Frequently Asked Questions (FAQ)

Both MHP & DMC-ODS Providers - Category: General

1. **Question:** What training will be provided to providers? Will the trainings be recorded and made available to providers?

   Answer: There will be a series of trainings which will be offered to county staff and to contract providers which includes documentation redesign, no wrong door, and co-occurring treatment. Contra Costa Behavioral Health Services (CCBHS) is hosting CalAIM training throughout June. These are required trainings for managers, supervisors, utilization review staff, or leads of any agency/program/clinic which are part of CCBHS or contract with CCBHS to do Medi-Cal billing or documentation. All managers, supervisors, utilization review staff, and leads which fall under this category should attend all the trainings. These individuals should become knowledgeable in the training topic, as they will be the first to answer questions staff may have.

   Official training correspondence was sent to County and contract providers from the CCBHS CalAIM email regarding links and registration instructions on upcoming trainings.

   Any agency staff which cannot attend will have access to view a recording of the training. Any staff which do Medi-Cal billing or documentation MUST access a recording of the training and complete a brief evaluation **by June 30th, 2022.** This training is expected to assist in preparation of the CalAIM changes that will go in effect **July 1, 2022.**

2. **Question:** Can the County post the answers to these questions on the website / publicly/ will there be a specific identified place where providers can go to find these FAQs?

   Answer: Frequently Asked Questions (FAQs) will be posted to the new county CalAIM website: https://cchealth.org/bhs/calaim.

3. **Question**: Will the Contra Costa Behavioral Health Access Line facilitate coordination between plans?

   Answer: The Contra Costa Behavioral Health Access Line will likely be central to coordination between providers/plans. The universal transition tool expected to be implemented on 1/1/23 will help streamline that process.

Both MHP & DMC-ODS Providers - Category: Peer Support Services

4. **Question**: The BHIN makes the following statement about Peer Support Specialists: *Peer support services must be based on an approved plan of care. The plan of care shall be*

Frequently Asked Questions Continued

documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services. How is "Peer support services" defined?

Answer: According to BHIN 22-026, Peer Support Services are defined as culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer Support Services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer Support Services can include contact with family members or other collaterals (family members or other people supporting the beneficiary), if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's goals. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

5. **Question**: If an agency has similar roles to a Peer Support Specialist but by a different name (e.g., Parent Partner) can they bill Rehab or other SMHS without a Care Plan?

   Answer: The need for a care plan is based on the type of service provided and not the title of the provider. A list of all services requiring a care plan can be found in BHIN 22-019 and its attachment 1. In short the following are the type of services that will continue to require a care plan:

   1. TCM (in the note) – Targeted Case Management
   2. ICC – Intensive Care Coordination
   3. IHBS – Intensive Home-Based Services
   4. TFC – Therapeutic Foster Care
   5. TBS – Therapeutic Behavioral Services
   6. NTP – Narcotic Treatment Programs
   7. STRTP – Short Term Residential Treatment Programs
   8. PSS (in the note) – Peer Support Services
   9. PHF – Psychiatric Health Facility
   10. STP-SNF – Special Treatment Program within Skilled Nursing Facility
   11. MHRC – Mental Health Rehab Center
   12. SRP - Social Rehab Programs

Frequently Asked Questions Continued

6. **Question:** How is "any treating provider who can render reimbursable Medi-Cal services" defined? Would this include paraprofessionals / BA level staff such as Rehab Specialists or Parent Partners?

   Answer: Minimum qualifications of a Medi-Cal Peer Support Specialist:
   - Must be at least 18 years of age. Provide a government-issued identification with
   - photograph, such as driver's license, identification card, or passport.
   - Possess a high school diploma or general equivalency degree (GED). Submission of
   - educational transcripts are required.
   - Self-identify as an individual with lived experience, a Peer.
   - Be willing to share their experience as a person with lived experience.
   - Have a strong dedication to recovery.
   - Agree, in writing, to adhere to the California Department of Health Care Services
   - Code of Ethics for Medi-Cal Peer Support Specialists in California.
   - Successfully complete and demonstrate completion of an 80-hour training covering
   - California's 17-core competencies for Medi-Cal Peer Support Specialists. Training
   - must be obtained from a CalMHSA-approved training program.
   - Successfully pass the state-approved Medi-Cal Peer Support Specialist Certification exam.

   CCBHS has not removed the requirement for clinical supervisors to be an LPHA. CMS Medicaid Directors Letter #07-011 says the following: Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

7. **Question:** Can Peer Support only bill "peer support services" if they are certified? Do all peer staff need to be certified?

   Answer: BHIN 22-026 provides specific codes to use in Mental Health, DMC-ODS and DMC for peer support services. In order to use these codes one must be a certified peer support specialist.

8. **Question:** If allowed to bill for rehab/collateral and not billing peer support services? If certified, do they only bill peer support services?

   Answer: CCBHS is currently seeking clarification from DHCS and will respond in a future FAQ when we receive more guidance.

Frequently Asked Questions Continued

MHP Providers - Category: Assessment

9. **Question:** Will the County be setting a standard for "reasonable timeframe" for doing an initial assessment and an updated assessment?

   Answer: Yes. Regarding the Mental Health Plan, assessments should be completed within the initial period of 60 days and annually thereafter. Care plans should also be completed within the initial 60-day period and annually thereafter.

10. **Question:** If an assessment is completed outside of the timeframe will this be considered a compliance issue and not a disallowance issue?

    Answer: CCMHP will focus on compliance and quality of care in its reviews and disallowances will be based on fraud, waste, and abuse.

11. **Question:** Since authorization for specialty mental health services are no longer necessary for billing, how will UR change to accommodate these changes?

    Answer: Authorization continues to be required. CalAIM is only taking away planned vs unplanned services, which means that a provider can provide necessary services even before the assessment has been completed and will be paid for those services. Upon review, Utilization Review will enter authorization.

12. **Question:** What does Children and Adolescent Needs & Strengths (CANS) "informing" the assessment mean?

    Answer: The CANS supplements the overall assessment.

13. **Question:** Can the CANS stand in for those sections (i.e., on trauma section of assessment say 'see CANS')?

    Answer: The assessment requires all 7 domains be addressed. According to BHIN 22-019 CANS Assessment tool may be utilized to help inform the assessment domain requirements.

14. **Question:** Is a narrative section still needed in the assessment document?

    Answer: The 7 domains are required in the assessment, and if it takes a narrative to complete them, then a narrative is required.

15. **Question**: If updates are only needed when clinically appropriate for assessment, is there an agreement on how often that would be?

Frequently Asked Questions Continued

Answer: For CCMHP, assessment updates must be completed annually.

16. **Question**: Must an updated assessment be completed in the "Assessment section" or is a progress note sufficient?

    Answer: The updated assessment must be completed in the assessment form and not on a progress note.

17. **Question**: What roles and assessment activities will the County authorize outside of waivered/licensed/registered staff, considering the statement?

    The Mental Health Plan (MHP) may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

    Answer: Our current scope of practice policy remains unchanged. Providers could always contribute to the assessment, but only licensed, registered/waivered interns, and approved trainees can complete the assessment.

18. **Question:** Will the County allow an MHRS to bill assessment code?

    Answer: MHRS may not bill Assessment.

19. **Question**: Does the assessment no longer require a signature by a licensed provider for AMFT, ASW, etc.?

    Answer: Registered and waivered interns do not require a co-signature. For more information, please review CCMHP's Guidelines for Scope of Practice at Provider Services :: Behavioral Health :: Contra Costa Health Services (cchealth.org).

20. **Question**: Assessment domains 3 and 4 list "comorbidity" in regard to behavioral health alone or medical and behavioral health, what does this mean?

    Answer: Comorbidity simply refers to the presence of two or more diseases or medical conditions in a patient.

21. **Question**: Will a checklist of interventions be acceptable as part of the narrative (per parity to medical doctor notes)? If interventions are repeated verbatim across multiple notes will that be interpreted as fraud even if those are accurate to the service being provided?

    Answer: Progress notes should be unique to the service provided.

Frequently Asked Questions Continued

22. **Question**: Is day of service included in 3-day timeliness? i.e., if service happens Monday, is note late on Thursday or Friday?

    Answer: Day of service is included in the 3-*business* day timeliness standard. If a service was provided on a Monday, then it would be late on Thursday, provided there were no holidays. Crisis notes, however, only allow for a 24-hour limit.

23. **Question:** Will the County shift to allow billing during "gaps" in authorization due to it not being fraud, waste, or abuse?

    Answer: Late paperwork would be a quality of care issue and not result in disallowance.

24. **Question**: Is there a reason that the ANSA is not going to be used as a part of the level of care assessment tool?

    Answer: Unlike CANS, ANSA is not currently required statewide.

25. **Question**: Can we get rid of the CANS?

    Answer: No, we cannot. CANS continues to be a state requirement.

26. **Question**: What is the timeline for completing the assessment and has there been a limit established for how long a Z-code can exist without an approved Diagnosis?

    Answer: Assessments should be completed within the initial period of 60 days and annually thereafter. Per BHIN #22-013 guidance issued by DHCS, a clinician may use ICD-10 codes Z55-Z65 or ICD-10 code Z03.89 during the assessment period. Z codes may be used prior to: (1) the completion of an assessment; and/or (2) the determination of a diagnosis. In other words, appropriate claims for services provided prior to the completion of an assessment or the determination of a diagnosis are allowed. ICD-10 codes Z55-Z65 and/or Z03.89 may be used up until the end of the assessment period.

MHP Providers - Category: Progress Notes

27. **Question**: Each progress notes currently needs to justify medical necessity. This BHIN no longer lists this (it states the assessment will need to show this).

    Answer: Correct, DHCS does not indicate a need for us to demonstrate medical necessity in each note.

Frequently Asked Questions Continued

28. Question: Please confirm this is no longer a requirement for individual progress notes. Or please clarify what should be included to document medical necessity for progress notes going forward with Cal-AIM.

Answer: The DHCS BHIN 22-019 requires the following:

A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

- The date that the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time.
- Location of the beneficiary at the time of receiving the service.
- A typed or legibly printed name, signature of the service provider and date of signature.
- ICD 10 code.3
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

29. Question: Can we drop all BIRPs and PIRPS and SOAPS formats and just include problems, interventions, and plan?

Answer: The DHCS does not require BIRP, PIRPS, or SOAPS formats.

30. Question: For group notes: BHIN indicates one provider can document and sign a progress note documenting for two providers for a group session. How will county system be adapted to allow for this?

Answer: Contra Costa County continues to require two separate notes per group with two mental health provider facilitators. ShareCare cannot facilitate two NPI numbers to be submitted on one billing note.

31. Question: Can we have notes for each specialty e.g. clinicians, mhs's, csw's, family partners in the training?

Answer: Yes, sample notes will be provided later in upcoming documentation trainings but will not be a part of the CalAIM trainings on the general topic of documentation redesign.

Frequently Asked Questions Continued

MHP Providers ONLY - Category: Treatment Plan

32. Question: Is a care plan the same as a treatment plan? What is the difference?

Answer: For the Mental Health Plan the reference to treatment plan and care plans are essentially the same.

33. Question: What are the minimal requirements for the treatment plan? (Goals? Strengths? Measurable objectives? Interventions?)

Answer: DHCS BHIN 22-019 states that the TCM care plan:

- specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary. Includes activities such as
- ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals;
- Identifies a course of action to respond to the assessed needs of the beneficiary; and
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

34. Question: Does the problem list replace all treatment plans?

Answer: While in most cases it does, some services still require a treatment plan/client plan/plan of care/individual service plan: Targeted Case Management (TCM), Intensive Case Management (ICC), Intensive Home Based Services (IHBS), Therapeutic Foster Care (TFC), Therapeutic Behavioral Health Services (TBS), Narcotic Treatment Programs (NTP) Peer Support Services (PSS), Short Term Residential Therapeutic Program (STRTP), Psychiatric Health Facility (PHF), Special Treatment Programs with skilled Nursing facilities (STP-SNF), Mental Health Rehabilitation Centers (MHRCs) and Social Rehab Programs (SRP).

35. Question: For a one-time service such as when TCM is offered as a onetime referral or support does that then require the creation of a Care Plan?

Answer: A one-time case management service does not require a care plan.

36. Question: Will Contra Costa County shift to using the State definition of collateral shared by other counties to reduce need to bill case management and therefore create care plans?

Frequently Asked Questions Continued

Answer: Contra Costa County continues to interpret "collateral" to personal rather than professional support people. However, for the purpose of evaluating, assessing, or coordinating to develop a plan for continuity of care, providers may use the corresponding codes for evaluation, assessment, and plan development respectively.

37. **Question:** If updates are only needed when clinically appropriate for a care plan, is there an agreement on how often that would be? Only when goals, objectives, interventions are met/changing?

    Answer: If the conditions change for a client such as hospitalization, step down, etc. then the expectation is to update the care plan accordingly to reflect the client's condition, needs and goals of treatment. However, this does not cancel that a plan when required (see BHIN 22-019) must be updated annually.

38. **Question:** Does IHBS need to be added to the care plan if authorized through ICC?

    Answer: IHBS and ICC both require a care plan.

MHP Providers ONLY - Category: Problem List

39. **Question:** Can we call the "Problem List" something else as long as it holds all required elements, if it's a term participants will hear or know about in their records?

    Answer: No. The term "Problem List" was established by the DHCS BHIN 22-019 and was named to align the MHP with Managed Care.

40. **Question**: Will the County defer to the provider or clinicians on the timeframe for the initial problem list creation?

    Answer: The MHP will not defer to the provider. The problem list will be due within the first 60 days.

41. **Question**: Will there be a definition/agreed upon timeframe for "updating the problem list within a reasonable time"? Is this just when problems are added/removed?

    Answer: DHCS does not designate what constitutes a "reasonable" time frame. The problem list should be updated as new problems and diagnoses both emerge and change.

42. **Question**: If a Problem List includes a change in diagnosis, must a licensed LPHA co-sign and will attest to the updated diagnosis?

Frequently Asked Questions Continued

Answer: Any change in diagnosis must be made within one's scope of practice.

43. **Question**: How will the "narrative" requirement of the progress note be defined? Can the narrative be simply a reference to addressing the Problem List or Client Plan or will there be county-specific length or content requirements?

Answer: The DHCS BHIN 22-019 calls for a narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

DMC-ODS Providers ONLY - Category: Assessment

44. **Question:** Will the County be setting a standard for "reasonable timeframe" for doing an initial assessment?

Answer: Yes. Regarding Drug Medi-Cal Organized Delivery System (DMC-ODS), the assessment for outpatient services should be completed within the initial period of 30 days for beneficiaries 21 and older or 60 days for beneficiaries 21 and under or 21 and older who are experiencing homelessness. Regarding DMC-ODS residential facilities, an initial assessment is due within 10 calendar days.

45. **Question**: What is the timeline for completing the assessment and has there been a limit established for how long a Z-code can exist without an approved Diagnosis?

Answer: Code selection during assessment period of outpatient Behavioral Health (BH) services, per BHIN #22-013 guidance issued as well as specific providers outlined by DHCS may use ICD-10 codes Z55-Z65 or ICD-10 code Z03.89 during the assessment period. Z codes may be used prior to: (1) the completion of an assessment; and/or (2) the determination of a diagnosis. In other words, appropriate claims for services provided prior to the completion of an assessment or the determination of a diagnosis are allowed. ICD-10 codes Z55-Z65 and/or Z03.89 may be used up until the end of the assessment period.

46. **Question:** Will the County shift to allow billing during "gaps" in authorization due to it not being fraud, waste, or abuse?

Answer: Tardy paperwork for DMC-ODS is deemed a matter of quality and generally would not impede approved authorization of services (gaps).

Frequently Asked Questions Continued

DMC-ODS Providers ONLY - Category: Problem List

47. **Question:** Can we call the "Problem List" something else as long as it holds all required elements, if it's a term participants will hear or know about in their records?

    Answer: No. The term "Problem List" was established by the DHCS BHIN 22-019 and was named to align with the term Managed Care uses for consistency.

48. **Question**: Will the County defer to the provider or clinicians on the timeframe for the initial problem list creation?

    Answer: DMC-ODS will not defer to the provider. The problem list will be due within 30 for beneficiaries 21 and older or 60 days for beneficiaries 21 and under or 21 and older who are experiencing homelessness. The problem list will be due within 10 days for residential services.

49. **Question**: Will there be a definition/agreed upon timeframe for "updating the problem list within a reasonable time"? Is this just when problems are added/removed?

    Answer: DHCS does not designate what constitutes a "reasonable" time frame. The problem list should be updated as new problems and diagnoses both emerge and change.

DMC-ODS Providers ONLY - Category: Treatment Plan

50. **Question:** Is a care plan the same as a treatment plan? What is the difference?

    Answer: DMC-ODS- does not require the development of a Treatment Plan with the exception of Narcotic Treatment Programs (NTP)s.