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2021-2022 CalAIM Behavioral Health Information Notices Frequently Asked Questions (FAQs)

August 17th, 2022

This CalAIM Behavioral Health FAQ document is intended to serve as a resource for county behavioral health agencies, providers, consumers, advocates, and stakeholders in the implementation of CalAIM behavioral health initiatives. For more information regarding CalAIM behavioral health initiatives, please visit the DHCS CalAIM behavioral health initiative website.

This CalAIM Behavioral Health FAQ document provides responses to frequently asked questions related to the following CalAIM Behavioral Health Information Notices (BHINs):

- BHIN 21-073: Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements
- BHIN 21-075: Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026
- BHIN 22-011: No Wrong Door for Mental Health Services Policy
- BHIN 22-013: Code selection during assessment period for outpatient behavioral health (BH) services
- BHIN 22-019: Documentation requirements for all SMHS, DMC, and DMC-ODS services

All published BHINs may be found here.

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SMHS ACCESS CRITERIA

1. **What is the difference between "medical necessity" and criteria for beneficiaries to access specialty mental health services (SMHS)?**

   Reference BHIN 21-073

   BHIN 21-073 separately addresses access criteria and "medical necessity" requirements. Beneficiaries must meet specific criteria to access SMHS through the county Mental Health Plan (MHP) delivery system, as identified in Welfare & Institutions Code (W&I) section 14184.402(c)-(d). Services provided to a beneficiary through the MHP delivery system must be "medically necessary" or be a "medical necessity," as set forth in W&I section 14059.5(a)-(b)(1).

   As context, CalAIM updated the definition of medical necessity for SMHS. Previously, in the former 1915(b) SMHS waiver that was authorized from 2015 through 2021, medical necessity for SMHS was defined in comprehensive detail, predicated on the establishment of specific diagnoses and expected outcomes of proposed interventions. This former 1915(b) waiver definition of medical necessity corresponded to California Code of Regulations (CCR), title 9, sections 1830.205 and 1830.210. Prior to CalAIM, beneficiaries were required to meet these diagnostic criteria, and SMHS services were required to meet the expected outcome criteria, in order for SMHS services to be covered and reimbursable. If, following assessment, these comprehensive medical necessity criteria were not documented as met for each service provided, the county MHPs were at risk of recoupment because the services would be determined to be an overpayment based on the beneficiary not meeting medical necessity requirements for SMHS.

   To streamline policies and improve access to care, CalAIM supersedes the definition of medical necessity for SMHS at CCR, title 9, sections 1830.205 and 1830.210 and in the former 1915(b) waiver. As a result of the CalAIM trailer bill AB 133, medical necessity for SMHS services is now defined at W&I Code section 14059.5.

   For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For beneficiaries under 21, medical necessity for SMHS services as defined as meeting the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, commonly referred to as the EPSDT mandate. As described in BHIN 21-073, *"This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health*

condition are thus medically necessary and covered as EPSDT services." DHCS has consistently included this description of the EPSDT mandate in all pertinent guidance it has issued under CalAIM with the goal of providing clear, plain-English information about medical necessity for beneficiaries under 21.

2. **Is a mental health diagnosis required for access to covered SMHS?**

   Reference BHIN 21-073

   No. Per W&I section 14184.402, subdivision (f)(1)(a), a mental health diagnosis is not a prerequisite to accessing covered SMHS.

3. **How long can SMHS be provided prior to a beneficiary receiving a mental health diagnosis?**

   Reference BHIN 22-019

   DHCS has not set an exact time limit for an assessment period for SMHS. However, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

4. **Which trauma screening tools have been approved by DHCS?**

   Reference BHIN 21-073

   DHCS has not approved any specific trauma screening tool for purposes of implementing SMHS access criteria. The Pediatric ACES and Related Life-Events Screener (PEARLS) tool is an example of a standard way of measuring trauma for children and adolescents through age 19. The ACE Questionnaire is one example of a standard way of measuring trauma for adults beginning at age 18. DHCS will explore the approval process and standards for trauma screening tools for beneficiaries under 21 years of age through continued stakeholder engagement. DHCS will issue additional guidance in the future regarding approved trauma screening tool(s) for purposes of determining access to SMHS.

5. **What is the difference between a beneficiary under the age of 21 (1) having a condition placing them at high risk for a mental health disorder due to experience of trauma; and (2) scoring in the high-risk range under a trauma screening tool?**

   Reference BHIN 21-073

   Covered SMHS shall be provided to enrolled beneficiaries under the age of 21 who meet one of two access criteria.

   The first criteria requires the beneficiary to have a condition that places them at high risk of a mental health disorder due to experiencing trauma. Scoring in the high-risk range under a trauma screening tool approved by DHCS is one way of evidencing that this criteria is met.

Other evidence includes involvement in the child welfare system, juvenile justice involvement, and experiencing homelessness. (Please see BHIN 21-073 for additional information, including definitions.)

Beneficiaries under the age of 21 who have experienced trauma who do not meet the first criteria to access SMHS may meet the second SMHS access criteria. The second criteria clarifies that beneficiaries with significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional, meet SMHS access criteria if they also have one of the following: a significant impairment; a reasonable probability of significant deterioration in an important area of life functioning; a reasonable probability of not progressing developmentally as appropriate; or a need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

Beneficiaries under the age of 21 only need to meet one of the two criteria described above and outlined in BHIN 21-073. They do not need to meet both criteria.

6. **Regarding access criteria b(iii) identified in BHIN 21-073 for beneficiaries under age 21, does a licensed mental health professional include a waivered or registered professional?**

   Reference BHIN 21-073

   No. Waivered or registered professionals are not licensed. Waivered or registered professionals may only provide services under the supervision of a Licensed Mental Health Professional (LMHP) in accordance with applicable laws and regulations governing the registration or waiver. (Cal. Code Regs., tit. 9, § 1840.314 (e)(1)(F); see California State Plan, Att. 3.1-A, Supp. 3, pp. 2, 2b; Att. 3.1-B, Supp. 2, pp. 2, 4.) Assessment services may only be provided by waivered or registered professionals within their scope of practice. If the assessment of the beneficiary is conducted by a waivered or registered professional within their scope of practice, an LMHP must evaluate that assessment with the waivered or registered professional and make the determination that the beneficiary has significant trauma placing them at risk of a future mental health condition.

7. **Do the new access criteria for beneficiaries under 21 add to or replace the criteria for admission to an STRTP?**

   Reference BHIN 21-073

   No. The SMHS access criteria identified in BHIN 21-073 do not replace the admission criteria for STRTPs. Please see W&I section 11462.01, subdivision (b) and Section 9 of the Interim STRTP Regulations, Version II for further information regarding admission criteria for STRTPs.

8. **Can the requirement to offer naloxone at a Narcotic Treatment Program (NTP) / Opioid Treatment Program (OTP) be met by offering a form of buprenorphine (Suboxone®) that contains both buprenorphine and naloxone?**

   Reference BHIN 21-075

   No. While NTPs/OTPs may offer formulations of buprenorphine that contain naloxone, this is not a replacement for naloxone. Naloxone (by itself) is used to reverse an opioid-involved overdose. The inclusion of naloxone in the combination buprenorphine/naloxone product is intended to prevent diversion and misuse of the buprenorphine medication; it is not intended to reverse an opioid-involved overdose.

9. **How can DMC-ODS providers leverage Medi-Cal for prescribing and dispensing naloxone to patients?**

   Reference BHIN 21-075

   DMC-ODS providers have flexibility to provide or arrange for naloxone to be provided for all DMC-ODS beneficiaries. For example, DMC-ODS providers can simply prescribe naloxone to all DMC-ODS beneficiaries who are receiving care at their program. The DMC-ODS beneficiaries would be able to fill the prescription at a pharmacy. DMC-ODS providers can also refer patients to community pharmacists who can furnish naloxone directly to the patient.

   In addition, DMC-ODS providers are able to dispense naloxone onsite to DMC-ODS beneficiaries by leveraging the Medi-Cal pharmacy benefit. As a best practice overdose prevention measure, DMC-ODS providers can prescribe naloxone to all DMC-ODS beneficiaries who are receiving treatment, and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of DMC-ODS beneficiaries. The community pharmacy would bill these naloxone prescriptions to the Medi-Cal pharmacy benefit. The staff could bring the dispensed naloxone back to the DMC-ODS provider site for furnishing directly to patients. This method would enable the DMC-ODS provider to better facilitate onsite access to naloxone reimbursed through the Medi-Cal pharmacy benefit.

10. **Can Medications for Addiction Treatment (MAT) be provided in settings other than NTPs?**

    Reference BHIN 21-075

Yes. While NTPs are the only providers that can provide methadone, all DMC-ODS providers are able to deliver other forms of MAT for opioid use disorder, such as buprenorphine and naltrexone, as well as MAT for alcohol use disorder.[1]

In the DMC-ODS program, MAT is covered, reimbursable, and can be provided in most DMC-ODS levels of care, including outpatient treatment, intensive outpatient treatment, partial hospitalization, residential treatment,[2] inpatient treatment, and withdrawal management. In addition, MAT is covered, reimbursable, and can be provided by DMC-ODS providers as a standalone service outside of these levels of care – for example, beneficiaries do not have to participate in a formal intensive outpatient treatment program in order to receive MAT from a DMC-ODS provider. DMC-ODS providers can also deliver MAT in non-clinical settings, such as mobile clinics and street medicine teams.

As described in BHIN 21-075, DMC-ODS counties shall ensure that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT services for beneficiaries with Substance Use Disorder (SUD) diagnoses that are treatable with medications or biological products. (Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient.)

In addition, MAT may be offered and is also available to Medi-Cal beneficiaries in various settings outside of the DMC-ODS program, including:

- **Primary care settings**. MAT can be provided in doctor's offices, community clinics, federally qualified health centers, and other primary care settings.
- **Emergency departments (EDs) and hospitals**. EDs can be a stabilization point for beneficiaries. Any provider in a hospital or emergency department may administer buprenorphine for up to three days in order to relieve acute withdrawal symptoms and facilitate patient referral to treatment. Over 150 EDs in California offer MAT, including through onsite MAT induction in the ED and short-term prescriptions to bridge the beneficiary until their first follow-up visit in the community with an MAT provider. Please visit the California Bridge Program website to find EDs that offer MAT throughout California.

In addition, the California MAT Expansion Project aims to increase access to MAT, reduce unmet treatment needs, and reduce opioid overdose related deaths through more than 30 programs focused on prevention, treatment, and recovery activities. The project has a special focus on populations with limited MAT access, including youth, rural areas, and American Indian & Alaska Native Tribal communities. For a list of providers and facilities offering MAT in your area, visit: http://choosemat.org/.

[1] A waiver from SAMHSA is required to prescribe buprenorphine.
[2] Licensed residential treatment programs that are authorized to provide incidental medical services (IMS) may also offer MAT using IMS.

11. How are collateral services covered under DMC-ODS?

Reference BHIN 21-075

"Collateral services" is no longer defined as a unique service component of the DMC-ODS service modalities. In accordance with SPA 21-0058 and as described in BHIN 21-075, the concept of including a collateral in a beneficiary's substance use disorder treatment has been incorporated into assessment services, individual counseling, and family therapy.

Assessment services may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary.

Additionally, individual counseling services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

Finally, family therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

SPA 21-0058 and BHIN 21-075 detail which DMC-ODS service modalities include assessment services, individual counseling services, and family therapy as billable service components.

12. What certification requirements must be met in order for a DMC-ODS county to offer Partial Hospitalization services through the DMC-ODS Program?

Reference BHIN 21-075

There is no DMC certification category specific to partial hospitalization. In order to provide partial hospitalization services through DMC-ODS, counties, or contracted network providers in counties, must be certified as DMC Intensive Outpatient Treatment providers, must be able to offer 20 or more hours of clinically intensive programming per week, and must demonstrate the ability to facilitate access to the psychiatric, medical, and laboratory services, as needed.

13. What are the plan documentation requirements relating to grievances?

As specified in the Intergovernmental Agreement, each DMC-ODS county shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality

strategy.

The record of each grievance or appeal shall contain, at a minimum, all of the following information:

- A general description of the reason for the appeal or grievance.
- The date received.
- The date of each review or, if applicable, review meeting.
- Resolution at each level of the appeal or grievance, if applicable.
- Date of resolution at each level, if applicable.
- Name of the covered person for whom the appeal or grievance was filed.

Each record shall be accurately maintained in a manner accessible to the Department and available upon request to CMS.

The written record of grievances and appeals shall be submitted at least quarterly to the plan's quality improvement committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified

14. What are the requirements for appeals?

The beneficiary or a provider and/or authorized representative, may file an appeal in-person, orally, or in writing. If they request expedited resolution, the beneficiary or representative must follow an in-person or oral filing with a written, signed appeal. The appeal must not count against the beneficiary or authorized representative in any way. Individuals deciding on the appeals resolution must be qualified to do so and not involved in any previous level of review or decision-making.

Beneficiaries and/or their authorized representative must:

- Have the right to examine their case files, including their medical record and any other documents or records considered during the appeal process, before and during the appeal process.
- Have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Be allowed to have a legal representative and/or legal representative of a deceased member's estate included as parties to the appeal.
- Be informed that their appeal is being reviewed using written confirmation.
- Be informed of their right to request a State Hearing, following the completion of the appeal process.

15. What are the requirements and timeframes for State Hearings?

Beneficiaries may request a State Hearing only after receiving notice that the plan is upholding an adverse benefit determination.

Beneficiaries have 120 days to request a State Hearing, beginning from the date that the plan gave the decision to the beneficiary in person, or the day after an appeal decision is postmarked. If the beneficiary did not receive a Notice of Adverse Benefit Determination (NOABD), they may file for a State Hearing at any time.

The California Department of Social Services will conduct an independent review within 90 days of receiving the request. Beneficiaries may request an expedited State Hearing. If a request qualifies for an expedited State Hearing, the decision will be issued within three working days from the date that the request is received by the State Hearings Division.

16. Can counties update the NOABDs? If not, will DHCS be issuing a NOABD that is specific to SUD services?

NOABD template language cannot be amended or modified. All templates must be used with the approved language and approved font. The section of each NOABD pertaining to the availability of large font, braille or electronic formats must not smaller than 20-point font; the rest of the NOABD should be in 12-point font.

The #4 Delivery System NOABD does not apply to SUD services. All of the other NOABDs apply to SUD services and should be used accordingly.

17. Should network providers send NOABDs when discharging clients for noncompliance? Do providers issue NOABD letters or only plans?

A NOABD must be sent to the beneficiary when discharging for non-compliance. The plan is ultimately responsible for ensuring that the NOABD letters appropriately reach the beneficiary. However, if they choose to make it a requirement of their providers, the plan must have a mechanism in place to be notified of their occurrences to ensure compliance.

18. What happens if a beneficiary never shows up for treatment after admission or never returns to treatment?

The plan is responsible for issuing a NOABD to the beneficiary, specifically a termination notice for non-compliance.

19. If a beneficiary's course of treatment is modified by the provider (e.g., change in level, frequency or type of service) must a Modification of Requested Service NOABD be issued to the beneficiary?

DMC-ODS treatment services are not required to be authorized by the Plan. If the provider determines a change in level of care or frequency of services is appropriate, they do not need to receive authorization from the Plan. Because the provider is modifying the services, and not the Plan, a modification notice is not required.[3] In this case, however, a

[3] Additional changes to documentation and treatment planning requirements are forthcoming and will be effective July 1, 2022.

beneficiary can appeal the provider decision to modify services, even without receiving a NOABD.

20. If a plan has an integrated behavioral health department (i.e., mental health and SUD treatment services are overseen by a single director), can it combine certain requirements of the DMC-ODS QI Plan with the MHP QI Plan?

Yes, for counties that have an integrated behavioral health department, the DMC-ODS QI Plan may be combined with MHP QI Plan?

21. What grievance and appeal information must be in the QI Plan?

The QI Plan must include information on how beneficiary complaints data will be collected, categorized, and assessed for monitoring. At a minimum, the QI Plan must include information on:

- How to submit a grievance, appeal, and request for a state hearing;
- The time frame for resolution of appeals;
- The content of an appeal resolution;
- Record keeping;
- Continuation of benefits; and
- Requirements of state hearings

22. If a plan has an integrated behavioral health department, can it use the same QI Committee required by the MHP contract to fulfill the DMC-ODS QI Committee requirements?

Yes, for counties with an integrated behavioral health department, the plan may use the same committee, with SUD participation.

23. Are student interns or trainees considered licensed practitioners of the healing arts (LPHAs), or considered license-eligible?

No. As described in SPA 21-0058, LPHAs include Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, and licensed-eligible practitioner working under the supervision of a licensed clinician. To be considered "license-eligible," the individual must be registered with the appropriate state licensing authority for their respective field. Interns who have not yet received their advanced degree within their specific field and/or have not registered with the appropriate state board are not considered LPHAs.

24. What does it mean to be a "registered" counselor?

According to 9 CCR 13005(a)(8), "registrant" means an individual registered to obtain certification as an Alcohol and/or Other Drug (AOD) counselor with the California

Association for Alcohol and Drug Educators, California Association of DUI Treatment Programs or California Consortium for Addiction Programs and Professionals.

25. Can a non-perinatal provider serve a pregnant beneficiary? What is the process to claim for these services?

Yes, a pregnant beneficiary can choose to receive services from a non-perinatal provider. If the beneficiary receives eligibility through a pregnancy aid code, the claim must include the PAT 9 pregnancy indicator to be valid. Please refer to the Perinatal Practice Guidelines for providers working with pregnant and parenting women seeking or referred to SUD treatment.

26. What is the methodology for billing group counseling services?

DMC-ODS group services should use the following methodology:

> *(Number of minutes for the group + travel / Number of beneficiaries in the group) = Total minutes per beneficiary + documentation time.*

Travel time can be included for the counselor's travel from facility to the community location where a group may be offered, and back to facility.

Documentation time captures the time it takes for the counselor to write a progress note for the group counseling session

27. Can you submit a claim for residential treatment if the beneficiary received no residential covered services on the date of service for the claim?

Reference BHIN 21-075

No. In order to claim for residential treatment, beneficiaries must receive at least one residential covered service (i.e. required structured activity) on the date of service for the claim. BHIN 21-075 outlines the services covered under Residential Treatment.

28. Are revenues other than 2011 realignment funds eligible for federal match?

Yes. Other local funds are eligible to be used as the non-federal match as long as they are non-federal public funds and are otherwise eligible to be used as match consistent with the requirements outlined in SSA §1903(w)(6) and 42 CFR §433.51.

29. Can care coordination for residential clients be claimed as an unbundled service on top of the residential per diem rate, assuming the residential per diem rate does not account for care coordination activities?

Reference BHIN 21-075

Yes. Care Coordination and Recovery Services can be claimed as standalone services on

top of the residential per diem rate.

NO WRONG DOOR

BEHAVIORAL HEALTH DOCUMENTATION REQUIREMENTS

30. **How do Medi-Cal providers reconcile the requirements of BHIN 22-019 with the AOD Program Certification Standards that pertain to treatment plans?**

    Reference BHIN 22-019

    The Department of Health Care Services is in the process of updating the AOD Program Certification Standards that pertain to treatment plans. Until the AOD Program Certification Standards have been updated, Medi-Cal providers may use a problem list, as defined in BHIN 22-019, in lieu of a treatment plan for beneficiaries.

31. **How do Medi-Cal providers that operate adult alcoholism or drug abuse recovery or treatment facilities comply with the requirements of BHIN 22-019?**

    Reference BHIN 22-019

    Medi-Cal providers may use a problem list, as defined in BHIN 22-019, in lieu of a treatment plan for beneficiaries.

32. **How may providers document the beneficiary's involvement in the treatment process?**

    Reference BHIN 22-019

    DHCS encourages strength-based, person-centered treatment. Under the documentation requirements outlined in BHIN 22-019, the beneficiary's perspective and involvement in treatment may be noted in the progress notes.

33. **Can DHCS provide examples of the seven required SMHS assessment domains?**

    Reference BHIN 22-019

    Descriptions for each of the seven required SMHS domains are included in Attachment 1 below. The descriptions included in Attachment 1 provide helpful guidance for addressing each respective domain and are not a prescriptive or required list of elements.

    DHCS highly encourages implementing a standard domain-based assessment that is implemented uniformly across county-operated and contracted providers.

34. **Can DHCS clarify the DMC-ODS treatment plan requirements?**

Reference BHIN 22-019

As part of Documentation Reform, DMC-ODS services no longer require treatment plans with the exception of the continued requirements in Attachment 1 of BHIN 22-019. Attachment 1 includes the federal requirements for Narcotic Treatment Program treatment plans and Peer Support Services plans of care.

35. Is DMC-ODS care coordination the same as Targeted Case Management?

Reference BHIN 21-075 & BHIN 22-019

No. The DMC-ODS Care Coordination service (formerly known as "case management") is not the same as Targeted Case Management and does not require a care plan. Targeted Case Management is a distinct SMHS.

36. Can Targeted Case Management services be provided prior to an assessment and completion of a Targeted Case Management Care Plan?

Reference BHIN 22-019

Clinically appropriate and covered services, including Targeted Care Management, can be provided prior to the Targeted Case Management Care Plan being developed.

37. Do progress notes need to include the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) descriptor in addition to the ICD-10 code?

Reference BHIN 22-019

No. While progress notes do not need to include a DSM-5 descriptor, it may be a best practice to include the additional descriptor.

38. If a provider reviews a beneficiary's chart, in preparation for a session with a beneficiary, and the beneficiary no-shows, is the time for chart review claimable?

Reference BHIN 22-019

The time spent reviewing a chart can only be included in the service claim when a covered service has been rendered, whether the chart review happens before or after the service.

For example, if a provider reviews a beneficiary's chart in preparation for a session with a beneficiary, and the beneficiary does not show up for their appointment that week, the provider may claim that time spent reviewing the beneficiary's chart during the next week's appointment in which they are able to provide a service to the beneficiary.

CODING DURING ASSESSMENT

1. **What ICD-10 codes should a provider use to claim for services provided to a beneficiary that has not yet received a diagnosis?**

   Reference BHIN 22-013

   MHPs, DMC and DMC-ODS programs and providers are required to use appropriate ICD-10 diagnosis codes to submit claims to receive reimbursement of Federal Financial Participation. BHIN 22-013 identifies ICD-10 codes that may be used during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

ATTACHMENT 1: SMHS ASSESSMENT DOMAIN DESCRIPTIONS

Each of the 7 domains identified in the first column are required components of the SMHS assessment, which shall be documented in the SMHS assessment and kept in the beneficiary's medical record. The assessment shall be completed within a reasonable time and in accordance with generally accepted standards of practice.

Descriptions for each domain are set forth in the second column. The descriptions included in the second column provide guidance for addressing each respective domain and are not a prescriptive or required list of elements.

For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths assessment tool may be used to help inform the assessment domains requirements.

Domain	Description
Domain 1 requirements: • **Presenting Problem(s)** • **Current Mental Status** • **History of Presenting Problem(s)** • **Beneficiary-Identified Impairment(s)**	Chief complaint: • Beneficiary-identified problem(s), history of the presenting problem(s), impact of problem(s) on beneficiary. • Beneficiary's mental state at the time of the assessment. • Impairment identified by the beneficiary including distress, disability, or dysfunction in an important area of life function.
Domain 2 requirements: • **Trauma**	History of trauma or exposure to trauma: • Any psychological, emotional response to an event that is deeply distressing or disturbing. • A measure of trauma by a trauma screening tool approved by the DHCS (e.g., Adverse Childhood Experiences screening tools), indicating elevated risk for development of a mental health condition. • Experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.
Domain 3 requirements: • **Behavioral Health History** • **Comorbidity**	Mental Health History: • Acute and chronic conditions. • Previous community-based treatment, including providers, therapeutic modality (e.g., medications, therapy, rehabilitative interventions, etc.) and response to interventions. • Inpatient admissions. • Crisis-based admissions.

Domain	Description
Domain 3 requirements: • **Behavioral Health History** • **Comorbidity**	Substance Use History: • Exposure/substance use, including past and present use. • Previous community-based treatment, including providers, therapeutic modality (e.g., medication-assisted treatment, rehabilitative interventions, etc.) and response to interventions. • Inpatient psychiatric admissions. • Intoxication/detox/withdrawal management-based admissions.
Domain 4 requirements: • **Medical History** • **Current Medications** • **Comorbidity with Behavioral Health**	Medical History: • Relevant current or past physical health conditions. • Prenatal and perinatal events, and relevant or significant developmental history. • History of medications, medical treatments, and responses. • Allergies to medications.
Domain 5 requirements: • **Social and Life Circumstances** • **Culture/Religion/Spirituality**	Psychosocial factors: • Living situation, daily activities, social support, and cultural and linguistic factors. • Legal or justice-involved history. • Family history and current family involvement. • Military history. • Tribal affiliation. • LGBTQ. • BIPOC.
Domain 6 requirements: • **Strengths, Risk Behaviors, and Safety Factors**	Strengths, risk behaviors and safety factors: • Strengths in achieving goals, including personal motivation, drive, and interest. • Resilience and coping skills. • Protective factors, including the availability of resources, opportunities, and supports (including support persons), interpersonal relationships, systems (family/community/ professional), activities (routines/ social hobbies/ etc.). • Situations and triggers that may induce risky behaviors. • Suicidal/homicidal ideation. • Safety planning, including an individualized plan that can be self-initiated or initiated by a trusted person (e.g. sponsor).

Domain	Description
Domain 7 requirements: • **Clinical Summary and Recommendations** • **Diagnostic Impression** • **Medical Necessity Determination** • **Level of Care/Access Criteria**	Clinical impression, including etiology, clinical complexity, and impairments: • Predisposing, precipitating, perpetuating and protective factors. • Diagnosis/ICD-code consistent with presenting problems, history, mental status exam and/or other clinical data, including any current medical diagnosis. Capture diagnostic uncertainty (provisional or unspecified). • Service recommendations for the treatment episode. • Level of care determination for DMC and DMC-ODS (i.e., ASAM) and/or for SMHS (Access Criteria for SMHS found in BHIN 21-073).