crucial distinction: the PSC-35 is completed by a client's caregiver during the assessment period and intervals, even if no caregiver is involved in treatment.

By entering the PSC-35 into IRIS, we provide valuable feedback to our Federal, State, and County researchers regarding caregiver involvement.

These outcome measures, mandated by the Department of Health Care Services, serve as both a screening tool in clinical practice and a data source for ongoing quality improvement efforts.

The PSC-35 is a screening tool with a total score at the end.

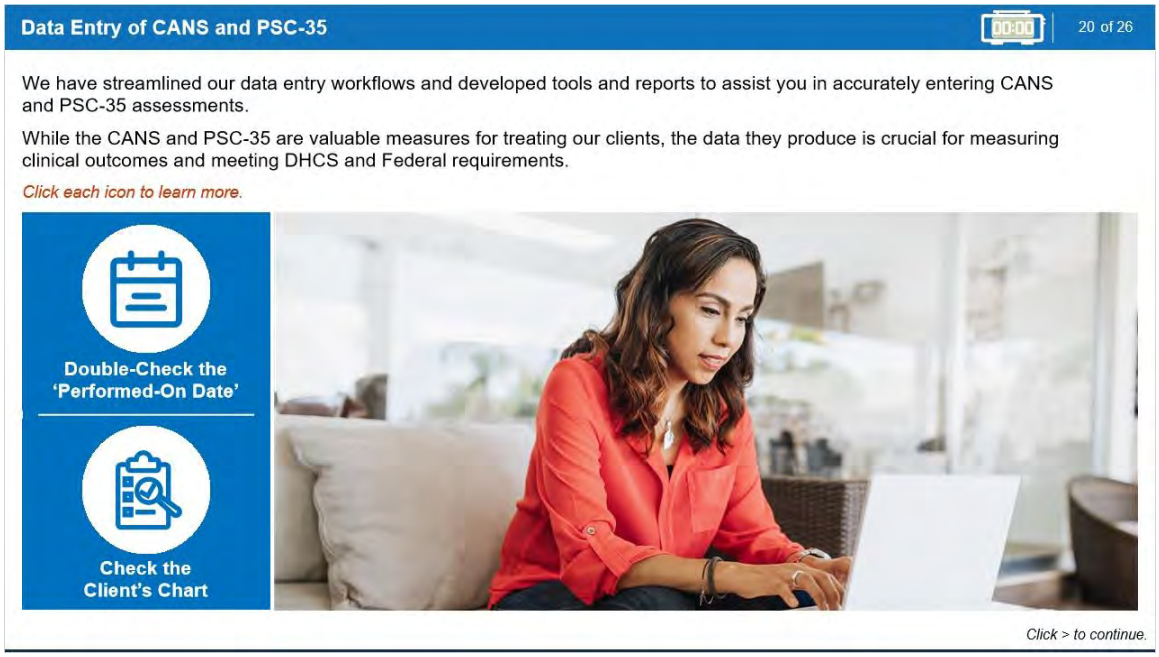
When completed, you'll obtain a total score, and there is a specific cut-off for different age groups.

For clients aged 6-17, a score of 28 or higher indicates psychological impairment, while for clients aged 3-5, the cut-off score is 24.

It's important to note that the Youth Outcome Questionnaire (YOQ) has become an optional screening tool as of April 1, 2022.

Additionally, QMS has made available both County and Community Provider Partners versions of the form.

3.13 Data Entry of CANS and PSC-35



Notes:

We have streamlined our data entry workflows and developed tools and reports to assist you in accurately entering CANS and PSC-35 assessments.

While the CANS and PSC-35 are valuable measures for treating our clients, the data they produce is crucial for measuring clinical outcomes and meeting DHCS and Federal requirements.

A few tips to improve data quality include:

- Double-check the 'Performed-On Date' and
- Check the client's chart.

IRIS records the date we indicate in the Performed-On Date as the date the form was administered.

The decision regarding whether to complete an Initial or Reassessment CANS or PSC-35, or whether to complete the CANS or PSC-35 at all, significantly impacts the assessment process.

Before entering CANS or PSC-35 forms, review the client's chart in IRIS.

If there are existing CANS or PSC-35 records, this may affect the timing and form type.

This can be done by going to the Form Browser section of the client's chart in IRIS, and sort by "Encounter – Date," then double-clicking on a form to see its contents.

Entering duplicate form types (e.g., two Initial CANS assessments within a month) will be flagged as an error in the State data collection system.

To avoid this, always check existing records in IRIS before entering new documents.

For example, in a recent audit, a chart was found to have a Discharge CANS, followed by two Initial CANS, and a Reassessment. This is not the correct order, nor the correct number of CANS.

Both the HCA IT team and the IRIS Liaison team have been conducting audits of charts with CANS and PSC-35 errors.

They are actively communicating with programs to address error correction procedures.

Additionally, error detail reports are in development to aid in monitoring these issues.

If you receive an email regarding error correction, please carefully follow the instructions and feel free to reach out to the IRIS Liaison Team with any questions or concerns. Ensuring timely administration of CANS and PSC-35 assessments is crucial, and consulting with QMS can assist providers in maintaining accurate timelines.

Tab 1 (Slide Layer)

Data Entry of CANS and PSC-35 20 of 26

We have streamlined our data entry workflows and developed tools and reports to assist you in accurately entering CANS and PSC-35 assessments.

While the CANS and PSC-35 are valuable measures for treating our clients, the data they produce is crucial for measuring clinical outcomes and meeting DHCS and Federal requirements.

Click each icon to learn more.

Double-Check the 'Performed-On Date'

Check the Client's Chart

Double-Check the 'Performed-On Date'

IRIS records the date we indicate in the Performed-On Date as the date the form was administered.

*Performed on: 02/11/2020 0752 PST

The decision regarding whether to complete an Initial or Reassessment CANS or PSC-35, or whether to complete the CANS or PSC-35 at all, significantly impacts the assessment process.

Click > to continue.

Tab 2 (Slide Layer)

Data Entry of CANS and PSC-35 20 of 26

We have streamlined our data entry workflows and developed tools and reports to assist you in accurately entering CANS and PSC-35 assessments.

While the CANS and PSC-35 are valuable measures for treating our clients, the data they produce is crucial for measuring clinical outcomes and meeting DHCS and Federal requirements.

Click each icon to learn more.

Double-Check the 'Performed-On Date'

Check the Client's Chart

Check the Client's Chart

Before entering CANS or PSC-35 forms, review the client's chart in IRIS.

If there are existing CANS or PSC-35 records, this may affect the timing and form type.

This can be done by going to the **Form Browser** section of the client's chart in IRIS, and sort by "**Encounter – Date**," then double-clicking on a form to see its contents.

Entering duplicate form types will be flagged as an error in the State data collection system.

Click the more info icon for details.

Click > to continue.

More Info (Slide Layer)

Data Entry of CANS and PSC-35 20 of 26

We have streamlined our data entry workflows and developed tools and reports to assist you in accurately entering CANS and PSC-35 assessments.

While the CANS and PSC-35 are valuable measures for treating our clients, the data they produce is crucial for measuring clinical outcomes and meeting DHCS and Federal requirements.

Click each icon to learn more.

Both the HCA IT team and the IRIS Liaison team have been conducting audits of charts with CANS and PSC-35 errors.

They are actively communicating with programs to address error correction procedures.

If you receive an email regarding error correction, please carefully follow the below instructions:

For **general questions or training concerns**, call QMS Support Team at:	For **County programs**, contact the IRIS Liaison Team at:	For **Contract Provider programs**, contact the Front Office Coordination Team at:
714-834-5601	714-347-0388	714-834-6007
AQISSupportTeams@ochca.com	bhsirisliaisonteam@ochca.com	bhsirisfrontofficesupport@ochca.com

Click to close.

Click > to continue.

3.14 Coordination of Care for CANS and PSC-35 in Medi-Cal Programs

Coordination of Care for CANS and PSC-35 in Medi-Cal Programs 21 of 26

For a majority of our forms and processes, each program is responsible for delivering services and satisfying Medi-Cal billing and documentation requirements.

CANS and PSC-35 break this mold slightly by carrying across Episodes of Care. This means that if a client is transferred from one program to another, the receiving program becomes responsible for continuing the process mid-stream.

To facilitate this coordination, QMS has created a Coordination of Care Quick Guide, which you can download from the CANS or PSC-35 support web pages.

It's recommended that programs explicitly address CANS and PSC-35 during the Coordination of Care process.

Click > to continue.

Notes:

For a majority of our forms and processes, each program is responsible for

delivering services and satisfying Medi-Cal billing and documentation requirements.

However, CANS and PSC-35 break this mold slightly by carrying across Episodes of Care. This means that if a client is transferred from one program to another, the receiving program becomes responsible for continuing the process mid-stream.

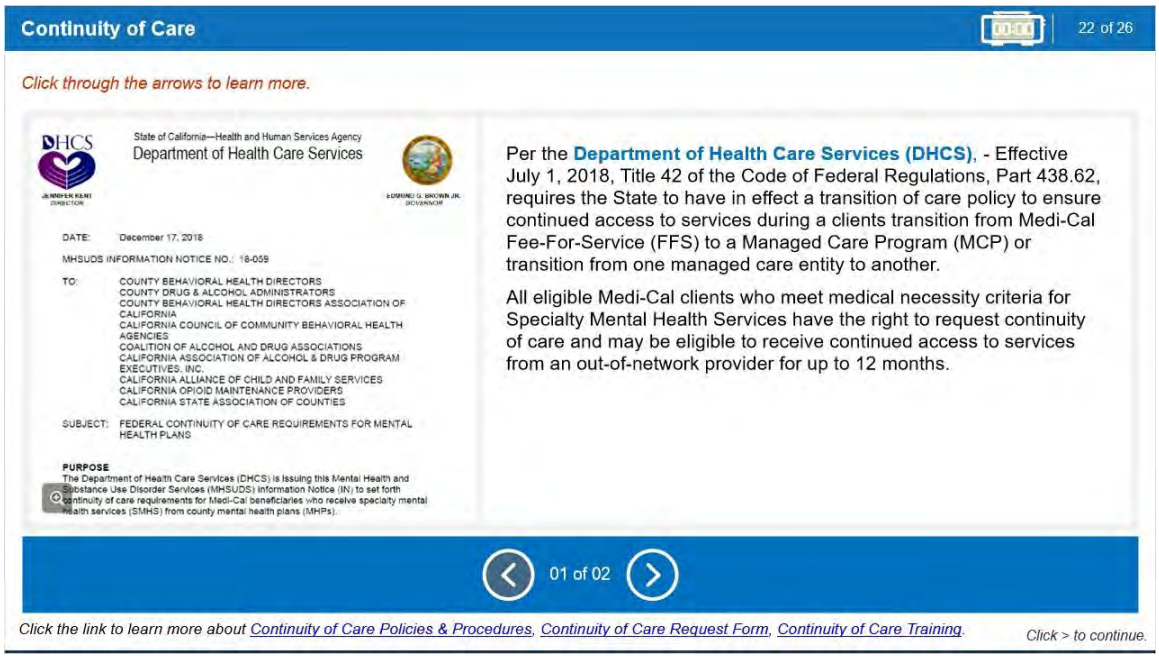
To facilitate this coordination, QMS has created a Coordination of Care Quick Guide, which you can download from the CANS or PSC-35 support web pages.

As a member of the County of Orange Mental Health Plan (MHP), you are allowed to coordinate care without an explicit Release of Information (ROI), including information related to CANS and PSC-35.

It's recommended that programs explicitly address CANS and PSC-35 during the Coordination of Care process.

Additionally, when working on a case shared with the Social Services Agency, coordination of CANS information and completion is essential.

3.15 Continuity of Care



Notes:

Per the Department of Health Care Services (DHCS), - Effective July 1, 2018, Title 42 of the Code of Federal Regulations, Part 438.62, requires the State to have in effect a transition of care policy to ensure continued access to services during a clients transition from Medi-Cal Fee-For-Service (FFS) to a Managed Care Program (MCP) or transition from one managed care entity to another, when the client, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

The image on the left shows Information Notice 18-059 from DHCS, which specifies requirements for continuity of care.

All eligible Medi-Cal clients who meet medical necessity criteria for Specialty Mental Health Services have the right to request continuity of care and may be eligible to receive continued access to services from an out-of-network provider for up to 12 months.

A Medi-Cal client or clients authorized representative may make a direct request to the MHP for continuity of care verbally, in writing, or via telephone and shall not be required to submit an electronic or written request.

To make a request without completing and submitting a form, a client may ask to speak with the Provider Representative, the Service Chief, or the Program Director at any Orange MHP County or contracted clinic or call Quality Management Services (QMS).

Clinic staff who receive a continuity of care request from a Medi-Cal client or clients representative may fill out the Continuity of Care Request Form on behalf of the client and submit the form and other associated documentation (ATDs and treatment records) to QMS by emailing.

A QMS representative will process the request and get back to the client in writing, no later than 30 days from the date QMS receives the request.

Tab 01 (Slide Layer)

Continuity of Care 22 of 26

Click through the arrows to learn more.

health CARE AGENCY **Continuity of Care Request Form**

A Medi-Cal client or client authorized representative may make a direct request to the MHP for continuity of care verbally, in writing, or via telephone and shall **not be required to submit an electronic or written request**.

To request continuity of care without completing a form, clients can contact the Provider Representative, Service Chief, or Program Director at any Orange MHP County or contracted clinic or call QMS at:

(866) 308-3074
(866) 308-3073 TDD

Clinic staff can complete the Continuity of Care Request Form on behalf of a Medi-Cal client and submit it, along with associated documentation to QMS at:

AQISSupportTeams@ochca.com

02 of 02

Click the link to learn more about Continuity of Care Policies & Procedures, Continuity of Care Request Form, Continuity of Care Training.

Click > to continue.

3.16 Practice Guidelines

Practice Guidelines 23 of 26

The purpose of BHS Practice Guidelines is to aid in the development and support of a standard of care guided by research and evidence-based practices

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MHRS PRACTICE GUIDELINES

The purpose of MHRS Practice Guidelines is to aid in the development and support of a standard of care that is guided by research and evidenced based practices. It is the policy of MHRS to maintain a process to develop, adopt and implement Practice Guidelines in order to continuously improve care processes and thereby improve outcomes of care for beneficiaries.

Practice Guidelines shall meet the following requirements:

1. Be based on valid and reliable clinical evidence or a consensus of behavioral health care professionals in the applicable field.
2. Consider the needs of beneficiaries.
3. Are adopted in consultation with health care professionals.
4. Are reviewed and updated periodically as appropriate.

MHRS will provide and/or coordinate the necessary training when implementing new and/or updating Practice Guidelines.

The current list of Practice Guidelines includes:

- BHS Clinical Supervision
- BHS Substance Use Disorder Practice Guidelines (Adopted)
- BHS Suicide Assessment & Treatment Practice
- BHS Trauma-Informed Care Workplace and Practice
- BHS Treatment Interventions for Trauma

ou

the most current Practice Guidelines as a model for service provision and professional practice.

Click the link to learn more about BHS Practice Guidelines.

Click > to continue.

Notes:

The purpose of BHS Practice Guidelines is to aid in the development and support of

a standard of care guided by research and evidence-based practices.

BHS maintains a process to develop, adopt, and implement Practice Guidelines to continuously improve care processes and outcomes for clients.

Practice Guidelines must be:

- Based on valid and reliable clinical evidence or a consensus of behavioral health care professionals,
- Based on the needs of clients,
- Adopted in consultation with health care professionals, and
- Reviewed and updated periodically.

BHS County and County-Contracted providers involved in the delivery of services in the Mental Health Plan should use the most current Practice Guidelines as a model for service provision and professional practice.

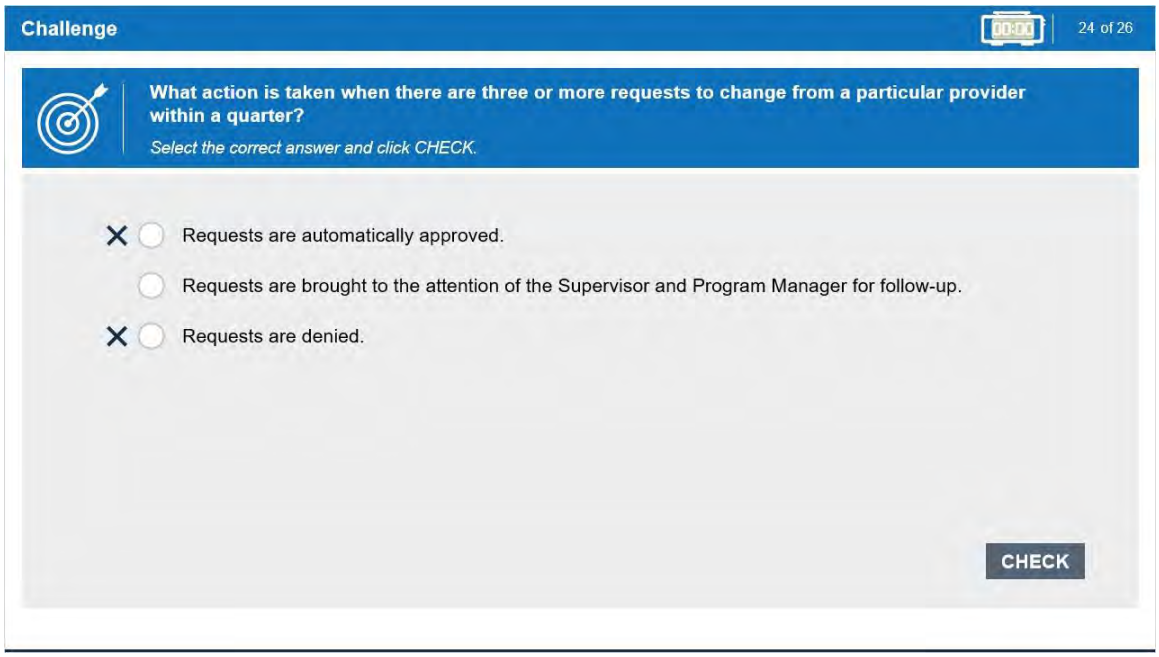
The current list of Practice Guidelines includes:

- BHS Clinical Supervision,
- BHS Substance Use Disorder Practice Guidelines,
- BHS Suicide Assessment & Treatment Practice,
- BHS Trauma-Informed Care Workplace and Practice, and
- BHS Treatment Interventions for Trauma.

QMS is responsible for monitoring and oversight of the Practice Guidelines workgroup, the process, and implementation within BHS.

3.17 Challenge

(Pick One, 10 points, 1 attempt permitted)



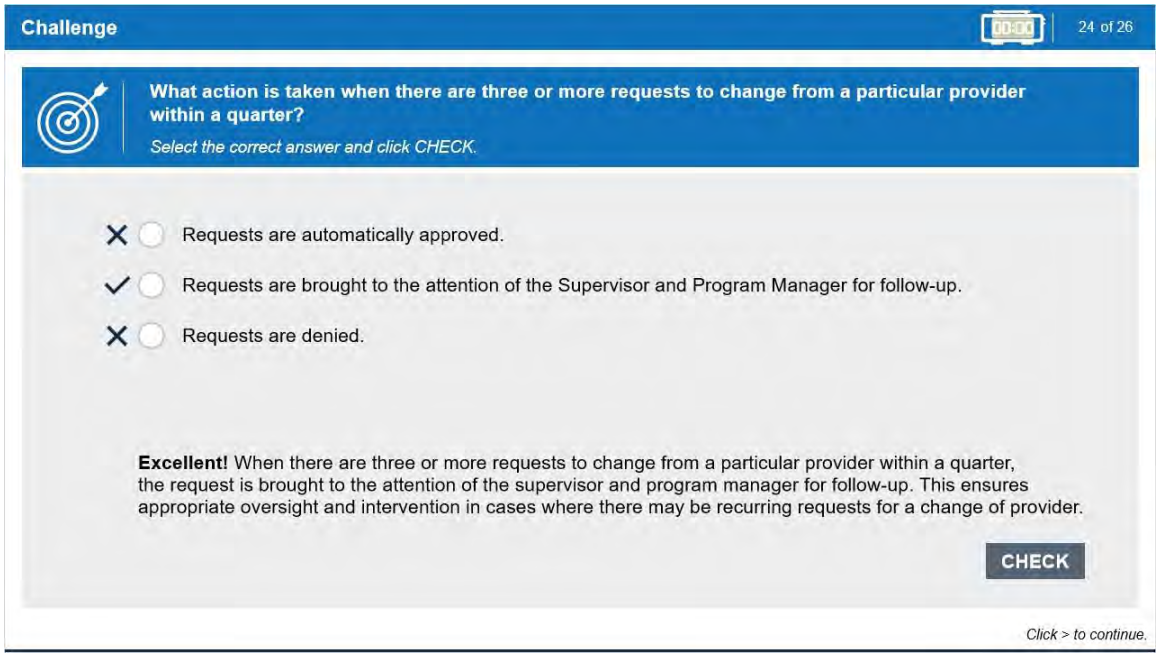
Correct	Choice
	Requests are automatically approved.
X	Requests are brought to the attention of the Supervisor and Program Manager for follow-up.
	Requests are denied.

Notes:

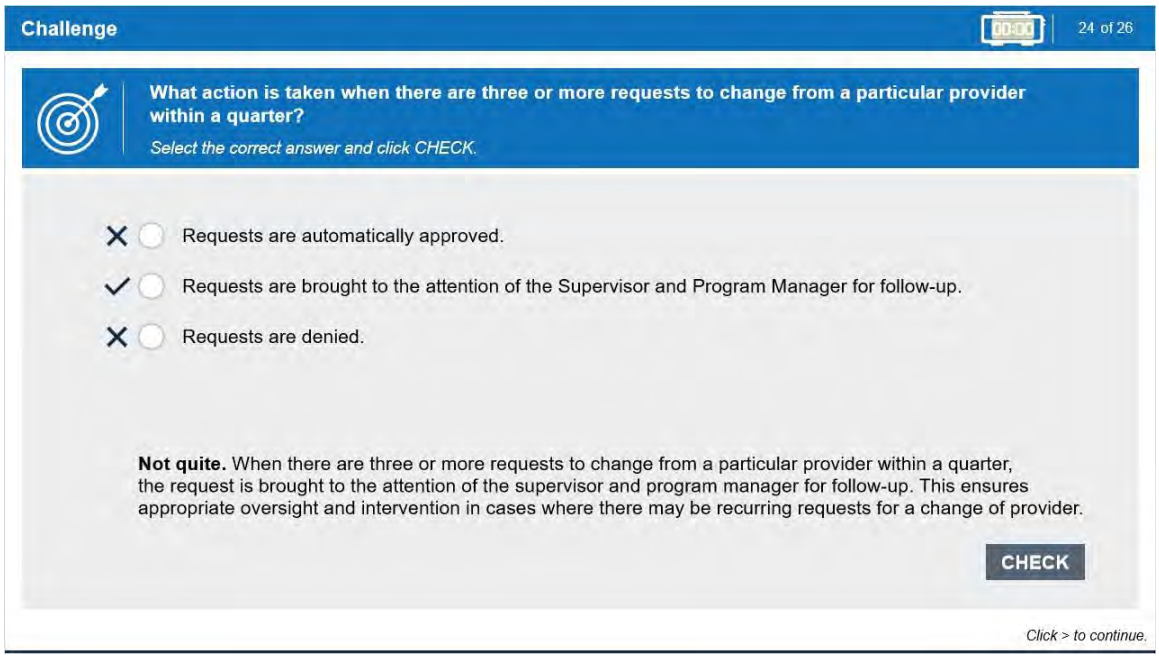
It's time for an activity.

What action is taken when there are three or more requests to change from a particular provider within a quarter?

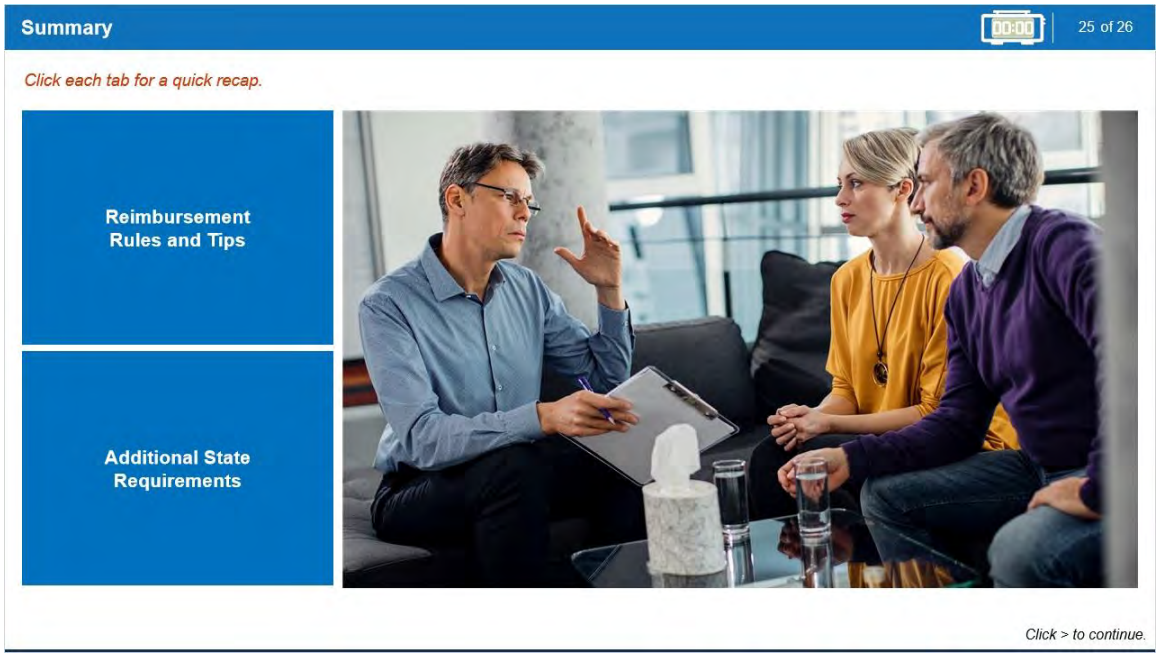
Correct (Slide Layer)



Incorrect (Slide Layer)



3.18 Summary



Notes:

We have come to the end of this module, let's summarize.

The HCA Code of Conduct guidelines state that one must not:

- Sign someone else's name,
- Change someone else's documentation,
- Estimate the time (billable and non-billable services), and
- Have a client sign a blank form of any kind.

The Coding and Documentation Manuals contain information on compliance, documentation, billing, and important reminders.

QMS QRTips serve the purpose of keeping providers informed about regulation changes, documentation standards, updates and reminders based on chart and billing review trends and State-mandated monitoring requirements.

The Service Chief or Program Director has a responsibility to verify that corrective action has taken place and to submit reports to QMS.

The 'Request for Change of Provider/Second Opinion Log,' which is used to monitor all requests, must be maintained in a timely manner.

Instances of three or more requests to change from a particular provider within a

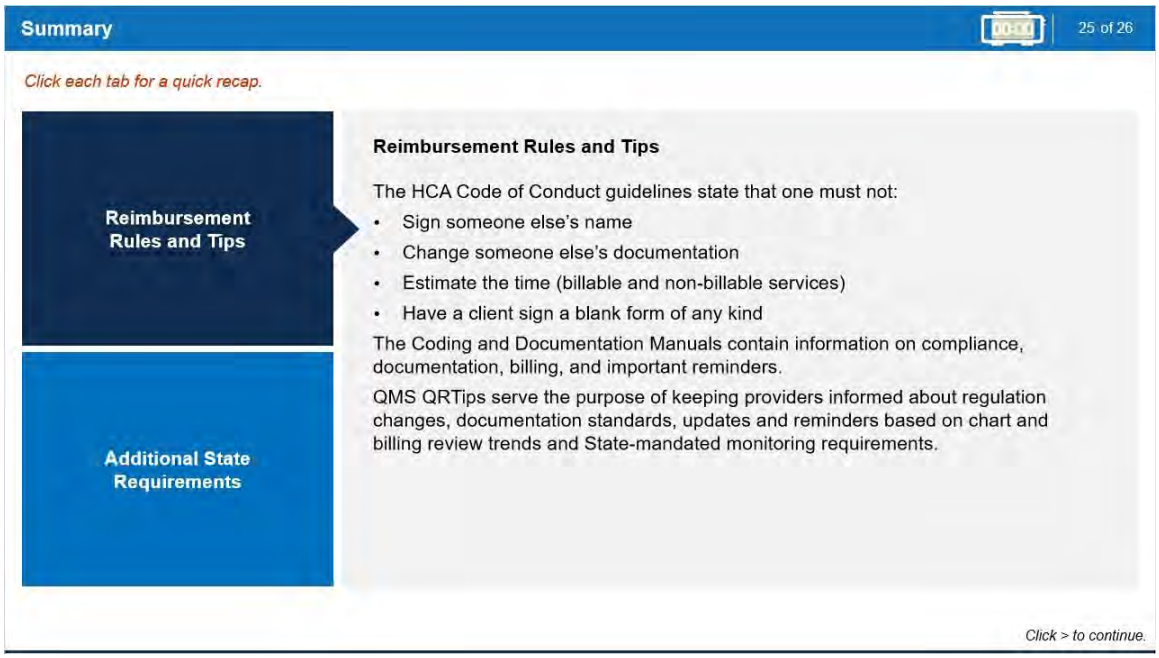
quarter are brought to the attention of the Supervisor and Program Manager for follow-up.

Clients have the right to request and receive a second opinion upon receiving notification from the MHP that they do not meet the medical necessity for Specialty Mental Health Services.

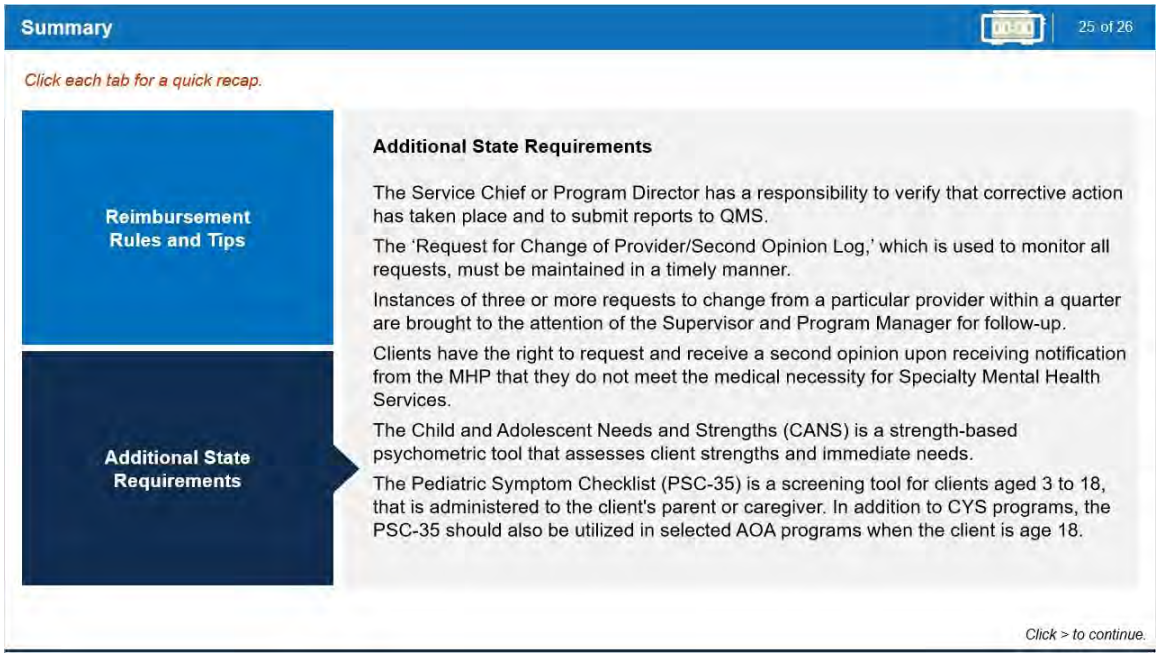
The Child and Adolescent Needs and Strengths is a strength-based psychometric tool that assesses client strengths and immediate needs.

The Pediatric Symptom Checklist (PSC-35) is a screening tool for clients aged 3 to 18, that is administered to the client's parent or caregiver. In addition to CYS programs, the PSC-35 should also be utilized in selected AOA programs when the client is age 18.

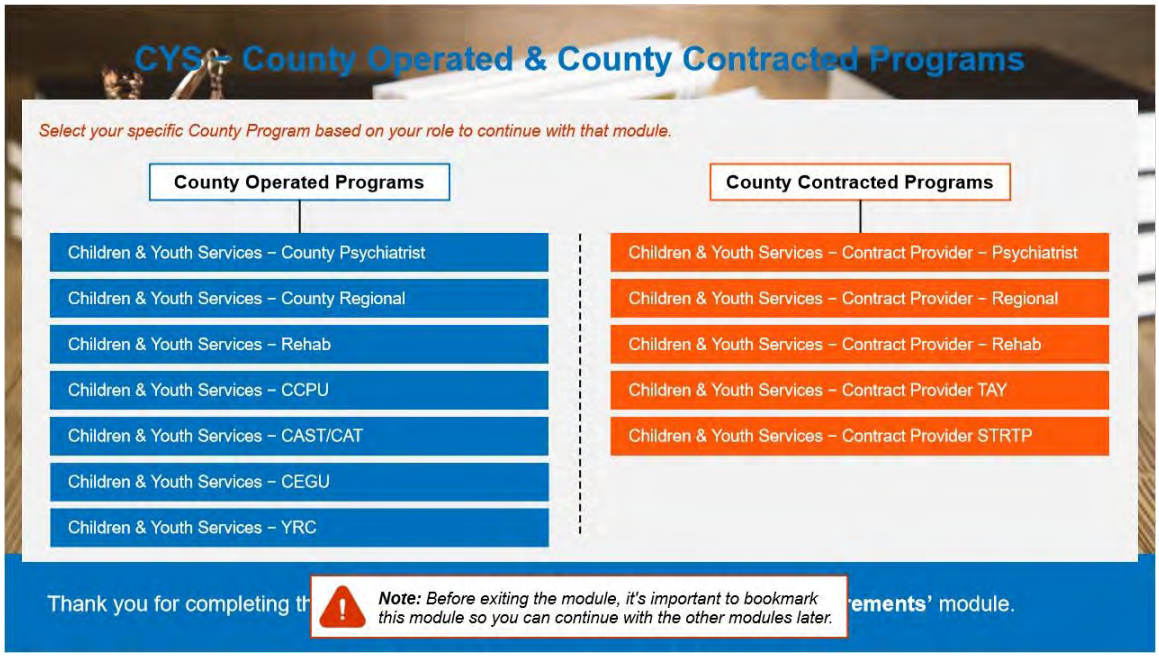
Layer 1 (Slide Layer)



Layer 2 (Slide Layer)



3.19 Thank you



Notes:

Thank you for completing the 'Children & Youth Services Additional State

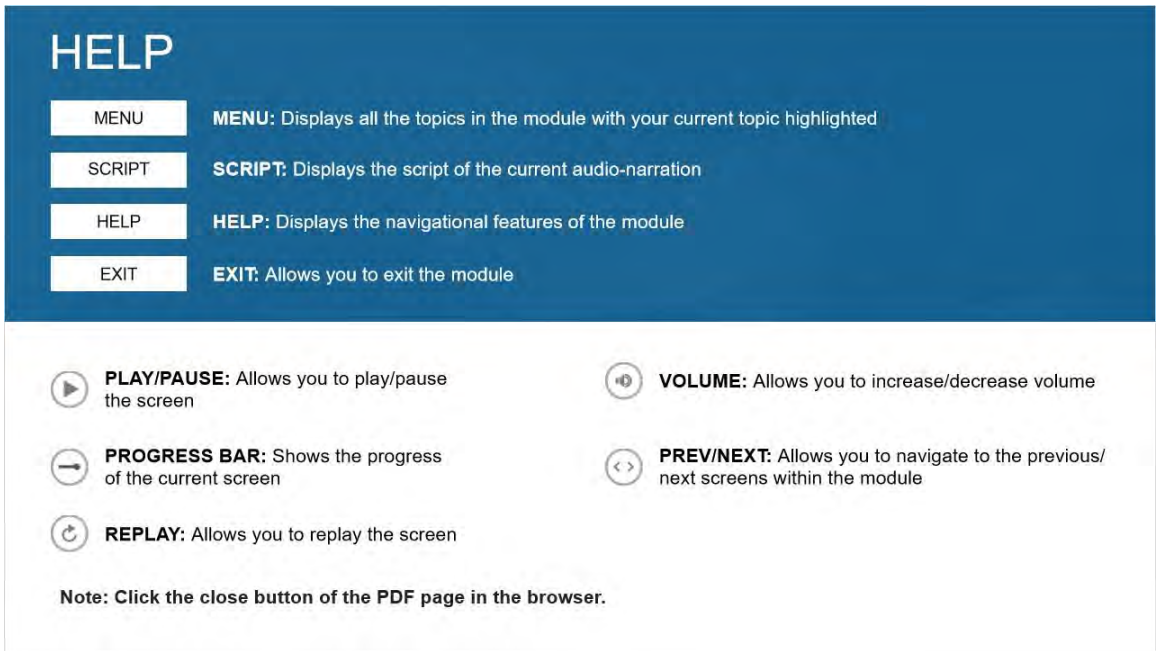
Requirements' module.

Now let's move on to the Children & Youth Services – County Operated & County Contracted Programs.

Select your specific County Program based on your role to continue with that module.

4. Help

4.1 Help



Notes: