

**PLEASE CLICK THE SURVEY MONKEY LINK IN THE
CHAT TO TAKE A QUICK
THREE-QUESTION SURVEY**



INITIATING TREATMENT: NO WRONG DOOR & TREATMENT PRIOR TO DIAGNOSIS

California Mental Health Services Authority (CaIMHSA)

MAY 18, 2022

INTRODUCTIONS

Amie Miller, PsyD
Director – CalMHSA

Dawn Kaiser, LCSW, CPHQ
Director of Managed Care Operations – CalMHSA

Lucero Robles, MSW, LCSW
Director of Quality Assurance & Compliance – CalMHSA

Courtney A. Vallejo, LMFT
Utilization Manager – CalMHSA

TRAINING OBJECTIVES

Participants will walk away with:

- A deeper understanding of Access Criteria vs. Medical Necessity
- Additional clarity regarding treatment being reimbursable prior to the determination of a diagnosis as well as who can use which codes
- An understanding of the main concepts of No Wrong Door and Co-Occurring Treatment and what this looks like operationally

WE ARE HERE



Transformation Webinars: For County Leadership & QI Staff

Welcome to CalAIM: Then vs. Now	04/27/22
Shifting our Focus: Compliance vs. Quality	05/04/22
Communication Plans: Change Messaging	05/11/22
Initiating Treatment: No Wrong Door/Treatment Prior to Diagnosis	05/18/22
Standardizing Documentation: Universal Assessment	05/25/22
Identifying Treatment Focus: Problem List	06/01/22
Documenting Care: Progress Notes	06/08/22
No Money, No Mission: Billable vs. Non-Billable Services	06/15/22
Outcomes That Matter: Quality Measurement	06/22/22
You've Got This: CalAIM – A Summary	06/29/22

WHAT'S NOW, WHAT'S NEXT

Changes Already Here

- New Specialty Mental Health Services (SMHS) Access Criteria for adults and youth became effective January 1, 2022

Looking Ahead

- For SMHS: Trauma Screening Tool, scoring, and thresholds for youth access criteria will be provided by DHCS
- For SMHS: Universal Screening Tools and Universal Transition Tools are under development, anticipated to “go live” in January 2023

ACCESS CRITERIA VS. MEDICAL NECESSITY

(Applies to MHPs, DMC &
DMC-ODS)



WHAT HAS CHANGED

ACCESS CRITERIA/TREATMENT PRIOR TO DIAGNOSIS:

- A diagnosis is no longer a prerequisite for accessing needed SMHS or DMC/DMC-ODS services (in other words, services rendered in good faith are reimbursable prior to the determination of an official diagnosis)
- No more “included” diagnosis list as part of determining if an individual should receive SMHS or DMC/DMC-ODS services

MEDICAL NECESSITY CRITERIA

- Criteria to access SMHS has been separated from medical necessity (we no longer refer to it as “medical necessity criteria”)

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***

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

ADULTS AGE 21+ SMHS ACCESS CRITERIA

Criteria 1 and 2

Criteria 1

One or both of the following:

- i. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; and/or
- ii. A reasonable probability of significant deterioration in an important area of life functioning.

and

Criteria 2

The condition in Criteria 1 is due to either (a) or (b)

- a) A diagnosed mental health disorder; *or*
- b) A *suspected* mental health disorder that has not yet been diagnosed.

YOUTH UNDER AGE 21 SMHS ACCESS CRITERIA

Criteria 1 or 2

Criteria 1

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

OR

Criteria 2

Both (a) and (b) must be present:

(a) At least one:

- i. A significant impairment;
- ii. A reasonable probability of significant deterioration in an important area of life functioning;
- iii. A reasonable probability of not progressing developmentally as appropriate; or
- iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a MCP is required to provide.

(b) The condition in (a) is due to:

- i. A diagnosed mental health disorder;
- ii. A suspected mental health disorder that has not yet been diagnosed; or
- iii. Significant trauma placing them at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

YOUTH UNDER AGE 21 – ACCESS TO SMHS CRITERIA NOW INCLUDES THE FOLLOWING



**INVOLVEMENT
IN CHILD
WELFARE**

HOMELESSNESS

**JUVENILE
JUSTICE
INVOLVEMENT**

MEDICAL NECESSITY VS. CRITERIA TO ACCESS SMHS RECAP

We are used to the concept of "Medical Necessity Criteria" but now the criteria to access SMHS and medical necessity are separate

Medical Necessity: refers to the service and is separate from the criteria that need to be met to receive services

Criteria to access SMHS: refers to the criteria that must be met by the individual seeking services and is not the same as medical necessity

MEDICAL NECESSITY DEFINED – DMC/DMC-ODS

Adults Age 21+

A service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain

*Welfare & Institutions Code
section 14059.5*

Youth Under Age 21

A service is “medically necessary” or a “medical necessity” if the service is necessary to correct or ameliorate screened health conditions. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

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

ADULTS AGE 21+ DMC/DMC-ODS ACCESS CRITERIA

To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older must meet one of the following criteria:

Criteria 1

Have at least one diagnosis from DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders

or

Criteria 2

Have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history

YOUTH UNDER AGE 21 DMC/DMC-ODS ACCESS CRITERIA

Criteria

Beneficiaries under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code.

SCREENING & TRANSITION TOOLS UPDATE (MHP ONLY)

An Important Component of No Wrong Door: COMING JANUARY 2023

- **Universal Screening Tools:** Will provide guidance to MHPs and MCPs regarding the most appropriate system of care for an individual seeking mental health services
- **Universal Transition Tools:** Will support more effective and coordinated transitions between systems of care

ADULT SCREENING TOOL - INITIAL FINDINGS

Initial adult screening tool findings:

Of the individuals screened using the screening tool,

- 44.6% were placed in a mild level of care,
- 28.7% were placed in a moderate level of care,
- 26.7% were placed in a severe level of care

94.8% of users believed that the screening tool placed the beneficiary in the right level of care.

TREATMENT PRIOR TO ESTABLISHING A DIAGNOSIS

(Applies to MHPs, DMC &
DMC-ODS)



AN OPPORTUNITY TO IMPROVE CARE AND OUTCOMES



TREATMENT PRIOR TO ESTABLISHING A DIAGNOSIS - THEN VS. NOW

Then	Now	Benefit
Many services were not reimbursable prior to diagnosis	Services are reimbursable prior to an official diagnosis	Providers can be reimbursed for all time spent conducting assessments
Providers not reimbursed for extensive time spent conducting assessments	Flexibility regarding timeline for determining diagnosis	Clients will receive more accurate diagnoses
Confusing rules about what services can be provided prior to diagnosis	Not rushed into diagnosing before getting to know a client and their needs	Less confusion for providers regarding what is allowable prior to the determination of an official diagnosis
	Can utilize Z codes when appropriate	

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)

**May be used during the assessment period prior to diagnosis; do not require supervision of a Licensed Practitioner of the Healing Arts (LPHA)*

ICD-10 Codes for LPHAs

- Any clinically appropriate code
- 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”

TREATMENT PRIOR TO ESTABLISHING A DIAGNOSIS MYTHS

WHAT YOU'VE HEARD:

"Treatment prior to diagnosis does not apply to DMC or DMC-ODS programs"

REAL DEAL

Treatment prior to diagnosis DOES apply to DMC and DMC-ODS programs but only for outpatient services. Keep in mind however, that DMC/DMC-ODS programs have specific timeliness guidelines. Specifically:

Covered and clinically appropriate DMC-ODS services (except for residential) are reimbursable for up to 30 days following the first visit with an LPHA or registered/certified counselor, whether or not a diagnosis is established, or up to 60 days if the individual is under age 21 or it is documented that the client is experiencing homelessness and requires additional time to complete the assessment

TREATMENT PRIOR TO ESTABLISHING A DIAGNOSIS MYTHS

WHAT YOU'VE HEARD:

"A diagnosis now has to be listed on every progress note"

REAL DEAL

A diagnosis needs to be listed on each claim—not each progress note. Keep in mind that prior to the determination of a diagnosis, the following diagnoses can be utilized: Z codes, ICD 10 or various "unspecified" diagnoses

This applies to SMHS as well as DMC/DMC-ODS services

TREATMENT PRIOR TO ESTABLISHING A DIAGNOSIS MYTHS (CONTINUED)

WHAT YOU'VE HEARD:

"If you ultimately determine that the individual you are serving does not have a diagnosis, you must disallow all of the assessment services you provided"

REAL DEAL

All services rendered in good faith, prior to the determination of an official diagnosis, are reimbursable and should be claimed

NO WRONG DOOR

(Applies to MHPs; Co-Occurring Treatment applies to MHPs & DMC/DMC-ODS)



NO WRONG DOOR – TREATING THE PRESSING NEEDS OF THE WHOLE PERSON



NO WRONG DOOR – SCOPE OF COMPETENCE AND PROGRAM CAPABILITIES MATTER



NO WRONG DOOR – KEY PRINCIPLES

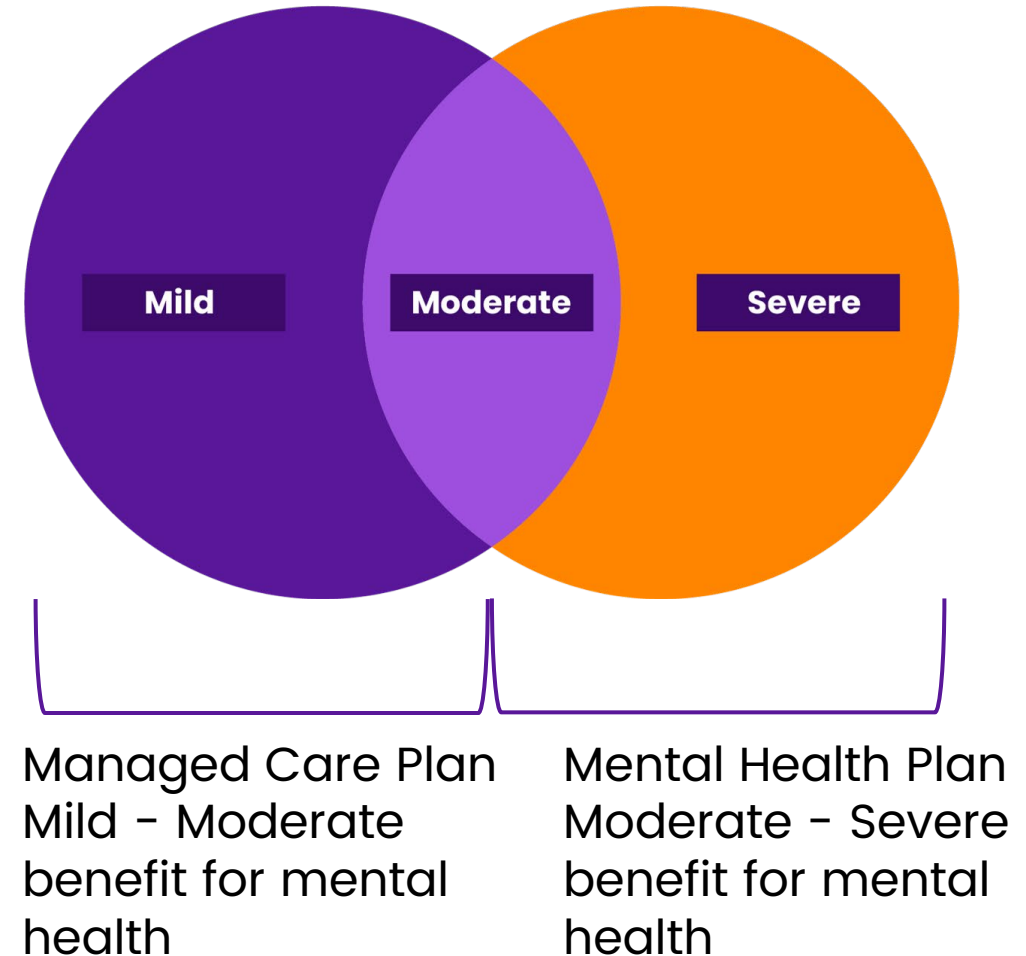
More Flexibility Based on Individual Needs and Preferences

- 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

The right care, in the right place, at the right time

WHAT HAS NOT CHANGED REGARDING NO WRONG DOOR

- Mental Health Plans (MHP) are still responsible for providing specialty mental health services for individuals with the highest needs
- Managed Care Plans (MCP) will continue to treat conditions due solely to a medical condition and adults with mild to moderate distress or impairment resulting from mental health disorders



PRE-NO WRONG DOOR VS. NOW

Then	Now	Benefit
Lack of clarity about the moderate benefit led to counties not claiming for services provided	<p>A “no wrong door” policy ensures clients receive treatment regardless of the delivery system where they seek care</p> <p>Ensures provider reimbursement even if the client is ultimately transferred to another system of care</p>	<p>Increased flexibility for providers</p> <p>Individuals can maintain relationships with trusted providers without interruption</p>

NO WRONG DOOR MYTH BUSTING

WHAT YOU'VE HEARD:

"A client must be served by any program to which they present"

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

NO WRONG DOOR MYTH BUSTING (CONTINUED)

The following scenarios are not examples of "No Wrong Door":

- An adult beneficiary walks into a children's department of an MHP and requests services=In this case you would refer them to the appropriate access point for someone seeking services
- A child without substance abuse needs is brought in by their parent to a DMC-ODS or DMC program=In this case you would refer to the appropriate access point for someone seeking services
- A client requests services for the first time and comes through door of a county contract provider in the community=The contract provider should follow their county's contractual terms regarding how clients initially access services

NO WRONG DOOR MYTH BUSTING (CONTINUED)

WHAT YOU'VE HEARD:

"If an individual calls the access line and wants to be seen, we have to treat them even if we do not think they will meet criteria to access SMHS because now there is no wrong door"

REAL DEAL

No Wrong Door does not mean an MHP has to serve every individual who reaches out for services

Until the screening and transition tools go live, MHPs will continue to follow current screening procedures to determine if an individual will be served by the MHP or if they should be referred to the MCP

BUT HOW DOES IT ALL FIT TOGETHER?

NO WRONG DOOR - A VISUAL



SCREENING: MHP conducts screening (eventually the Screening Tool) This occurs BEFORE a client "comes through the door"). If the screening suggests the client receive an MHP assessment, they will move on to be assessed by the MHP. If not, a referral is made to the MCP



NO WRONG DOOR: MHP begins assessment and can bill for services rendered prior to determination of an official diagnosis



DETERMINATION: Individual referred for ongoing services with the MHP OR if it is determined that the client does not meet criteria to access SMHS, the MHP will support a coordinated transition/referral to the MCP

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

CO-OCCURRING TREATMENT

(Applies to MHPs &
DMC/DMC-ODS)



CO-OCCURRING TREATMENT: AN OPPORTUNITY TO ENGAGE THE WHOLE PERSON





WHY THIS MATTERS

CO-OCCURRING TREATMENT THEN VS. NOW

Then	Now	Benefit
<p>Concerns regarding potential disallowances if a co-occurring condition was as part of the client's treatment</p> <p>Potentially confusing client experience</p>	<p>Treatment in the presence of a co-occurring disorder reimbursable when medically necessary service is documented</p>	<p>Clients experience a more streamlined process for obtaining services</p> <p>Reduced risk of disallowance</p>



CO-OCCURRING TREATMENT MYTHS



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 and abilities. There is now greater flexibility to support an individual with both conditions



CO-OCCURRING TREATMENT MYTHS (CONTINUED)



WHAT YOU'VE HEARD:

"If we mention SUD treatment in our MH documentation, we are at risk of having the service disallowed" OR, "If we mention MH treatment in our SUD documentation, we are at risk of having the service disallowed"

REAL DEAL

SMHS are covered whether or not the beneficiary has a co-occurring SUD mentioned in the clinical documentation or is part of the beneficiary's treatment

SUD services are covered by DMC and DMC-ODS whether or not the beneficiary has a co-occurring MH condition

Co-occurring treatment provides greater flexibility to provider and allow the opportunity to treat the client in a more holistic manner

FEEDBACK? QUESTIONS?



CALAIM@CALMHSA.ORG



Thank You!

**PLEASE CLICK THE NEW SURVEY MONKEY LINK IN
THE CHAT TO COMPLETE OUR POST-TRAINING
EVALUATION.
THANK YOU!**