Fresno County Department of Behavioral Health

CalAIM Q & A

As of 2/24/2023

(Red font = New Info, Update or Correction)

Fresno County Department of Behavioral Health (DBH) is committed to providing the most up to date information during our transition to the California Advancing & Innovating Medi-Cal (CalAIM) initiative. We have put together a list of questions and answers that will provide information on the initiative. If you would like to submit a CalAIM question for Mental Health (MH), please send your inquiry to DBHCompliance@fresnocountyca.gov. For questions related to the Drug Medi-Cal Organized Delivery system (DMC-ODS), please submit questions to SAS@fresnocountyca.gov.

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Problem List

PQ1: How many days from intake does the problem list (PL) have to be completed? How often should it be updated? Will we be provided with a template and sample?

A: There is no regulatory guidance defining how many days from intake the Problem List should be completed. Problems should be added to the Problem List as they are identified through the assessment and other interactions with the person served. DHCS did not prescribe how often the Problem List should be updated, leaving it to the clinical judgment of providers. Problems should be added and resolved as clinically appropriate. DBH QI will be providing training and a sample Problem List.

PQ2: Are we able to document PL in progress notes instead of a separate form since we are discontinuing the use of treatment plans?

A: No, identified problems should be added to the problem list which is a separate document. The identified problem should also be documented in an assessment or progress note.

PQ3: Regarding the PL that is scheduled to go live on 9/19/2022, we are actively working with our EHR vendor to build a problem list that will meet the needs of the county, but we are unsure that it will be ready to go live on 9/19/2022. Is it possible to get an extension as we work to get the problem list built?

A: We understand that some providers may need time to program their EHRs or make other changes to facilitate use of the problem list. As such, September 19th is the date the PL will go live in Avatar, and the expectation is that Avatar users will begin using when available. Non-Avatar users should

work toward implementation, but it is not expected that these programs go live on September 19th. Rather, they should demonstrate progress toward problem list implementation.

PQ4: Diagnosis and PL codes seem to be redundant. Is there a way to have them combined so that there is one list amongst all episodes?

A: No, this is not a capability of Avatar at this time. For now, all problems including the diagnosis should be listed on the PL that will go live on 9/19/22, and the diagnosis will continue to be documented as usual.

PQ5: For new persons served, can I use the PL now even though it isn't being implemented until 9/19/22?

A: Yes, you may use the PL now. If a contracted Individual Provider, Group Provider, or contracted Organization is ready to implement PLs per standards set in the CalMHSA Documentation and Billing Manuals, they may do so prior to the Sept. 19th date.

PQ6: Will UCWC complete initial assessment when referring person served or will they be doing PL only?

A: Please reach out to your supervisor for direction. This program specific process question is not answered by CalAIM regulation.

PQ7: When is the deadline for creating PL for entire caseload? Can treatment plans continue to be used during transition to PL?

A: The PL will be live in Avatar on 9/19/22. Please work with your supervisor regarding goals for transitioning your caseload to a PL. Mental Health treatment plans can remain in place while PLs are being developed.

PQ8: Can we run an Avatar report to track who has a PL on file?

A: DBH IT is working on a solution in Avatar and in Domo to track PLs for persons served. The Department will notify Avatar users when the solution is available.

PQ9: Once the PL is implemented on 9/19/22, will it replace the need to update the current treatment plans?

A: Yes, only for those services that no longer require a treatment plan. The services that continue to require treatment plans are TBS, IHBS, ICC, TFC, STRTPs, and NTPs. The Peer Support and Case Management plans are to be documented in a progress note in narrative format. All SUD services continue to require Tx plans.

PQ10: Is there a timeframe required to resolve the PL items?

A: No. You would update the PL as clinically appropriate.

PQ11: For persons served with existing treatment plans, will the problem list be the first service provided on 9/19/22?

A: Yes, at the next appropriate service on or after 9/19/22, you will enter the problem list with the person served and/or family member, or as clinically appropriate, and discontinue the treatment plan for any service that does not require one.

PQ12: Are the items on the PL meant to be general, i.e., PTSD can have different symptoms?

A: Yes, per the direction and examples from the CalMHSA documentation manual. According to BHIN 22-019, “the problem list is a list of symptoms, conditions, diagnoses, and/or risk factors”. Therefore, the symptoms identified within a diagnosis can be listed separately or as a diagnosis itself (e.g. using Z codes).

PQ13: Do we add any problems that a person served identifies even if it is not a mental health problem/diagnosis?

A: Yes, problems identified by the person served and/or support persons should be included on the problem list including physical health and social determinants of health. Per BHIN 22-019, “the problem list shall include problems or illnesses identified by the beneficiary and/or significant support person”. Providers entering problems on the PL should add problems that are within their scope of practice. If a problem is identified that is outside the scope of practice, the problem should be documented in a progress note and a referral made to the appropriate provider.

PQ14: Can a non-LPHA (case manager, rehab specialist, LVN) enter physical health problems identified by the person served/support person?

A: Providers should add problems to the problem list that are within their scope of practice. At this time, there is no mechanism in Avatar to add a problem to the problem list without also selecting an ICD 10 code. Since medical conditions are outside the scope of practice for an LPHA, a medical problem reported by a person served should be documented in a progress note. Providers entering problems on the PL should add problems that are within their scope of practice. If a problem is identified that is outside the scope of practice, the problem should be documented in a progress note and a referral made to the appropriate provider.

PQ15: When will the PL form be accessible in Avatar?

A: It will be available in Avatar (LIVE) on 9/19/22.

PQ16: Currently, on the progress note form, staff could view the problems listed on the treatment plan and select the problem they addressed in Avatar. Will that functionality change to allow staff to view the current problems on the problem list within the progress note?

A: The progress note does not have this functionality.

PQ17: Will Avatar Lite users need to complete the PL form in Avatar?

A: Users will need to create their own PL within their own EHR or paper chart. DBH has developed a paper PL that can be utilized by providers without an EHR.

PQ18: Can I complete the PL and targeted case management (TCM) care plan narrative in one service?

A: Yes.

PQ19: Do we list provider on the PL as Therapist or LMFT or LMHC, SLMHC, UMHC, CMHS, AMFT, ASW, etc.?

A: BHIN 22-019 states that the name and title of the provider that identified and entered the item on the Problem List must be present.

PQ20: Where can I find a copy of DBH’s Policy or information about the PL?

A: There is not a DBH policy as of yet but a News You Can Use was sent by DBH QI in early September 2022 regarding the problem list. DHCS's BHIN 22-019 and CAL MHSA clinical documentation guide also provide details on the problem list.

PQ21: Can we delete a problem on the PL that was created in error in Avatar?

A: No, you must mark it as resolved and complete a corresponding progress note to document the error.

PQ22: If a problem is being identified that was not previously mentioned in the assessment, would we need to update the assessment or complete a core assessment addendum?

A: Maybe. If the new problem is a significant piece of clinical information that adds to or changes the clinical picture or adds value to the diagnostic formulation, then it may be appropriate to update the assessment. Assessments are updated as clinically appropriate. The Assessment is not required to be updated simply because a new problem is added to the Problem List.

PQ23: Is there an updated list of specifically ICD-10 codes for medical conditions related to pregnancy? Should our LMHCs, CMHS, and Psychiatrists be including pregnancy related to whether those need to be included in the Problem List, and if so, can they list those ICD-10 codes in terms of their scope of practice (like we used to do under 5-axis assessment under medical condition section). Sorry, but there doesn't seem to be any real clarity about this, especially since Perinatal Wellness Center exists to support mental health conditions arising from the medical condition of being pregnant (Perinatal Mood and Anxiety Disorders, a.k.a., PMADs).

A: Providers should add problems to the problem list that are within their scope of practice. At this time, there is no mechanism in Avatar to add a problem to the problem list without also selecting an ICD 10 code. Since medical conditions are outside the scope of practice for an LPHA, a medical problem reported by a person served should be documented in a progress note.

PQ24: I need clarification, last week in a meeting we were told to let staff know to start transitioning individuals in their caseloads from treatment plans to problem list as soon as today (I know this will take time, but it was stated that if a person served had an expired TP or soon to expire TP, that as of today we would start doing the PL). However, in the most updated Q and A (dated 9/16/2022) DQ4 stated to continue with Treatment plans until DBH QI issues guidance on the PLs, but in another section of the same Q and A PQ7 it stated to work with supervisor to transition TPs to PLs.

A: Both statements are accurate. Guidance referred to in DQ4 regarding the problem list was sent on 9/8/2022. The response to PQ7 directed individuals to work with their supervisor regarding timeline to transition persons served on their caseload to problem lists as it is not likely that the caseloads would be transitioned to PL in one day. This is a process issue that should be decided at the program level.

PQ25: We understand that we can claim to any suspected diagnoses during the assessment process. After the assessment is completed, if we want to add a diagnosis code to the PL and bill to it, do we need to do a reassessment or do we just add the code to the PL and start providing services to address that new diagnosis/problem and claim to it?

A: If after completing the assessment you find that a problem (suspected diagnosis) no longer applies you would mark the problem as resolved and this would be documented in a progress note. If a new problem is identified after the assessment is completed, the problem (updated diagnosis or problem) should be added to the problem list and should be documented in a progress note. If completing the

assessment results in a change or update to a diagnosis you must also update the diagnosis page. BHIN 22-019 specifies that the time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessment within a reasonable time and in accordance with generally accepted standards of practice. It is up to the clinical discretion of the provider taking into consideration the generally accepted standards of practice whether the new problem identified warrants a reassessment of the person served.

PQ26: To confirm, staff will continue to use the 159 billing code when they complete a PL. Will there be a way to distinguish between the treatment plan and the PL, for example within the DOMO report?

A: In Avatar, the 159 service code is specifically "plan development by a non-physician", so they should not continue to use it when adding a problem to the problem list. Newly identified problem(s) should be added to the Problem List whenever they are identified. This could be during the course of the assessment, an individual therapy session, a case-management session, a group rehab session, etc. 159 will continue to be used for treatment plans and there's no need to differentiate in DOMO. Creating a problem list or adding a problem to the problem list is not an intervention on its own. Instead, it drives the focus of each intervention.

PQ27: Will there be more "problems" listed that we may choose from? The issue is that we are forced to choose a more general, non-specific problem which doesn't represent the real issue. Example: 'negative thinking' is the real issue, but I had to choose 'dysphoric mood'. Perhaps there's a better available choice that I haven't come across yet? In the case above, the REAL problem isn't conveyed.

A: Though there are a variety of ICD-10 codes to choose from, unfortunately there may not be a specific code for every symptom, impairment, or problem. In cases where the problem that is being addressed in treatment does not have a corresponding ICD-10 code, please select the most appropriate alternative ICD-10 code and describe the problem in your subsequent progress note.

PQ28: Are we allowed to collaborate with person-served to write a list for the problem list and then after the session input the problems into AVATAR? I noticed while doing the problem list with a person-served in session that I was spending time searching for terms/items that would fit the identified problems when I could have been using the time to support person-served in other ways instead. Also, if we input the problems after the session; is this time billable?

A: For direction on specific implementation of new practices such how to collaborate with a person served in creating a problem list in session, please consult with your immediate supervisor. If you are documenting items in the problem list immediately following your engagement with a person served as part of your documentation of the session, this time could be rolled into the service activity claim; however, if completing documentation on a later date, the time it takes to simply complete documentation may not be claimable. This is not new direction specific to CalAIM documentation standards and we again recommend you consult with your immediate supervisor for direction.

PQ29: Does a clinician need to add the Dx to a CMHS staff's PL?

A: All providers work off a single PL for each person served. A problem list would not necessarily "belong" to CMHS or a single clinician rather it is to be a shared list to be used and actively created by each provider within their own individual scope of practice.

PQ30: For persons-served applying for and/or participating in federal funded subsidized housing programs; do they need to have a current treatment plan, or will the PL replace the treatment plan? What about other affordable housing programs not receiving federal funds?

A: If the provider is engaging in targeted case management to address housing problems identified on the PL, including assistance in applying/participating in federally funded housing programs, a TCM treatment plan narrative in a progress note is required in addition to the housing problem being identified on the PL.

PQ31: If a person served receives services from us at RMH and All 4 Youth, do we create a separate PL for each program or do we work off of one PL for both programs?

A: As the two Fresno County MHP contracted programs are utilizing a shared EMR, the person served should have one problem list. The two MHP contracted providers should be consulting on a regular basis about ongoing care and identification of problems on the PL.

PQ32: On the treatment plan there was a box to check for asking and providing the PS with information on how to establish an Advance Directive. With the PL, this is no longer included on the form. Is this something we need to still be asking persons served about and providing them the informational pamphlet if they do not have one established already?

A: CalAIM does not change the requirement to provide information regarding the Advance Directive. Please continue to provide the informational pamphlet if the person served does not have an established Advance Directive. This action can be documented in a progress note.

PQ33: Does PS with both Medi-Cal and Medicare coverage require a treatment plan to be completed as before CalAIM or does a Problem List suffice because they have Medi-Cal?

A: If the person served has both Medi-Cal and Medicare coverage then both the treatment plan and the Problem List are required. CalAim does not change Medicare requirements. Medicare is always billed before Medi-Cal and therefore the treatment plan is required.

PQ34: Is it true that a Problem List must be completed before any services can be billed?

A: The problem list does not need to be completed prior to the delivery of a Medi-Cal reimbursable service. The problem list may be created at the same time as the initial service. In Avatar, identified problems must be added to the diagnosis list in order to claim for the service provided. There is no mechanism in Avatar for Problem List items to be automatically added to the diagnosis list. This is why both the Problem List and the diagnosis screen are needed at this time.

PQ35: Is it true that a Problem List alone allows medication services to be billed?

A: Outside of the specific times when a treatment plan is otherwise required (i.e., the person served has Medicare or SD/MC, etc.), medication support services may not be claimed based on the problem list. Billing/claiming is based on the diagnosis list, not the problem list. Identified problems must be added to the diagnosis screen list in order to claim for services. There is no mechanism in Avatar for PL items to be automatically added to the diagnosis list.

To bill for medication services there must be a diagnosis. In the instances that a treatment plan is required there must also be a treatment plan. Every person served needs a Problem List. Billing in Avatar is based on the diagnosis on the medical note. There is no mechanism in Avatar for the Problem List to be automatically added to the diagnosis list.

PQ36: Is it true that a Problem List does not expire as long as there are problems to be addressed?

A: A problem list does not have an expiration date. The Problem List should be reviewed regularly and is updated as clinically appropriate by the addition and removal of problems.

PQ37: Are there specific Z-codes we can anticipate utilizing more frequently when providing behavioral health services and if so, where can we find a list for these Z-codes?

A: Yes, we do anticipate that there will be more frequently used Z-codes. You can find a list to these Z-codes on the DBH CalAIM webpage or by clicking here for the list. Please note, this list is meant to be a tool/guide for anticipated commonly used Z-codes and not meant to limit which Z-codes may be used.

PQ38: Can both clinicians and CMHS staff use the R and T codes?

A: This is a great question that we are still seeking clarification on. Though there are a variety of ICD-10 codes that fall under "R" and "T", not all are appropriate to support medical necessity for a SMHS or DMC-ODS intervention activity for Medi-Cal reimbursement as not all "R" or "T" codes are specific to behavioral health needs or impairments. At this time we strongly encourage LPHA/LMHP providers to use the following options when a diagnosis has yet to be established: ICD-10 codes Z55-65; ICD-10 code Z03.89; or in cases where services are provided due to a suspected disorder that has yet to be diagnosed, options are available for an LPHA or LMHP to use any clinically appropriate ICD-10 code such as codes for "other specified" and "unspecified" or "factors influencing health status and contact with health services." CalAIM information notices identified the use of Z codes only for non-LPHA staff; R and T codes were not included. For further guidance, please refer to the CalMHSA clinical documentation guide.

PQ39: I believe I heard during a Q&A or read in a Q&A that medication services cannot be billed unless there is an assessment completed as well as a Problem List (and POC if the PS has Medicare). Is it correct that a completed assessment is required to bill for medication services whereas for other services, they may be billed before the assessment is completed?

A: A prescriber must have completed an assessment, diagnosis and prescribed medication before medication services can be billed. This is not specifically a CalAIM or Medi-Cal billing rule, but rather a general order of practice. Currently, this is done via the Core Assessment and/or the Psychiatric Evaluation in Avatar for those providers using Avatar as an EHR. There are extenuating parameters if the person served is a Medicare beneficiary. In most situations as long as the proposed intervention, in this case medication support, is consistent with addressing one or more problems as identified on the established problem list, then the service would be eligible for Medi-Cal reimbursement.

PQ40: If a clinician reaches a different diagnosis than the prescriber (i.e., Schizophrenia vs. Schizoaffective D/O), should both be listed in the Problem List?

A: Yes. The problem list has a column to list who identified the problem. Best practice would be to consult among the treatment team regarding the person's diagnosis, but in the meantime, there is a record of who identified what problem/diagnosis.

PQ41: I have some questions regarding the problem list and targeted case management plan. We currently have a section on our EHR that will allow us to add problem list on to person served's EHR, however I want to make sure that it meets the formatting standard that Fresno County wants before continuing with it. Do you have a format standard in place that I can look

over to ensure that our problem list section meets your guideline? In addition, is there a timeframe that the targeted case management needs to be completed by and do you happen to have a template or example for me, so I can support my team with it?

A: The DBH Problem List template was sent to all MHP providers in September. The template can be found on the DBH CalAIM Web-Based Trainings Page here. Though we have no similar template for the targeted case plan narrative, the CalMHSA Documentation Guides at California Mental Health Services Authority | Documentation Guides (calmhsa.org) has all the information needed to complete the TCM care plan. The TCM care plan may be completed the same day the targeted case management is delivered.

PQ42: Can we enter all issues on PL regardless of Share of Cost (SOC)?

A: Only enter problems within your scope of practice.

PQ43: Are we required to provide a copy of the PL along with the Discharge Summary for continuity of care?

A: There is nothing in writing stating it is required, but it is best clinical practice. Additionally, for continuity of care, best practice is the warm hand off which is collaborative and comprehensive and ensures linkage.

PQ44: Just to confirm, there is no signature requirement for the PL?

A: No signature is required.

PQ45: If there is an active problem on the Problem List, should it be included in the diagnosis updates for every episode with active services?

A: The Problem List is separate and distinct from a program's diagnoses list in a medical record, as not all "problems" equal a diagnosis. The Problem List is used to inform the diagnostic impressions for a person served. The responsibility to maintain a single, current Problem List belongs to each provider delivering care. It is important that the services rendered are consistent with the problems as identified on the Problem List. Two persons served with the same diagnosis may experience different impairments and have different needs as identified, but a problem itself may not be a mental health condition that would be included in a diagnoses list. Please note that for Avatar users, billing is based off the diagnosis list, not the problem list.

PQ46: One of my staff recently used the code, R 45.89 (Guilty Feelings) on the Problem List for one of her persons served. She attempted to use it yesterday with one of her other persons served; however, it was not available. Do you know what may have occurred?

A: The problems from the problem list would not show in the progress note, only the diagnosis since a diagnosis is needed to claim the service. If the staff wants to use that code for claiming the service on the progress note, then they would need to update the diagnosis form with that code first.

PQ47: For the problem list, can a case manager transferring (transcribing) a diagnosis already on file from an assessment by a therapist or doctor put the name and date that the doctor or therapist gave that diagnosis? This is more for existing persons served who do not yet have a problem list. Since they are not themselves giving a diagnosis, would this be okay? Or will this need to be done solely by doctor or therapist when dealing with non-Z codes?

A: The entries in the PL need to be manually completed by the user including the provider who identified the problem. And the provider must enter problems that are within their scope of practice.

PQ48: Is it possible to get a list of R-codes that are appropriate for Licensed Mental Health practitioners to use? From my understanding R-codes are Medical codes used by physicians, and seem to capture a single symptom. So far we've been discouraging use of these codes due to them not capturing medical necessity for services beyond a short-term skill building type of thing. However, we have had some situations where other DSM & SDOH codes don't seem to capture the issue and there have been requests to use R-codes in those situations.

A: There is no specific list of R-codes appropriate for LPHAs to use. The recommendation is for an individual LPHA to use their clinical judgement when selecting a diagnosis when the LPHA believes an R-code is more appropriate than a SDOH or other specific DSM diagnostic code.

PQ49: We have a person served who was receiving services with TP Diversion but transferred to RMH. The RMH clinician completed a new assessment for the person serviced and did not agree with the dx of Schizoaffective they had from Diversion and decided to give a dx of Schizophrenia, which was justified in the clinical summary of the assessment. The question we had was whether the RMH clinician leaves the Schizoaffective dx and adds Schizophrenia to the problem list or does the clinician have to change Schizoaffective to "resolved" to remove it? Is it okay to have both dx active on the problem list?

A: If after the new assessment the new treating LPHA determines the diagnosis of Schizoaffective is no longer appropriate for the Problem List, the treating LPHA would mark the diagnosis as "resolved".

PQ50: With new direction on documentation procedures connected to CalAIM to create a progress note for explanation of updating problem list and initial assessment screening, I'm concerned about the future process of reviewing historical information (i.e. reasons problems were added to problem lists and initial presentation when referred for clinically appropriate services). For example, if in 6 mo. to a year staff wants to review progress by checking the initial reason for a problem being added; will we need to go through the progress notes to identify that specific note? Or will there be a form that we can click on to review this information (like what we currently have in AVATAR for the POC and assessment, etc.)?

A: To obtain documentation that pertains to the decision to add a problem to the Problem List, the provider can reference the **Problem List Viewer** or **Problem List Widget** within Avatar to obtain the date that the problem was added and then search for documentation on or around this date.

PQ51: Can the Case Manager (non-LPHA) write in the diagnosis previously determined by the LPHA that originally determined the mental health condition of person served in order to build the PL?

A: When the diagnosing LPHA is no longer available, you can do one of the following:

1. The LPHA currently directing care can enter the diagnosis into the PL, or
2. The Case Manager may do it as long as they identify the person who made the diagnosis, the provider type and the date the problem was added to the PL (along with the appropriate diagnosis). We also recommend one of the following:
    a. The Case Manager note this in the progress note; therefore the PS also knows it's on the PL, or
    b. The Case Manager write an administrative note-to chart that simply says this case manager added the dx determined by [name of LPHA] on [date LPHA gave Dx] to the problem list and will notify the treating clinician.

AQ1: During yesterday's training we were notified that we must have a consent form signed by the person served allowing telehealth or telephonic services be provided during the course of treatment. Has the County developed an approved form of this consent, or will the present Consent to Treatment form be modified to include the consent? I don't want to create our own SUD Consent for Treatment form and have it not meet the DBH standards. Will a statement in the intake note suffice for now without a signed form?

A: New SUD Telehealth Consent form has been created and is now available on the Provider page.

AQ2: In the DSM-V, we weren't able to find questions related to Tobacco Use Disorder (TUD) as indicated in the question on the new health questionnaire. It just lists impairments to come up with a diagnosis. Are you aware of a list of questions we should be asking?

A: Behavioral Health Information Notice 22-024 includes links to resources with several tools that can be used to meet this requirement. The Fresno County SUD Assessment was created to identify all substance use disorders, including tobacco use. All questions found in the "Substance Use History" section of the Fresno County SUD Assessment can be used to identify TUD.

AQ3: Can you clarify what "stand alone" care coordination means?

A: A standalone service refers to a service that can be provided without receiving concurrent services with other levels of care. CalOMS is not required when providing a standalone care coordination service. Additional intake paperwork is not needed in order to bill for this service, although DBH recommends that an appropriate release of information and consent to treatment is completed.

AQ4: Does "Clinician Consultation" include conversations between residential programs and Beacon when seeking residential authorizations and there is a disagreement about the appropriate level of care?

A: Clinician Consultation does not include conversations between residential programs and Beacon when seeking residential authorizations. The authorization process includes a review of the DSM and ASAM Criteria to ensure that the person served meets the requirements for residential service. Clinician Consultation is designed to assist clinicians with seeking expert advice on treatment needs for specific DMC-ODS persons who may have complex cases.

AQ5: For "Clinician Consultation" does the consulted clinician need to be credentialed to provide services? (Managed Care)

A: Clinician consultation, which was formerly known as physician consultation, allows for any DMC-ODS LPHA to consult with addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists on complex cases. Providers can receive clinician consultation at no charge through the Clinician Consultation Center by calling 844-326-2626.

AQ6: Can we have more clarification on the group sign-in sheet requirements? What is mandated on a group participant list?

A: According to BHIN 22-019, when a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider. Although not specified in the BHIN, best practice would indicate that the list of group participants also contain the date of service, time of service, whether the group was in-person or telehealth, and the name/title of provider(s) rendering the service.

This would enable DHCS, the County or other entity adjudicating claims to verify information included in claims submitted.

AQ7: Do the relaxed reassessment timelines apply to both residential and outpatient?

A: The reassessment timelines apply to every level of care except NTP/OTP. Residential providers will still follow established reauthorization timelines.

AQ8: Can we use the ASAM-C for the initial assessment, or does it have to be the Fresno County SUD Assessment Tool?

A: The Fresno County SUD Assessment Tool must be used.

AQ9: Did the reassessment timelines for residential services change?

A: Residential providers will continue to follow the established reauthorization process and timelines.

AQ10: I would like to hear more on how to arrive at medical necessity with an SUD unspecified diagnosis.

A: If the person served only meets criteria for an SUD unspecified diagnosis, medical necessity cannot be established beyond the assessment period. If the person served meets criteria for an additional SUD diagnosis, the SUD unspecified diagnosis can be a secondary or tertiary diagnosis beyond the assessment period. An unspecified SUD diagnosis is allowed throughout the assessment period as you gather information to make the final determination if medical necessity is met for an actual SUD diagnosis. For example, you could initially assign an Unspecified Alcohol-Related Disorder to a PS whom you have identified as having a pattern of alcohol use, but yet to complete the assessment process to see how their alcohol use has impacted their life.

AQ11: Do all providers already have access to Recovery Service programs in Avatar?

A: Yes, search for the programs in Avatar with your provider number followed by “RS” (for example 101030-RS). If providers cannot find their RS programs, please contact your assigned staff analyst for support.

AQ12: Can a person being served in residential treatment stay in treatment if its longer than 120 days and meets medical necessity for that placement of care if the timeline of treatment has been removed?

A: Yes, as long as they meet medical necessity and ASAM criteria. The average length of stay goal is 30 days for our system of care, but that doesn’t mean that it is a hard cap on the length of stay.

AQ13: What about Recovery Service billing codes/rates?

A: Recovery Service rates should have been submitted by your program prior to the start of the fiscal year. If they were not, contact your assigned analyst. Recovery Service codes will be made available to you in Avatar under your “RS” program along with their associated rates.

AQ14: Will you be providing a new template for the daily residential note at some point or will it remain the same and we just document daily?

A: DBH is revising the residential progress note to reflect the new requirement. The revised note will be made available to all providers once it has been finalized.

AQ15: It would be helpful to clarify the program modalities impacted by BHIN 22-024 Tobacco Assessment, and BHIN 22-025 Naloxone. It is my understanding these requirements are not applicable to NTPs.

A: The BHIN 22-024 applies to all licensed residential facilities or SUD facilities certified by DHCS in accordance with AOD certification standards. BHIN 22-025 applies to all licensed residential SUD facilities. Although form DHCS 5103 can be used to satisfy this requirement, it is not required to be completed by SUD programs who are not required to comply with AOD certification standards.

AQ16: Do delays in 30-day timeframes for treatment plans require a new treatment plan?

A: Marker will be the day the assessment was completed not the beginning of the stay. If a reassessment is needed during the term of the treatment plan, do a reassessment. Providers will need to use good clinical judgement.

AQ17 What do we need to be doing right now?

A: Complete the documentation trainings available on CalMHSA's website. SUD providers should attend DBH SUD provider meetings for support. SUD providers are encouraged to submit questions regarding CalAIM to the SAS inbox. https://www.calmhsa.org/calaim-2/

AQ18: The new Health Questionnaire includes the question about tobacco use and we were provided with samples of questions that could be asked. Our question is, "if a person served identifies that they may have a TUD, however the LPHA is not able to identify that TUD due to lack of questions on the assessment, are we to do anything other than provide them with the link to address the issue?" I heard mention of putting it on the treatment plan or problem list, however I wouldn't know where to put it on the treatment plan or how to address it as we don't provide treatment for TUD.

A: The new Health Questionnaire addresses tobacco use with a question attesting that tobacco use has been assessed with DSM-5 or similar evidence-based tools. To make the appropriate diagnosis of TUD, tobacco use should be assessed like any other substance during the assessment process.

AQ19: Are substance use counselors required to obtain signatures or some kind of okay from a LPHA on the items on their problem list?

A: The problem list does not require signatures or co-signatures rather it only records the person who identified/added/removed each problem within their scope of practice. SUD counselors would only be able to utilize Z55-Z65 codes on the problem list. An LPHA would need to add any items outside of Z55-Z65 codes while working within their own scope of practice on the problem list.

AQ20: How can a SUD Counselor/Case Manager bill for completing a problem list? Since they are performed simultaneously with a treatment plan, should we just add the additional time to the formulation of a treatment plan or include it in the documentation time? Or at all?

A: Newly identified problem(s) should be added to the Problem List whenever they are identified. This could be during the assessment, an individual counseling session, during care coordination, etc. Overall, it depends on the service you are providing; you would bill under that service's respective code.

AQ21: Since we are still supposed to complete a SUD treatment plan, many of the problems identified in the assessment have to do with identifying physical health as well as mental

health issues. I understand we are not supposed to reflect those on the problem list as they are outside of our scope, however, there are many other issues that we identify such as getting a physical examination that we cannot align with a Z code. Is there any indication as to what problems we should and what problems we should not carry over to the problem list? If we identify problems on a treatment plan that don't align with a Z code what should be our course of action?

A: Providers entering problems on the Problem List should add problems that are within their scope of practice utilizing the proper code. If a problem is identified that is outside the scope of practice, the problem should be documented in a progress note and a referral made to the appropriate provider. The need for a physical examination would be documented on the treatment plan only. At this time, the direction is to place any identified risks/needs (physical/mental health) that do not align with a particular Z code on the Treatment Plan only. DBH is currently looking at all Z codes to see which might be the most frequent/relevant for providers to utilize on the Problem List. More information regarding this topic will be shared in the future.

AQ22: When will the progress notes be updated on the SUD website?

A: The updated progress note forms are available now and can be found on the SUD Providers webpage: Substance Use Disorder Providers | County of Fresno

SUD Residential Treatment Programs

RQ1: Who decides what gets recouped and who gets that money? Why does the DMC Contract have to be for less money than any other contract when it requires more work and staff than any other contract?

A: Recoupments are based on requirements in the Intergovernmental Agreement, Provider Manual, Behavioral Health Information Notices, Contractual obligations, etc. Any recouped funds are returned to DHCS or SABG depending on the funding source. DBH has not actually recouped for services in several years.

RQ2: Why do we need to do a daily group note in residential treatment? If persons served are in residential treatment and they are not participating in every group every day, then they will be discharged from treatment for non-compliance.

A: Daily progress notes are now required by DHCS as identified in BHIN 22-019. A daily progress note should be completed for each person served.

RQ3: Why is there a 30 day limit on treatment and why do we have to get a reauthorization every 30 days?

A: There is no limit on treatment. Treatment is based on medical necessity. The State would like to see a trend toward a 30-day average, but treatment is still based on medical necessity. We are unable to change the prior authorization guidelines, so authorizations will continue at least every 30 days.

RQ4: Has the date to complete the initial assessment changed from 3 days? What is the purpose of utilizing the initial assessment for the purpose of a reassessment, when the

current reassessment form is much more useful in documenting progress? The initial assessment's questions are pretty much just relevant to intake purposes.

A: The assessment is needed to request authorization for the residential stay, so the timeframe of 3 days has not changed. In regard to reassessment, the Fresno County ASAM based reassessment captures all domains and will continue to be accepted until such time as DHCS issues additional guidance. The reassessment will be renamed "Updated Assessment" and uploaded to the County website.

RQ5: Is the assigned counselor required to write the note or can a facilitator write the note? What is the purpose of the daily note? Would the note just consist of the group they attended, topic, and if they did or did not participate?

A: For clinical or treatment services, the credentialed staff member who provided the service should write the note. Further discussion and direction regarding the implementation of the daily note in SUD residential is scheduled for October 3, 2022 at the CalAIM Provider Collaborative meeting from 2 PM-4PM.

RQ6: Is the timeframe for assessments changing in residential from 3 days to 6 days? Will the timeframe for assessments change for persons served 21 and younger in residential?

A: The assessment is needed to request authorization for the stay so the timeframe of 3 days has not changed. It is the same for adult and adolescent. BHIN 21-075 indicates that residential is an exception to the changes in assessment timeframes.

RQ7: Who will document daily progress notes? Primary SUD Counselor, LPHA, or any registered/certified or licensed staff?

A: For clinical or treatment services, the credentialed staff member who provided the service should write the note. Further discussion and direction regarding the implementation of the daily note in SUD residential is scheduled for October 3, 2022 at the CalAIM Provider Collaborative meeting from 2 PM-4PM.

RQ8: Will group notes be acceptable as daily progress notes?

A: Yes, as long as it is a clinical group (between 2-12) and facilitated/documented by a credentialed staff member. Separate notes for each service provided during the day will be accepted in place of a daily progress note.

RQ9: Will providers be receiving notices in writing when each new CalAIM requirement is required to be implemented?

A: Providers have already received notices and training on CalAIM requirements and the department will continue to support changes. CalAIM implementation is a work in progress that we will navigate together. It is less about hard and fast start dates and more about demonstrating that we are moving towards the new CalAIM requirements.

RQ10: Will budget adjustments be allowed or an additional rate setting period once we figure out how the changes will impact our staffing patterns?

A: Providers can request a rate review during this fiscal year. The county will consider adjustments up to the maximum county reimbursement rate. In order to submit a rate review, an OER must be submitted up to date.

General Questions

GQ1: How do MHP providers enter services and what are the steps?

A: There is no change to the way in which providers enter services (i.e., access line, UCWC, YCWC, contacting a provider in the provider directory, transition from MCP to MHP, etc.). Continue to follow the same steps as before.

GQ2: How do we complete the Access form?

A: CalAIM does not address DBH's access form. There are no changes to timeliness standards or to the access form completion requirements.

GQ3: How are other counties implementing these changes?

A: Each county has a BHQIP implementation plan and is implementing the changes according to their county plan.

GQ4: If multiple MHP providers are working with a family, does each agency have to have their own care coordinator or is it like the ICC coordinator where there is one person per family designated?

A: Every person served (PS) receiving SMHS must have an identified Care Coordinator. The identified care coordinator may be part of the existing mental health team (i.e., the treating therapist or a program case manager) but there must be a care coordinator that the person served can reach out to for linkage, etc. From the CalMHSA documentation clinical documentation manual p. 20 "Care coordination also meets federal requirements to ensure that each person in care has an ongoing source of care appropriate to their needs. Additionally, a person or entity must be formally designated as primarily responsible for coordinating the services accessed by the person in care. The person in care must be provided information on how to contact their designated person or entity."

GQ5: How can we get more information from the state for our most frequently asked questions?

A: The Department of Health Care Services (DHCS) has posted version 1 of the CalAIM Behavioral Health Frequently Asked Questions (FAQ) document: https://www.dhcs.ca.gov/Documents/8-8-22-V1-CalAIM-Behavioral-Health-Initiative-FAQ.pdf. This FAQ document will be updated regularly. The DHCS FAQ document linked above can be found at the following webpage: https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx. A new DBH webpage devoted to addressing CalAIM Behavioral Health information can be found here.

GQ6: Are we mandated to have suicide prevention training as a provider?

A: There is no requirement in CalAIM regulations for suicide prevention training. The CalMHSA documentation guide references the use of standardized screening tools. Domain 6 of the Assessment includes: "May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used." CalMHSA LPHA Documentation Guide,

pg.14. However, there are suicide prevention training requirements per the Board of Behavioral Sciences (BBS).

GQ7: Can anyone assist with a copy of DBH's policy about new hire CalAIM training that we can look at?

A: DBH does not have a policy regarding new hire CalAIM training. However, a Compliance Bulletin was sent out notifying the system of care that all providers of SMHS and DMC-ODS services must complete the CalMHSA trainings. This CalMHSA video training series is intended to prepare all existing and new providers.

GQ8: If a PS is being seen by an individual or group provider under contract with FCMHP, is that provider presumed to be providing care coordination? If not, how does PS receive this service?

A: Yes, if a person is being served by an individual or group provider, the individual or group providers is responsible for providing care coordination as needed by the person served.

GQ9: Are all staff required to take the CalMHSA trainings or only those who provide direct services to persons served?

A: All providers in the Fresno County system of care, which includes anyone who provides, documents and bills for mental health and/or substance use disorder services are required to complete the video trainings. And we encourage those who monitor or supervise these clinical services to complete the video trainings, though it is not required.

GQ10: Are Office Assistants required to take the CalAIM Trainings as well?

A: CalAIM training is required for direct care providers providing direct client care. OA training is a program level decision. It would depend on what role OAs are taking in particular programs.

MH Billable Services

BQ1: Will prescriber services also be billable without a completed assessment?

A: Prescribers must complete an assessment of the person in order to develop at a minimum a working diagnosis that would support the prescribing of a medication.

BQ2: My team works with persons served who are in an acute care psychiatric hospital, PHF, CSU or jail. We previously used 956 or 300 codes for billing lock outs. I see in the Clinical Documentation Manual that the emphasis is on care coordination. Can we bill for the care coordination that we provide while the person served is in one of these facilities?

A: There are no changes to the lockouts with CalAIM. Per Compliance Bulletin: Proper Use of Service Codes 956 and the 300-series, 300 codes are used for SMHS that occur in lock out settings.

BQ3: Can we bill for anything on a problem list besides ICD-10 diagnostic codes including F codes and Z codes?

A: Yes, a provider working within their scope of practice may address any problem on the problem list. Please submit claims using the ICD 10, which include F and Z codes.

BQ4: We have a person served that is awaiting conservatorship and is in an IMD. We have been in contact with the conservator. Is this a billable or non-billable (NB) service?

A: CalAIM does not change billable services in relation to services provided in an IMD. Services provided in an IMD are still a lockout. The only exception to the SMHS lock out is for Case Management – Placement.

BQ5: Can the Community Mental Health Specialist (CMHS) and Mental Health Rehabilitation Specialist (MHRS) bill 159 for themselves with or without the LPHA co- signature being required?

A: CalAIM does not change scope of practice or signature requirements. Individuals may sign documents within their scope of practice. 159 is used for completion of the treatment plans. Treatment plan information may be gathered by CMHS but must be signed by LPHA. Targeted Case Management plans are written as a narrative in the body of the note and can be signed by a CMHS.

BQ6: Is the discharge summary and plan able to be claimed as 159 without the PS/supportive person/parent present to review the plan? i.e. PS has an unplanned discharge, no contact to resume Tx.

A: No, if there is an unplanned discharge and no contact with the person served, completing the discharge summary is a non-billable administrative action. Additionally, discharge planning is not a standalone service, but an activity that takes place within the context of several service types: Care Coordination, Case Management, Individual Therapy, Treatment Planning and can be included (billed) as part of that service.

BQ7: Perinatal Clinicians are making phone calls the day prior for intake assessment to provide psychoeducation and other services. We understand that with CalAIM, we can bill that as a 205T case management service. Are we allowed to bill for services provided prior to the assessment or treatment plan?

A: With CalAIM, services can be delivered prior to the completion of the assessment and for many outpatient services. An assessment and treatment plan will no longer be required to begin SMHS. In order to bill for SMHS an ICD-10 code or Z code is placed on the problem list. For Targeted Case management, a case note is written and the narrative Targeted Case Management plan is written in the note.

BQ8: For medication services follow up appointments, can the psychiatrist bill medication services for the follow up appointment if the person served is not present (i.e., meeting with caregiver only)?

A: Yes, meeting without the person served present would still be a medication support service. Per the DHCS SMHS Billing Manual published in July 2022, medication support is defined as:

Medication Support Services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary.

Services may include: providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined to be clinically appropriate); how the use of the medication may improve the effectiveness of other services a beneficiary is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing not to take medications.

The service includes one or more of the following service components

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects
- The obtaining of informed consent
- Medication education including instruction in the use, risks, and benefits of and alternatives for medication
- Collateral
- Plan Development

BQ9: Can non-LPHA level staff bill for limited assessment services if they meet the degree and experience requirements?

A: With CalAIM, providers other than an LPHA can gather some of the documentation for an assessment, but there is currently no mechanism in Avatar for a non-LPHA to build or bill for an assessment. The Department will work toward solutions for this issue and advise providers when non-LPHAs can conduct assessment activities.

BQ10: How do staff bill for a case consultation meeting? Can all staff bill for the entire meeting?

A: If staff are billing for case management, each staff member would have their own unique provider NPI and would submit separate claims. This would not be considered a duplicate service and may be billed. Please note, this information applies to specialty mental health services only.

Please see **DHCS Specialty Mental Health Services Medi-Cal Billing Manual, May 2022 Version 1.1**. On page 27, under **5.5.0 Duplicate Services: Outpatient Services,** the manual reads:

Outpatient services are listed in service tables 1-10. Except for Sign Language or Oral Interpretive Services (T1013) and Interactive Complexity (90785), a claim for an outpatient service is considered a duplicate if all the following data elements are the same as another service approved in history:

- *The beneficiary's CIN*
- ***Rendering provider NPI***
- *Procedure code(s)/modifier(s)*
- *Date of service*

In addition, on page 28, under 5.6.0 Co-Practitioners, the manual reads:

If multiple practitioners render services to the same beneficiary at the same time, each provider must submit a separate claim for the distinct service each practitioner rendered. Please see MHSUDS Information Notice 18-002 and BHIN 20-060R for more information about submitting claims to SD/MC for services rendered by multiple practitioners rendered to the same beneficiary at the same time.

BQ11: Can case managers and Peer Support Specialists (PSS) receive list of acceptable codes within their scope? They do not have a DSM or familiarity with Z codes.

A: Case Mangers and Certified PSSs may use Z codes with particular emphasis on Z codes 55-65 known as the Social Determinants of Health (SDOH). There is a list of SDOH codes on page 21 of the Certified Peer Support Specialist manual CalMHSA-MHP-CPSS-Documentation-Guide-06222022-1.pdf and page 36 of the MHRS and Other Qualified Staff manual which would include Case Managers CalMHSA-MHP-MHRS-Documentation-Guide-06222022-1.pdf.

BQ12: Will there be an expiration of an unspecified or NOS diagnosis? A point in time where diagnosis will no longer be reimbursed if not specified.

A: With the elimination of the list of included diagnoses, unspecified or other specified diagnoses are claimable diagnoses. DHCS has not set limits determining the length of time an unspecified or other specified diagnosis can be claimed. However, best practice is to be as precise as possible in your diagnostic opinion upon completion of the assessment.

BQ13: Traditionally we had to submit our claims for the specific diagnosis we were treating during that service. With CalAIM, we understand that there is no included diagnosis list, so can we submit all claims to the primary diagnosis that is on the problem list even if the service did not address that specific diagnosis? If that is not the case, how do we submit claims to get paid?

A: At this time, DBH will not change the way claims must be submitted or paid. Your service intervention should address an item on the problem list. All diagnoses (primary, secondary, etc.) should be on the PL, along with any applicable z-code (social determinants of health (SDOH)). The claimed diagnosis should correspond to the problem addressed in the progress note. More direction is forthcoming as Fresno County implements further system changes.

BQ14: Is it true that we can be paid for any claim submitted under any DSM5 code, including V codes (for example Parent-Child Relational Problem – V61.20) both during the assessment and any time after (for the duration the person served is enrolled in our program and meets medical necessity)?

A: Yes, enter DSM5 codes addressed during the intervention. You may use this code during the assessment and any time after and it should be listed on the Problem List. CalAIM moves us closer to whole-person care and providers should anticipate entering all problems identified and within their scope of practice as identified when assessing/interviewing the person served.

BQ15: Here's an example: A child has a clear trauma history, we do the assessment and they do not demonstrate medical necessity and do not have an F code DSM5 diagnosis. They do have some other V code diagnoses, such as V60.0 Homelessness, Child Neglect, Confirmed 995.52. Can we claim to the homelessness and neglect codes during the assessment process and any time after for ongoing treatment?

A: Yes, services to a person served under the age of 21 with a clear trauma history meets eligibility requirements for services and do not need to meet criteria for an F code in order to receive services. Services can be claimed during and after the assessment for ongoing treatment using a V (DSM5)/Z

(ICD 10) code. In this instance, the history of trauma (for person served under the age of 21) makes them eligible for Specialty Mental Health Services.

According to BHIN 21-073, persons served under the age of 21 shall meet either of the following criteria:

(1) The person served has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following:

a. scoring in the high-risk range under a trauma screening tool approved by the DHCS
b. involvement in the child welfare system
c. juvenile justice involvement, or
d. experiencing homelessness.

OR

(2) The person served meets both of the following requirements in a) and b), below:

a. The person-served has at least one of the following:

i. 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 specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan (CalViva Health or Anthem Blue Cross) is required to provide

b. The person's condition as described in subparagraph (2) 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 and the International Statistical Classification of Diseases and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the person served at risk of a future mental health condition, based on the assessment of a licensed mental health professional

BQ16: How would I bill for creating the problem list? Would this still be 159?

A: It depends on the service you are providing; you would bill under that service's respective code. If only problem list creation and related interventions are discussed, then 159 could be used.

BQ17: Is there a list of "R" diagnostic codes available to reference?

A: There is no longer a list of included diagnoses. Please use the DSM 5 and corresponding ICD 10 codes.

BQ18: Will the programs still be required to take private insurance persons served since those services are not paid for by the private insurance or will there be another funding stream for those services?

A: The implementation of the new CalAIM documentation standards does not alter any of the programming components of individual MHP contracts. CalAIM documentation standards do not change previously established funding streams.

BQ19: Can staff bill travel time from traveling from a school site to another school site? My Team has not billed for travel time since they have been assigned school sites and provide services on-site. However, now that staff do not have office space, my team is now providing services in school sites not assigned to them and to cases from the Outpatient program.

A: No, staff cannot bill travel time when driving from school site to another school site. Staff can bill for travel time from the office to the PS's home.

BQ20: I was confused about the guidance on use of R codes and if they are billable, specifically, R45.89 Emotional dysregulation. Is this a billable code?

A: Under CalAIM guidance in BHIN 21-073, claims must include a CMS approved ICD-10 diagnosis code. R45.89 is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. Only LPHA/LMHP may utilize this diagnosis within their scope of practice.

BQ21: Since all providers can bill without splitting time as long as there is justification for multiple providers providing services, are we still required to use lockout 300 codes? Let's say for instance, person served is at CRT and I consulted/collaborated with a case manager there to help person served with linkage to a phone and coordinating psychiatric appointment. Can I bill a 205 or do I still need to bill a 305?

A: CalAIM has made no changes to Lock-out rules. Billing a service separately when it is already part of the facility's bundled rate, or day rate is still not allowed.

BQ22: I was wondering if the payment reform initiative was going to impact how individual/group providers are paid?

A: Yes, the CalAIM payment reform will have an impact on how all MHP providers are reimbursed, including our MHP providers in our individual/group provider network; however, as a County we are still formulating those adjustments and innovations and will be sharing the reforms once firmly developed later this year.

MH Documentation

DQ1: For Progress Notes, do we still include the following information: the location of the session, travel distance, and the method of Telehealth?

A: Yes, CalAIM does not change these requirements.

DQ2: Does the county have a template for the care plan required in TCM notes?

A: No, DBH does not have a template. Per the CalMHSA documentation guide for clinical services (pgs. 17-18), targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. 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 person in care.

- Includes activities such as ensuring the active participation of the person in care, and working with the person (or the person'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 person in care; and
- Includes development of a transition plan when the person in care has achieved the goals of the care plan. These required elements shall be provided in a narrative format in the person's progress notes.

DQ3: Do we have to continue to complete the Treatment Plan 5 page assessment?

A: The treatment plan has been replaced by a Problem List and the DBH Quality Improvement (QI) team is establishing training and education for the Problem List. Until the County provides guidance and training, please continue to utilize the treatment plan. Please note that due to federal regulations a treatment plan will continue to be required for, Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), Therapeutic Foster Care (TFC), Therapeutic Behavioral Services (TBS), and Peer Support Services (PSS). Targeted Case Management can be provided once the Targeted Case Management Plan is written in narrative format in the note.

The current assessment covers the 7 domains required by CalAIM:

- **Domain 1**: Presenting Problem(s) • Current Mental Status • History of Presenting Problem(s) • Beneficiary-Identified Impairment(s)
- **Domain 2**: Trauma
- **Domain 3**: Behavioral Health History • Comorbidity
- **Domain 4**: Medical History • Current Medications • Comorbidity with Behavioral Health
- **Domain 5**: Social and Life Circumstances • Culture/Religion/Spirituality
- **Domain 6**: Strengths, Risk Behaviors, and Safety Factors Domain
- **Domain 7**: Clinical Summary and Recommendations • Diagnostic Impression • Medical Necessity Determination/Level of Care/Access Criteria

Please see detailed information on pages 10-16 of the Medical Documentation Guide CalMHSA-MHP-Medical-Documentation-Guide-06232022.pdf and 11-15 of the LPHA Documentation Guide CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf if you choose to revise the assessment.

DQ4: We have persons served that have expired treatment plans. We have been working on updating their treatment plans, however given the CalAIM guidelines, do we need to complete the process? And are services billable or NB since the treatment plan is technically expired?

A: Yes, please continue to update and use treatment plans until DBH QI issues guidance on the Problem List. According to the Annual Review Protocol for FY 21-22, an expired treatment plan is not listed as a reason for recoupment, so services are billable. When documenting the service provided the appropriate service code should be used for the service. The code does not change because of an expired plan. Please update the expired plan as soon as possible. **Note that for some services (ICC, IHBS, TBS, TFC, etc.) treatment plans are still required due to federal regulations.**

DQ5: Can we have a version of the paperwork or chart note the state is approving? Is there a new form for progress notes or are the progress note requirements less than they used to be? Do we have new guidelines for how to do this or is it just from the trainings that were given?

A: There is no new progress note form. Pages 25-27 of the LPHA Documentation Guide outline progress note requirements and examples are provided in **Appendix V** https://www.calmhsa.org/wp-content/uploads/CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf

DQ6: Because this will not take effect until 8/1/2022, will we need to go back to all new existing patients with new type of paperwork?

A: The County, CalMHSA, and DHCS support a rollout plan within a reasonable timeframe. If the plans are to implement changes on 8/1/2022, please start your new documentation on 8/1/2022. It is not necessary to go back and make any changes prior to that date.

DQ7: How do the ATD form, Discharge Plan and Summary and progress note fit in with streamlining the documentation?

A: DBH's ATD form is used to enroll a person into a service program and serves to track their course of treatment and while they are enrolled in a program. ATD accounts for who is currently in treatment with your program and who is not. It demonstrates the start and end of treatment. Discharge Plan and Summary are required parts of clinical practice and indicate the plan for transition out of a program and summary for the next provider as the case is closed These instruments are used in clinical care as part of treatment to assist with transitions, identifying and documenting levels of care, and help ensure that persons served are in the appropriate level of care, and tracking those transitions. CalAIM does affect the use of these required documents.

The required content of progress notes has been simplified:

1) A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors), and
2) Next steps including, but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate. Please watch the CalMHSA training video and the review the CalMHSA documentation guides.

DQ8: When and how is the Consent for Treatment completed?

A: This is an internal process issue not governed by CalAIM and should be completed in accordance with the program's procedures.

DQ9: Are barriers still required to be included in progress notes, such as Travel time more than 60 minutes, interpreters, telehealth barriers?

A: CalAIM does not make any changes to documentation of barriers. Per the CalMHSA documentation manuals, clinical documentation should reflect the content of the service provided including describing the intervention used, a narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors, and the plan for next steps (p. 25-26 of the LPHA Documentation Guide). CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf.

DQ10: Do all EPSDT covered minors still require a treatment plan? Do we need to create a treatment plan to authorize TBS for our minors?

A: Treatment plans are required by federal regulations for TBS, IHBS, ICC, TFC, & STRTPs. Additionally, a treatment plan in the form of a narrative in a progress note is required for TCM

(formerly known as CM) and Peer Support Services. These are the services that still require a treatment plan under CalAIM. As mentioned above, TBS does require a treatment plan. Per BHIN 22-019, the two authorities to reference are:

1. DMH IN 08-38
2. Department of Mental Health Therapeutic Behavioral Services Coordination of Care Best Practices Manual

DQ11: If our EHR allows it, can we have two providers with one note?

A: This question is under review with the Department's IT and Business Office teams. A response will be provided in subsequent edition of this Q & A document.

DQ12: Can a treatment plan be documented within a progress note?

A: Targeted Case management treatment plans are required to be documented in narrative format in a progress note. Please note the required components:

- 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 person in care.
- Included activities such as ensuring the active participation of the person in care and working with the person (or person'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 person in care; and
- Includes development of a transition plan when the person in care has achieved the goals of the care plan.

DQ13: Are all FCMHP providers still required to complete the CANS and PSC-35?

A: Yes, CalAIM does not make changes to this requirement. FCMHP providers are still required to complete:

- The CANS for all Medi-Cal persons served from ages 6 through 20, at assessment, every 6 months, and at discharge. To complete this functional assessment tool, providers are required to be certified every year.
- The PSC-35 for all Med-Cal persons served from ages 3 through 18, at assessment, every 6 months, and at discharge

DQ14: Can a case manager/MHRS complete a Discharge Summary and Plan without an LPHA co signature?

A: CalAIM does not change the requirements for completion of the Discharge Summary and Plan. If the Discharge Summary and Plan are currently co-signed by a LPHA, please continue that practice.

DQ15: For the two-year valid period for assessments, does that start from the date of the assessment or the date the assessment is completed/finalized in Avatar?

A: Due to CalAIM documentation changes effective July 1, 2022 (BHIN 22-019) there is no longer a required timeframe for a reassessment. A reassessment should be completed when clinically appropriate based on the clinical judgement of the treating provider.

DQ16: Will a Medicare only person served still require a Treatment Plan?

A: CalAIM does not make changes to requirements regarding treatment plan for persons with Medicare only.

DQ17: Are we still allowed to have paper charting?

A: Yes, paper charting is acceptable.

DQ18: Our program is paper base; can we create a word document based on the 7 domains for our clinical staff to use for the assessment or can the county provide a word document for my clinical team to use?

A: Fresno County is working on developing a sample version of the assessment and will roll out once the sample assessment has been vetted and processed by the Forms Committee. While waiting for the sample assessment, providers may choose to update their own assessment based on the criteria noted in BHIN 22-2019 and the CalMHSA documentation guides. A word document is acceptable. See the answer to **DQ3** above for links to detailed information.

DQ19: Is the start date of PL on 9/19/22 also the start date of clinical assessments no longer being updated every 2 years?

A: Effective 7/1/22, the time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice (BHIN 22-019 pg. 3; CalMHSA LPHA Documentation Guide pg. 38). There is no longer a requirement for an update every two years; rather, an updated assessment should be based on clinical judgement.

DQ20: Can we get a guideline of when we should be prompted to update the assessment or addendum?

A: See response above. There is no guideline or prompt to conduct a reassessment. An updated assessment should be based on clinical judgement (e.g., change in person served diagnosis, condition, impairments, major life changes, etc.)

DQ21: Can we get an example of a progress note that has sufficient description of the problem or symptoms since we're no longer using Tx plan goals in the narrative?

A: Appendix V of the CalMHSA LPHA Documentation Guide has examples of various types of notes, including a progress note. CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf

DQ22: Will a TCM treatment plan need to be part of every case management progress note?

A: No. Once a TCM plan has been developed in narrative in a progress note, the plan does not have to be included in every case management progress note.

DQ23: For Full-Service Partnership (FSP) programs, are treatment plans no longer required?

A: Correct; however, all other requirements are still in place, including the Individual Service and Support Plan.

DQ24: For mental health outpatient services, will we be completing both the Treatment Plan and PL because we are providing case management services?

A: You will complete the PL and a plan for case management services shall be completed in a narrative in the progress note. A treatment plan is no longer completed.

DQ25: How often will the treatment plans be required to be updated for persons served with Medicare/Medi Medi or other qualifying services?

A: CalAIM does not make changes to requirements regarding treatment plan for persons with Medicare.

DQ26: Do I need an updated treatment plan for medication? I started problem lists and got flagged on the medication side that the treatment plan was expired. Can you clarify if the updated treatment plan is needed so I can fix this?

A: If the medical record of the person served contains a current problem list, no treatment plan/POC/care plan is needed to support medication support services. Please ensure that the medical record continues to contain an accurate medication consent.

DQ27: What is required for our prescribers to provide services? The same for our nonprescribers? I've seen that they must complete their psychiatric evaluation also.

A: Prescribers still have to complete their own psychiatric evaluation to determine if medication is needed.

DQ28: Does CalAIM change anything for nursing staff who support the psychiatrists?

A: There are no noted changes for nursing. There are however guidelines and practice expectations in the CalAIM nursing/medical manuals. California Mental Health Services Authority | CalAIM (calmhsa.org)

DQ29: Do we need to develop a new progress note for each case management service provided?

A: Yes. Each Targeted Case Management (formerly Case Management) service requires its own progress note. The initial TCM note would contain the TCM Plan and does not need to be repeated on each subsequent TCM note.

DQ30: Is a Treatment Plan required if the PS has Other Health Coverage (OHC) only, or in addition to Medi-Cal? If a Treatment Plan is required, then either a Core Assessment or Psychiatric Evaluation is required beforehand, correct?

A: The California Advancing and Innovating Medi-Cal (CalAIM) documentation standards are specific to Medi-Cal. The requirements for any other health coverage have not changed. If a treatment plan is required, an assessment must be completed prior to development of the treatment plan as treatment plans are based on information gathered in the assessment.

DQ31: Should the PS diagnoses be the same in all of the episodes with current services?

A: That depends. Within a treatment team, it is expected that the mental health team consult with one another regarding the identification of symptoms, impairments and diagnoses. If the person served is receiving SMHS from multiple MHP providers utilizing separate medical record systems, care coordination should be clearly documented especially if there are conflicting diagnostic determinations.

DQ32: I have a 2-part question on the group therapy progress note related to CalAIM. Based on the information from the CalAIM documentation guide, would this mean that if I run a group with clinician Jane Doe and we decide I write the note for this week, would the progress note have to detail what each clinician did? My second part of the question is from what is stated in the CalAIM documentation guide regarding the specific amount of time of involvement of each

practitioner in the group activity. For example, if I joined the group late, and I facilitated the group for 32 minutes and Jane facilitated for the full 55 minutes, how do I reflect that on the progress note?

A: We are allowed to create one group note per CalAIM; however, the way our billing structure is set up we are not able to separate and claim the billing for each group practitioner. The solution is to have each practitioner create separate group notes for each PS in the group and document their own specific interventions and outcomes. If a provider was not there for the entire group, then that would be reflected on the service time of that specific provider's note.

DQ33: With the new process of CMHS gathering and billing assessment activities, is the process of asking and obtaining verbal responses from the parent/guardian for the purpose of completing the PSC-35 a billable activity under assessment?

A: The PSC-35 is a State-mandated functional assessment tool that must be completed for every youth. If the information gathered by the CMHS in the process of completing the PSC-35 collaboratively with the parent is subsequently used to inform the written assessment (meaning the information gathered is integrated into the content of the MH assessment document), then it would be an activity billable under assessment. If the information gathered to complete the State-mandated PSC-35 is not integrated into the assessment, and only completed for the sake of meeting the State mandate, then the time taken to complete the outcome measurement tool should not be claimed. Also important to note – the PSC-35 is a simple survey tool that is supposed to be completed by the parent and should not take too long to complete even in a collaborative setting.

DQ34: Per the BHIN 22-065, we understand that contracted providers of the MHP are not required to use the screening tools if an individual seeking services contacts them directly. Our question is whether clinical programs operated by the county, rather than contracted with the county, are considered a "provider" of services and therefore exempt from completing the screening tools? Or, because these programs are operated by the county, are the individuals seeking services at a county operated program considered to be contacting the MHP and thus required to use the screening tools?

A: The Screening Tools are not required for use with persons served who contact mental health providers directly to seek mental health services. This definition of provider is inclusive of county-operated clinics. Mental health providers who are contacted directly by persons served seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in All Plan Letter (APL) 22-005 and BHIN 22-011.

While the Screening Tools are not intended for use at the provider/clinic level, you are permitted (not required) to practice alternative uses of the tools in county-operated clinics if you wish. You are correct that the county is not permitted to require contracted providers to use the screening tool, but they are also permitted to opt-in to alternative usage as well.

DQ35: Would the Needs and Services plan fall under case plan and management?

A: No. The Needs and Services Plan required by California Department of Social Services/Community Care Licensing is not a clinical document and does not contain the elements equivalent to a care plan. The STRTP staff member is not able to claim case management for working on the Needs and Services Plan.