CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Frequently Asked Questions (FAQ)

FAQ Revised on 10/10/2022 - See revised language in red p.3

Overview of Topics Included in this FAQ

A. Understanding Timelines

B. Clarifying Expectations for Progress Notes / Daily Notes

C. Overwhelm Related to Documentation and No Wrong Door

D. Other Questions
(Case Management (CM) vs Targeted Case Management (TCM), Residential/CR programs, Problem List, Access vs Medical Necessity, and Scope of Practice)

A. Understanding Timelines

1. **Question:** Can you please clarify the timeline for CalAIM and expectations. Specifically, what went into effect July 1 and what, if anything, will have a future deadline?

   Answer: Documentation redesign and No Wrong Door policy went live on 7/1/22. For all utilization review (UR) paperwork due 7/1/22 and after, a problem list and targeted case management note (if applicable) should be submitted initially and annually along with all other required UR paperwork. Visit the website for more information: https://cchealth.org/bhs/calaim.

2. **Question:** Can staff wait to complete the new forms for existing clients until they would normally need to be done annually?

   Answer: Use of the new assessment forms is not required until your current assessment on file is no longer valid. Problem lists should begin within a reasonable time frame. Targeted case Management (TCM) plan notes are, like the assessment, only required when the current partnership plan on file is no longer valid.

3. **Question:** What are the consequences for late documentation?

   Answer: Timely documentation continues to be expected. Patterns of late documentation may result in implementation of a corrective action plan.

B. Clarifying Expectations for Progress Notes / Daily Notes

4. **Question:** When documenting a Daily Note, if the Licensed Practitioner of the Healing Arts (LPHA) has nothing to contribute, is it necessary to include the LPHA portion of the note & indicate "n/a"? For the sake of saving paper is it OK to just leave the LPHA attachment off entirely?

   Answer: Specifically, for the SUD System of Care, it is not necessary for an LPHA to write anything in the Residential and Intensive Outpatient daily progress note if there is nothing to add.

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The LPHA can leave the section blank on the Progress Note form in this case.

5. **Question:** If Community Based Organizations (CBOs) make changes to our Progress Notes for CalAim, do we need to send in our new progress note template for approval?

   Answer: Forms created during this transitional period do not require approval by the County Forms Committee; however, CBO's would be asked to make alterations if it is discovered that any form lacks essential information per the BHIN 22-019.

6. **Question:** On the new progress note template, in the TCM Care Plan, if the clinician and client identified a goal, i.e., apply for food stamps or obtain housing, how long does that content stay on subsequent notes if it is an issue that requires extra steps or takes time? Does it repeat from note to note or do we add it only on the first note where it was identified?

   Answer: Like the traditional partnership plan, the TCM plan note is required at the end of each track; updates are required annually or when a significant event has taken place that would warrant an additional goal. The TCM plan note is only required on one note and need not be carried over to every case management note thereafter.

C. Overwhelm Related to Documentation and No Wrong Door

7. **Question**: With No Wrong Door, can you please clarify the process of referring out to services if we don't have the bandwidth or appropriate practitioners to provide those services? And what do we do if the agency/organization we'd refer to doesn't have availability?

   Answer: No Wrong Door is meant to afford programs an adequate opportunity to assess beneficiaries who are likely to, but do not necessarily, qualify for specialty mental health services. No Wrong Door does not mandate a program provide services for individuals who ultimately do not meet medical necessity.

8. **Question:** How will the County support providers that are overwhelmed by these changes and feel like they cannot keep up with them and their workloads?

   Answer: CalAIM changes are meant to lighten paperwork demands, relax stringent expectations, and diminish associated financial pressure. The County looks to provide ongoing training and communication to facilitate the transition.

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D. Other Questions

9. **Question**: Can you please clarify the different requirements for Case Management (CM) vs Targeted Case Management (TCM)?

   Answer: The State does not distinguish CM and TCM within Specialty Mental Health.

10. **Question:** What is expected from Residential and Crisis Residential programs?

    Answer: Treatment plans are still required at the Mental Health residential and Mental Health crisis residential programs. Treatment Plans are not required at SUD Residential programs.

11. **Question:** On the Problem List should the Diagnosis and ICD10 code be the first thing listed?

    Answer: No, there isn't a particular order for listing problems on the Problem List for a client. Any issue can be listed in any order, however, it is necessary to include the ICD10 code and the Diagnosis as soon as it is determined.

12. **Question:** What is the difference between Access criteria and medical necessity?

    Answer (For MHP Only):

    a. Access criteria is broadened but still limited to the assessment period.
    b. CalMHSA suggests that the length of the MHP assessment period is at the discretion of the individual provider; however, CCBHS has established and maintains that the MHP assessment period ends at 60 days, but may extended up to an additional 3 months according to circumstances.
    c. ~~Z codes may be used indefinitely but must accompany a primary F code ICD 10 diagnosis at the end of the assessment period.~~ For beneficiaries under age 21, CMS approved ICD 10 codes (which include Z codes) for use when there is a suspected mental health disorder not yet diagnosed, or due to trauma. In these cases, the assessment can be completed using Z codes and a full authorization will be provided. Providers should continue to assess the beneficiary and update the assessment and diagnosis as needed.
       For adults, a Z code can be utilized while a clinician takes time to gather information about the individual's presenting needs and determine the most appropriate diagnosis and next steps. However, the Z code should not be utilized indefinitely.

    d. There is no longer a State determined "included" diagnosis list.

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13. Question: Can you clarify the limitations on billing with regard to scope of practice?

Answer:

a. DMHW may not bill for assessment, though they may contribute to the form.
b. DMHW may bill for evaluation (code 313) when collecting information to be used on the assessment form.
c. DMHW may bill crisis (371) but requires LMHP must co-sign.
d. CCC scope of practice remains as it was prior to CalAIM.