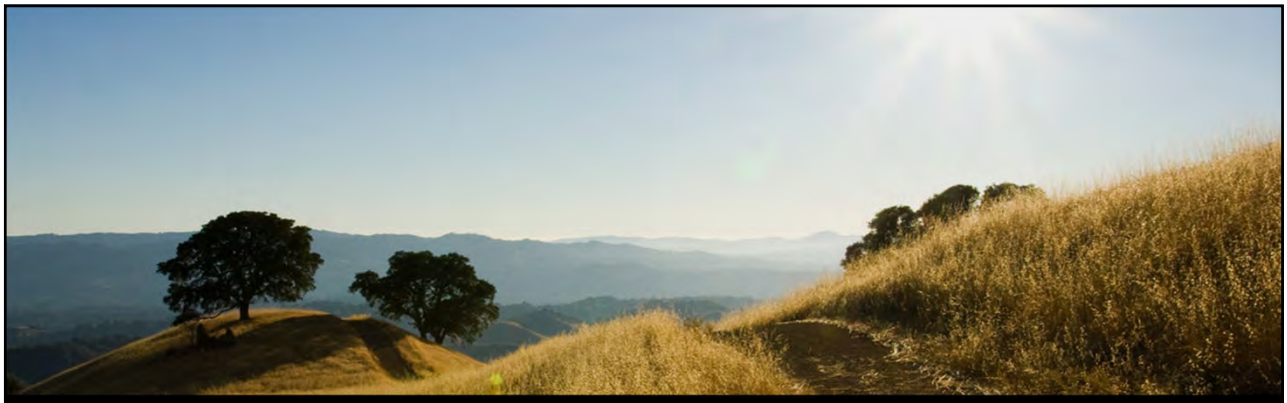

Documentation Redesign, No Wrong and Co-Occurring Treatment Training Contra Costa Behavioral Health Services Network Providers

Katy White, LMFT
Regina Griffiths, LCSW

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Housekeeping

- Please put your name and program/clinic (if applicable) in the Zoom chat
- Please put questions in the chat; Q&A will be held briefly at the end of each section, and more at the end.
- Please turn videos off during presentation to allow for increased bandwidth
- Please ensure you are on mute, unless asking a question
- Brief survey at end confirms attendance

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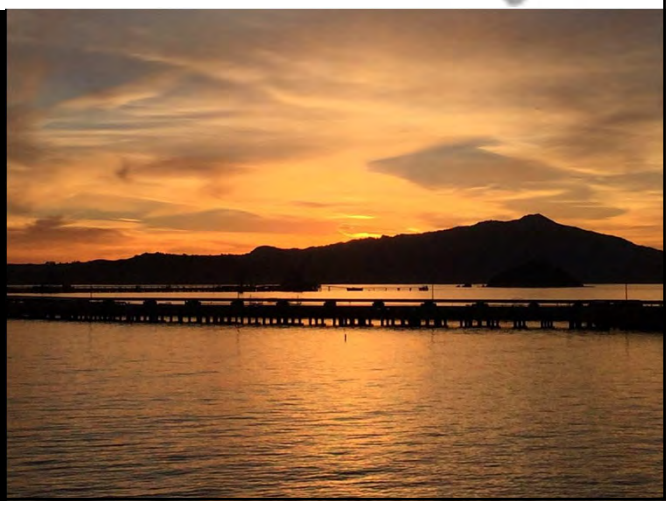
Agenda

I. Welcome & Introductions
II. CalAIM Overview
III. Access Criteria
IV. Tx Prior to Dx
V. No Wrong Door/Co-Occurring Tx
VI. Documentation Redesign
VII. Resources
VIII. Evaluation
IX. Q&A



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Glossary

- AODS: Alcohol and Other Drug Services
- ASAM: American Society of Addiction Medicine
- DHCS: Department of Health Care Services
- DMC-ODS: Drug Medi-Cal Organized Delivery System
- ICD: International Classification of Disease
- MAT: Medication Assisted Treatment
- MCP: Managed Care Plan
- MHP: Mental Health Plan
- NSMHS: Non-Specialty Mental Health Services
- SMHS: Specialty Mental Health Services
- SUD: Substance Use Disorder

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Primary Goals of CalAIM

Manage Risk

- Through whole person care approaches and addressing Social Determinants of Health (SDOH)

Reduce Complexity

- Move Medi-Cal to a more consistent and seamless system and increasing flexibility

Improve Outcomes

- Reduce health disparities, and drive delivery system transformation and innovation

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CalAIM Timeline Goals

Timeline

January 2022	July 2022	January 2023	July 2023	January 2027
Access Changes	Documentation Reform	Universal Screening Tools	Payment Reform	Mental Health and Substance Use Administrative Integration

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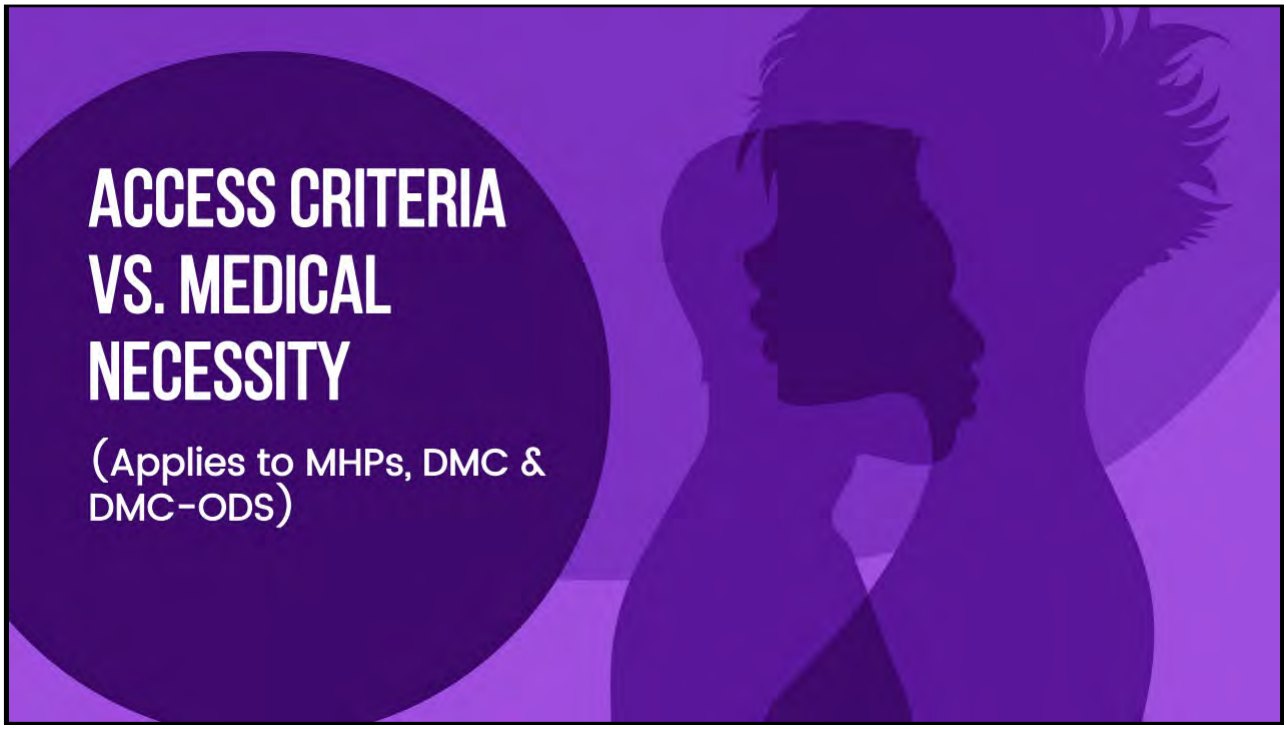

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SPECIALTY MENTAL HEALTH SERVICES (SMHS) ACCESS CRITERIA & MEDICAL NECESSITY - WHAT IS THE DIFFERENCE?

Access Criteria

Is the individual eligible to receive SMHS?

Redefined criteria make it so individuals can receive needed services without barriers

Medical Necessity

Is the service provided clinically appropriate?

Services provided to a beneficiary must be medically necessary and clinically appropriate to address their presenting condition

*Under CalAIM, SMHS Access Criteria and Medical Necessity are **separated** and **redefined***

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MEDICAL NECESSITY DEFINED – SMHS

Adults Age 21+

A service is "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

Welfare & Institutions Code sections 14184.402(a) & 14059.5

Youth Under Age 21

A service is "medically necessary" if it is necessary to correct or ameliorate a mental illness or condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition.

Section 1396d(r)(5) of Title 42

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TREATMENT PRIOR TO ESTABLISHING A DIAGNOSIS (CONTINUED)

Keep in Mind:

- While a diagnosis is no longer a prerequisite to access care, Medi-Cal claims still require an ICD-10 code (the code does not need to be on the progress note—it needs to be on the claim)
- In cases where services are provided due to a suspected mental health disorder not yet diagnosed, the codes to the right can be utilized

ICD-10 Codes for All Providers*

- Z55-Z65 (Persons with potential health hazards related to socioeconomic and psychosocial circumstances)
- Z03.89 (Encounter for observation for other suspected diseases and conditions ruled out)
- "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services"

**May be used during the assessment period prior to diagnosis*

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DHCS "Priority" Social Determinants of Health (SDOH) Codes

For Managed Care Plans, DHCS seeks to prioritize the use of a set of pertinent SDOH codes to maximize the capture of actionable SDOH data

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	*Inadequate drinking-water supply*
Z59.00	*Homelessness unspecified*
Z59.01	*Sheltered homelessness*
Z59.02	*Unsheltered homelessness*
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	*Food insecurity*
Z59.48	*Other specified lack of adequate food*
Z59.7	Insufficient social insurance and welfare support
Z59.811	*Housing instability, housed, with risk of homelessness*
Z59.812	*Housing instability, housed, homelessness in past 12 months*
Z59.819	*Housing instability, housed unspecified*
Z59.89	*Other problems related to housing and economic circumstances*
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

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NO WRONG DOOR – KEY PRINCIPLES

More Flexibility Based on Individual Needs and Preferences

- Medi-Cal beneficiaries shall receive timely mental health services without delay regardless of the delivery system in which they seek care
- Clinically appropriate SMHS delivered by MHP providers are covered whether or not an individual has a co-occurring substance use disorder (SUD)
- To ensure beneficiary choice and help maintain established therapeutic relationships, non-specialty mental health services (NSMH) and SMHS can be provided concurrently, as long as services are coordinated between MCP and MHP providers and are not duplicative
  - Example: An individual may only receive psychiatry services in one network, not both networks, or an individual may only access individual therapy in one network, not both networks

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No Wrong Door

Behavioral Health Information Notice 22-011

- **Universal Screening Tool**
  - To be released in January 2023
  - Will provide guidance to MHPs and MCPs regarding the most appropriate system of care for an individual seeking mental health services
- **Transitions of Care**: Decisions via patient-centered decision-making process
  - Universal Transition Tool
    - To be released in January 2023
    - Will support more effective and coordinated transitions between systems of care

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NO WRONG DOOR MYTH BUSTING

Real Deal

No Wrong Door does not mean a client can obtain services from any possible program within the MHP

No Wrong Door refers to systems of care: MHP vs. MCP

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CARE COORDINATION & AVOIDING DUPLICATION OF SERVICES

- Coordinate early and often
- Discuss and agree upon on the responsibilities each provider will hold
- Schedule regular care coordination meetings
- Address potential "gaps" in meeting the individual's needs and how they will be addressed
- Help with transitions of care when appropriate

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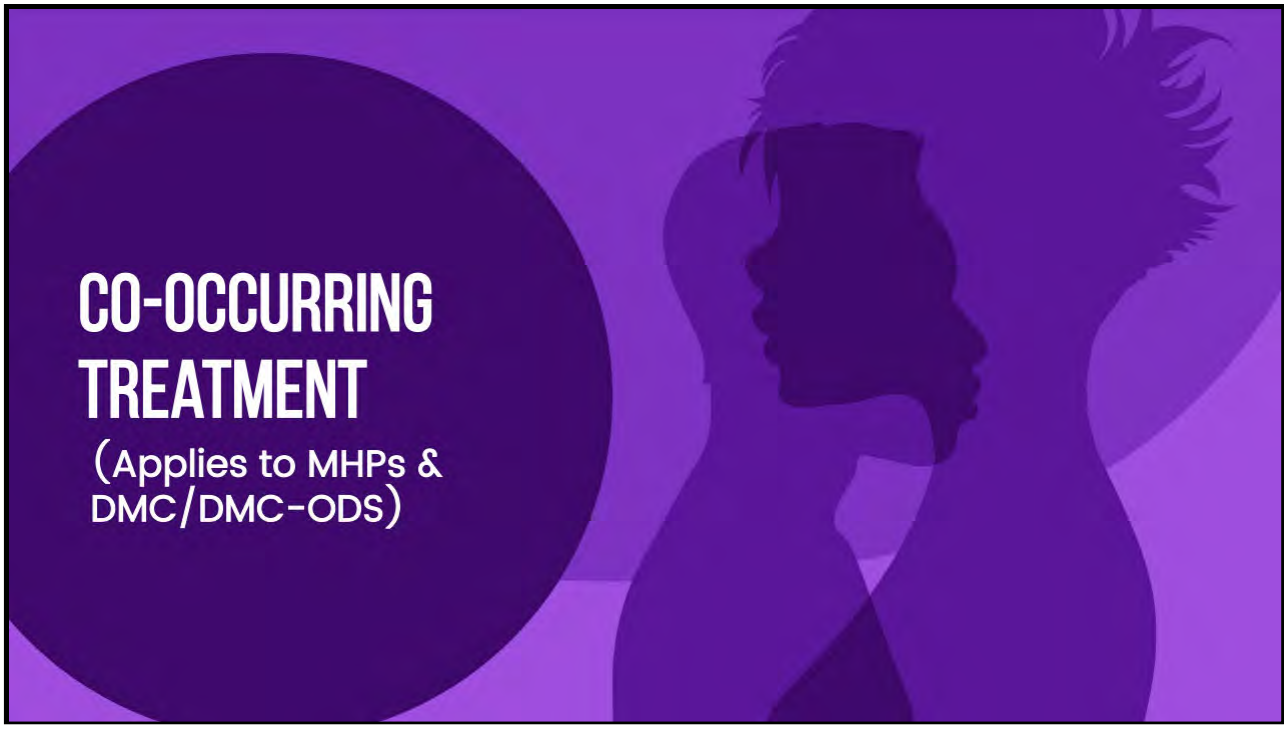

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CalMHSA CalAIM Webinar Initiating Treatment: No Wrong Door/ Treatment Prior toDiagnosis
Video clip at 32:43 minutes of Gary Tsai, MD

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CO-OCCURRING TREATMENT

WHAT YOU'VE HEARD:

"MH providers now have to treat substance use disorders and SUD providers now have to treat MH disorders"

REAL DEAL

Providers are not being required to work out of their scope. There is now greater flexibility; however, for assistance to be provided to a beneficiary while the provider works to connect the beneficiary to either MH or SUD services for more in depth support/treatment

BENEFITS

Greater flexibility for treatment providers

Beneficiaries are able to receive immediate support for their presenting concerns while being supported with connecting to the appropriate care

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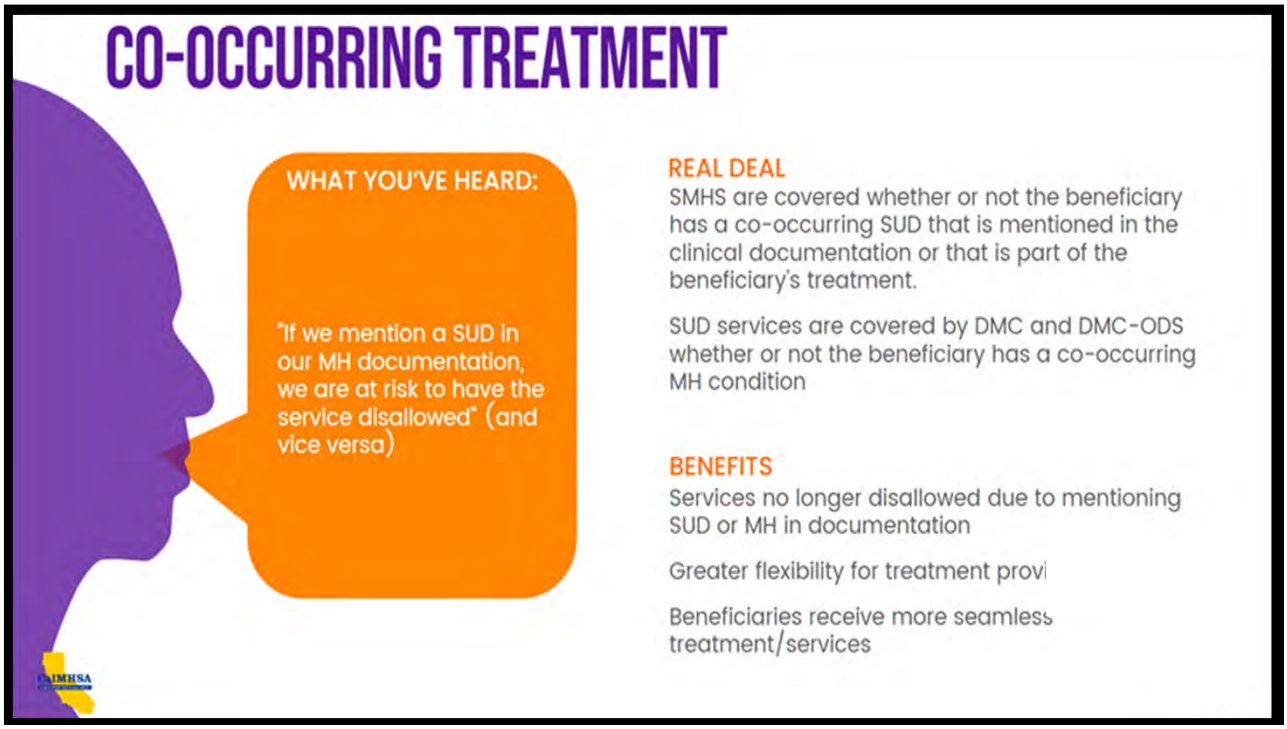

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DOCUMENTATION REDESIGN

- **Assessment** form has been modified.
- Partnership Plan has been replaced by a new form, "**Problem List**".
- **Progress note** form has been modified.

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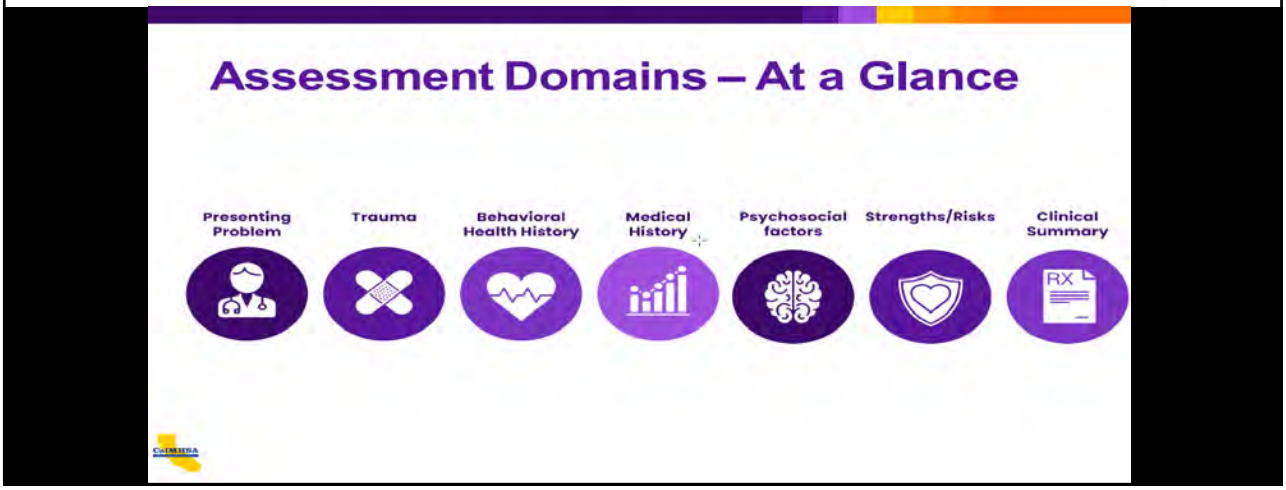
Documentation Redesign



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Assessment

- Changes
  - Condensed from 4 pages to 3 pages + 1 blank page
  - Demographic information removed from 1st page
  - No longer rating functional impairments as mild/moderate/severe
  - Added Trauma History/Exposure section
  - Added Psychosocial Factors section
  - Added Beneficiary Protective Factors section
  - Added Clinical Summary
  - Beneficiary is no longer required to sign the assessment
  - Removed: Targeted Symptoms, Impairment/Intervention Criteria, Life Goals, & Partnership Plan

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Assessment - Question

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.

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Documentation Redesign

- Problem List
  - Dynamic! A Living Document
  - Looks at diagnoses, symptoms, conditions and/or risk factors
  - Problem doesn't have to live on Problem List before being treated
  - Problems can be identified by client, significant support person or provider

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Problem List

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Problem List - Questions

Question #1: 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 #1: No - The term "Problem List" was established by the DHCS BHIN 22-019 and was named to align the MHP with Managed Care.

Question #2: Will we be able to see the Problem Lists from other providers?

Answer #2: They are working on allowing Network Providers to see the Problem List from other providers without the ability to edit the document. The Problem List does not need to be duplicative.

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Documentation Redesign

- Progress Notes
  - Reflect planned action steps by client or provider
  - Collaboration with the client, and/or other providers
  - Any update to the problem list, as appropriate
  - Include a place to include care plan as relevant

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WHAT SHOULD NOT BE INCLUDED

- A lengthy narrative that does not add clinical value
- A copy and paste of the last progress note (even if some elements remain the "same" as the last visit)
- Jargon: special words or expressions that are used by a particular profession or group and are difficult for others to understand
- Specific note formats such as BIRP, SOAP, SIRP, etc. are not required

CalMHSA

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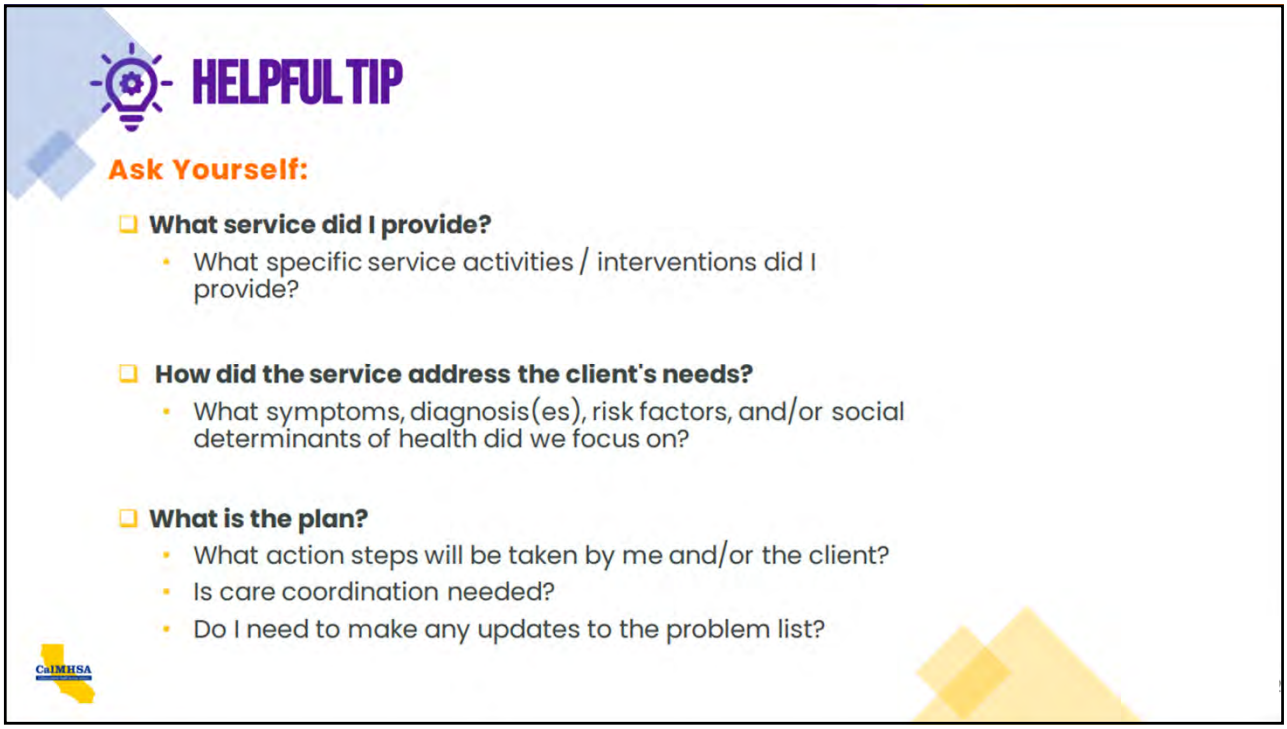
HELPFUL TIP
Ask Yourself:
What service did I provide?
What specific service activities / interventions did I provide?
How did the service address the client's needs?
What symptoms, diagnosis(es), risk factors, and/or social determinants of health did we focus on?
What is the plan?
What action steps will be taken by me and/or the client?
Is care coordination needed?
Do I need to make any updates to the problem list?
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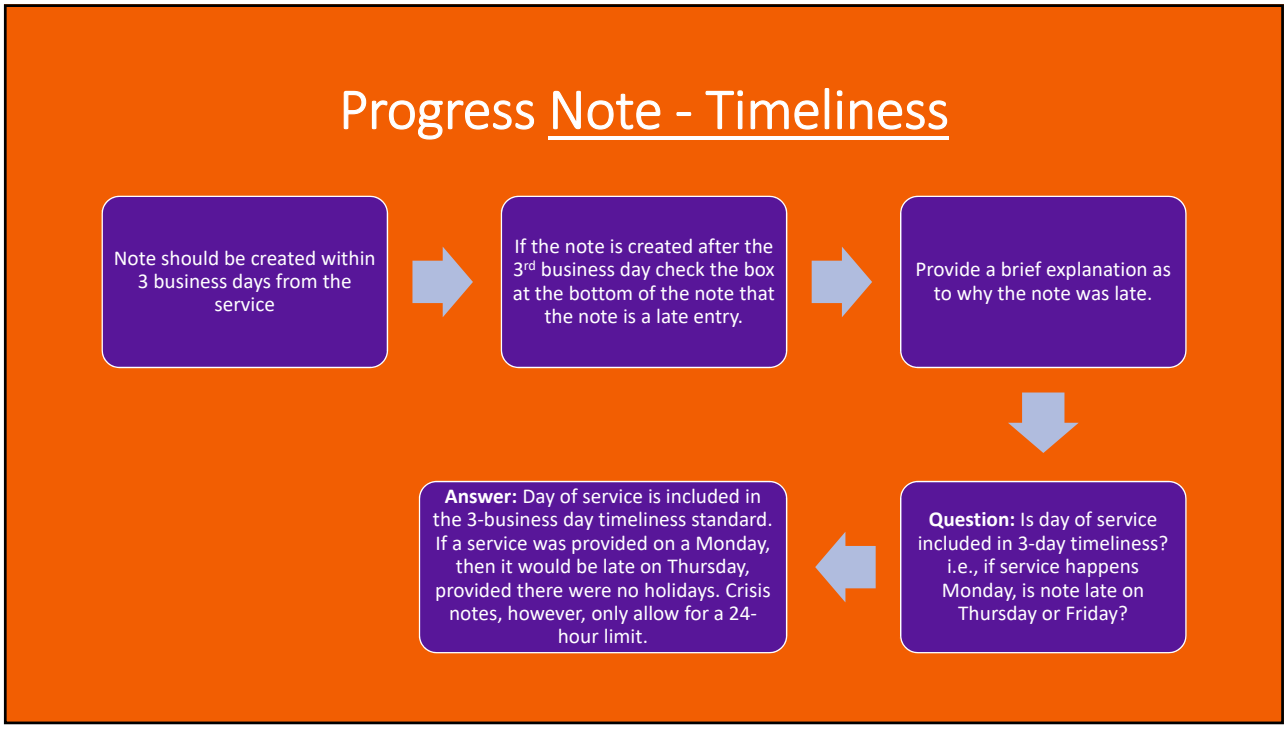
Progress Note - Timeliness
Note should be created within 3 business days from the service
If the note is created after the 3rd business day check the box at the bottom of the note that the note is a late entry.
Provide a brief explanation as to why the note was late.
Question: Is day of service included 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.

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Fraud, Waste and Abuse Definitions

- **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. §1347).
- **Waste** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **Abuse** includes actions that may, directly or indirectly, result in:
  - Unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.
  - Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

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What Constitutes Fraud, Waste and Abuse?

- Medicaid fraud and abuse negatively impacts health care use by wasting limited resources and potentially endangering patients through unnecessary care or preventing access to medically necessary services.
- Most providers try to work ethically, provide high-quality patient medical care, and submit proper claims.
- Most mistakes made in clinical documentation are **not** fraud, waste or abuse.
- More details to come in the DHCS 2022-2023 Annual Review Protocol (coming later in 2022).

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What is NOT Fraud, Waste and Abuse?

- Selecting the incorrect service code/CPT
- Entering incorrect service/documentation/travel time
- Billing when the client was a "no show" or the session was cancelled
- The service does not meet the definition of a SMHS
- The content of the progress note does not justify the amount of time billed
- The note that was billed is not present in the chart
- The date of service of the progress note does not match the date of the service claimed
- Documenting non reimbursable services or including mention of "non-billable" interventions during an otherwise billable note
- Service provided was not within scope of the person delivering the service
- Documentation was completed but not signed
- Group services not properly apportioned to all clients present

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What Conduct Can Raise An Inference of Fraud, Waste or Abuse?

- Repeated pattern of unnecessary services
  - Example: "assembly line" non-individualized treatment patters, or "cookie-cutter" progress notes
- Pattern of knowingly false statements on billings, or corresponding progress notes
  - Example: deliberately listing wrong location of service or provider to conceal license/eligibility issues
  - Intentional concealment of known errors or overpayments
  - Example: use of inaccurate statements, or deliberate failure to disclose adverse facts, in response to audit questions

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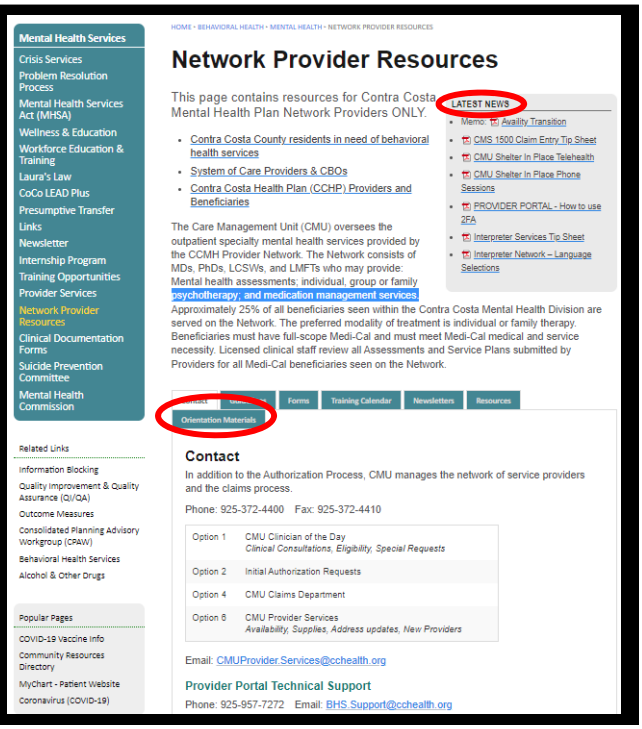
Resources

CCBHS Network Provider Resources Website:
https://cchealth.org/mentalhealth/network-provider

- Visit the site and look under the ***Latest News*** and ***Orientation Materials*** tab to find the recording and slides for this training.

Email: CMUProvider.Services@cchealth.org
- If you have questions, please send an email to the CMU Provider Services email.

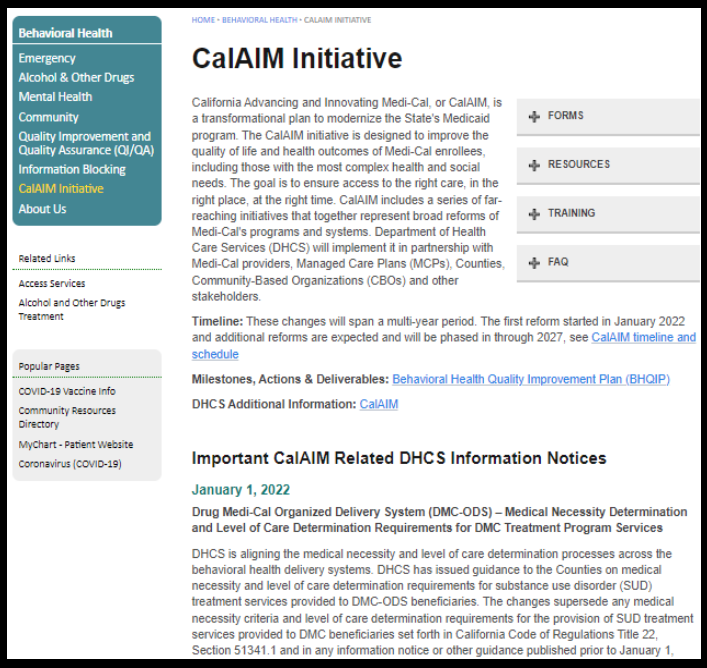


Resources (contd.)

CCBHS CalAIM Website:

https://cchealth.org/bhs/calaim

- The ***FAQ*** tab may be helpful to Network Providers.
- Network Providers should submit questions to the CMU email and reference the forms on the Network Provider Resources site, indicated on the previous slide.



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Resources (contd.)

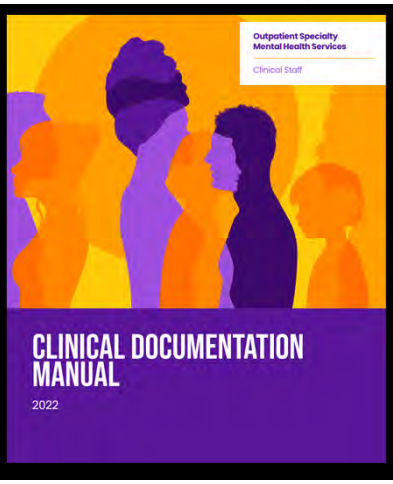
CalMHSA Resources:

https://www.calmhsa.org/calaim-support-for-counties/

CalMHSA Documentation Guides: (available May 2022-new) role specific guides for both MH and SUD that encompass all clinical documentation standards. Will be updated in Jan 2023 to include CPT codes as part of payment reform.

Department of Health Care Services CalAIM:

https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx



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Network Provider Evaluation

Please complete the evaluation at the link below to verify your completion of this training.

https://forms.office.com/g/jsZE6rQufz

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What Happens Next?

Future Trainings / FAQs

- This training/slides will be posted on our Network Provider website
- FAQs will be posted on the county website

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Q & A Session

- Are we still expected to comply with the new paperwork starting July 1st, less than 1 week from the training?
  - Yes –
    - if you have a current authorization, you do not need to submit the Assessment until it is time for the Annual.
    - You will need to start using the new Progress Note and develop a Problem List starting 7/1/2022

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