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No Wrong Door for Mental Health Services Policy

Approval Date	06/23/2022	DocuSigned by: Dr. Georgina Yoshioka, Interim Director 7DF8077EFA674B3...
Effective Date	07/01/2022	Georgina Yoshioka, DSW, MBA, LCSW, Interim Director

Purpose

The purpose of this Behavioral Health Information Notice (BHIN) is to provide County Mental Health Plans (MHPs), Drug Medi-Cal (DMC) counties, and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties with guidance and clarification regarding the No Wrong Door for Mental Health Services Policy. This policy ensures that Medi-Cal beneficiaries receive timely mental health services without delay regardless of the delivery system where they seek care, and that beneficiaries are able to maintain treatment relationships with trusted providers without interruption. Corresponding guidance to Medi-Cal Managed Care Health Plans (MCPs) is contained in All Plan Letter (APL) 22-005.

Background

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to address Medi-Cal beneficiaries' needs across the continuum of care, ensure that all beneficiaries receive coordinated services, and improve beneficiary health outcomes (see note #1). DHCS' goal is to ensure that beneficiaries have access to the right care in the right place at the right time.

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to the criteria to access Specialty Mental Health Services (SMHS), implementation of standardized statewide screening and transition tools, payment reform, and other changes summarized in the CalAIM proposal and BHINs.

Per forthcoming DHCS guidance, Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (NSMHS), and the Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services, MCPs are required to provide or arrange for the provision of the following NSMHS (see note #2):

- Mental health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs (note #3:), supplies and supplements

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Background, continued

MCPs must provide or arrange for the provision of the NSMHS listed above for the following populations:

- Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (see note #4);
- Members who are under the age of 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis (see note #5); and,
- Members of any age with potential mental health disorders not yet diagnosed

In accordance with Welfare and Institutions (W&I) Code sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.). The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that are Medicaid coverable (as described in 42 U.S.C. Section 1396d(a)) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance from the Centers for Medicare & Medicaid Services (CMS), behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition (see note #6). Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition, are thus medically necessary, and are thus covered as EPSDT services.

MCPs must also cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR). This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services includes facility and professional services and facility charges claimed by emergency departments. MCPs must provide covered substance use disorder (SUD) services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for

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No Wrong Door for Mental Health Services Policy, Continued

Background, continued

Children and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21- 014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Further, MCPs must provide or arrange for the provision of:

- Medications for Addiction Treatment (MAT, also known as medication-assisted treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings; and
- Emergency services necessary to stabilize the member (see note #7)

The NSMHS and SUD services described above are covered services via the Fee-For Service (FFS) delivery system for Medi-Cal beneficiaries who are not enrolled in an MCP. MHPs are required to provide or arrange for the provision of medically necessary SMHS for beneficiaries in their counties who meet access criteria for SMHS as described in BHIN 21-073.

Notes:
#1: Please visit the CalAIM webpage for further information: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

#2: APLs are searchable on the APL webpage: (https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx). Please visit the Medi-Cal provider manual: (https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.aspx) for, Non-Specialty Mental Health Services: Psychiatric and Psychological Services. See W&I Code section 14184.402(b)(1): (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14184.402). State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml

#3: This does not include medications covered under the Medi-Cal Rx Contract Drug List located at: https://medi-calrx.dhcs.ca.gov/home/cdl/

#4: Presence of a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not “mental health disorders” for the purpose of determining whether a beneficiary meets criteria to receive NSMHS. However, MCPs must provide or arrange for NSMHS for beneficiaries with any of these or other co-occurring physical health or substance use disorders if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.

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Background, continued

#5: See Section 1396d(r)(5) of Title 42 of the U.S.C.: https://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim (requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)): https://www.ssa.gov/OP_Home/ssact/title19/1905.htm and that are necessary to correct or ameliorate a condition, including a behavioral health condition, discovered by a screening service, whether or not such services are covered under the State Plan), U.S.C. is searchable at: https://uscode.house.gov/

#6: CMS federal EPSDT guidance: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf

#7: Including voluntary inpatient detoxification as a benefit available to MCP members through the Medi-Cal fee-for-service program, as described in APL 18-001 at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-001.pdf)

Policy

It is the policy of the county MHP to provide or arrange for clinically appropriate, covered SMHS to include prevention, screening, assessment, and treatment services. These services are covered and reimbursable even when (see note #8):

1. Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met;
2. The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
3. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

Note: (#8) W&I Code section 14184.402(f): Section 14184.402 - Medically necessary determinations for covered specialty mental health services and substance use disorder services; non-specialty mental health services coverage, Cal. Welf. and Inst. Code § 14184.402 | Casetext Search + Citator

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No Wrong Door for Mental Health Services Policy, Continued

Procedure: SMHS Provided During the Assessment Period Prior to Determination of a Diagnosis or Prior to Determination of Whether SMHS Access Criteria Are Met

Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS (see note #9). Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS. MHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the beneficiary does not meet criteria for SMHS or meets the criteria for NSMHS.

Likewise, MCPs must not disallow reimbursement for NSMHS services provided during the assessment process if the assessment determines that the beneficiary does **not** meet criteria for NSMHS or meets the criteria for SMHS.

MHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established (see note #10):

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

- In cases where services are provided due for a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS-approved ICD-10 diagnosis code list (see note #11), which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code (see note #12). For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

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No Wrong Door for Mental Health Services Policy, Continued

Procedure: SMHS Provided During the Assessment Period Prior to Determination of a Diagnosis or Prior to Determination of Whether SMHS Access Criteria Are Met, continued

Notes:

#9: For more information regarding coverage and reimbursement policies for DMC and DMC-ODS services during the assessment process, please refer to:

- BHIN 21-071: (https://www.dhcs.ca.gov/Documents/BHIN21-071-Medical-Necessity-Determination-Level-of-Care-Determination-Requirements.pdf), and
- BHIN21-075: (https://www.dhcs.ca.gov/Documents/BHIN-21-075-DMC-ODS-Requirements-for-the-Period-2022-2026.pdf), respectively.

#10: https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf

#11: The ICD 10 Tabular: (https://www.cms.gov/medicare/icd-10/2022-icd-10-cm)

#12: The Short-Doyle Medi-Cal Claim System accepts all valid CMS approved ICD-10-CM codes for outpatient services; refer to ICD 10 Tabular.

Procedure: Co-occurring Substance Use Disorder

Clinically appropriate and covered SMHS delivered by MHP providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring SUD. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary who meets SMHS criteria on the basis of the beneficiary having a cooccurring SUD, when all other Medi-Cal and service requirements are met. Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the beneficiary has a co-occurring mental health condition. Likewise, clinically appropriate and covered NSMHS are covered Medi-Cal services via the FFS and MCP delivery systems whether or not the beneficiary has a cooccurring SUD. Similarly, clinically appropriate and covered SUD services delivered by MCP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) are covered by MCPs whether or not the member has a co-occurring mental health condition.

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No Wrong Door for Mental Health Services Policy, Continued

Procedure: Concurrent NSMHS and SMHS

Beneficiaries may concurrently receive NSMHS via a FFS or MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a beneficiary meets criteria for both NSMHS and SMHS, the beneficiary should receive services based on individual clinical need and established therapeutic relationships (see note #13). MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary on the basis of the beneficiary also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a beneficiary on the basis of the beneficiary also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure beneficiary choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for beneficiaries receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. Such decisions should be made via a beneficiary-centered shared decision-making process (see note #14).

- Beneficiaries with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from an MHP provider (billed to the MHP), as long as the services are coordinated between these delivery systems and are non-duplicative (e.g., a beneficiary may only receive psychiatry services in one network, not both networks; a beneficiary may only access individual therapy in one network, not both networks).

- Beneficiaries with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if they simultaneously receive NSMHS from a FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are nonduplicative.

DHCS is developing a set of statewide tools (effective in 2023 pursuant to future guidance) to facilitate screenings and care transitions for the SMHS, NSMHS and FFS systems.

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Procedure: Concurrent NSMHS and SMHS, continued

Notes:

#13: Nothing in this BHIN supersedes the criteria for beneficiary access to SMHS described in BHIN 21-073: (https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf)

#14: This BHIN does not supersede beneficiaries' rights to request continuity of care consistent with federal regulations and state code, as described in MHSUDS 18-059: (https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-059_Continuity_of_Care/MHSUDS_Information_Notice_18-059_Continuity_of_Care.pdf).

- Please note the components of MHSUDS 18-059 that describe SMHS medical necessity criteria have been superseded by BHIN 21-073: (https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf).

Definition(s)

Drug Medi-Cal (DMC): Drug Medi-Cal is a treatment funding source for eligible Medi-Cal members. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal members must receive substance use disorder (SUD) services at a Drug Medi-Cal certified program. SUD services funded by Drug Medi-Cal are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6). Title 9 and Title 22, CCR govern DMC treatment.

Drug Medi-Cal Organized Delivery System (DMC-ODS): The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021 to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and Specialty Mental Health Services (SMHS).

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Definition(s), continued

Fee-For-Service (FFS) Medi-Cal Delivery System: Under FFS, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal beneficiaries. FFS providers render services and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.

Managed Care Plan (MCP): MCPs are responsible for the Medi-Cal physical healthcare benefit. They are also responsible for a portion of the mental health benefit and must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services to children under the age of 21. MCPs refer to and coordinate with county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

Mental Health Plan (MHP): MHP means an entity that enters into a contract with DHCS to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly, or another governmental or non-governmental entity.

Non-Specialty Mental Health Services (NSMHS): NSMHS are delivered via MCP and FFS delivery systems and are provided to recipients 21 years and over with mild-to-moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders. NSMHS may be provided to recipients under age 21, to the extent otherwise eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and recipients of any age with potential mental health disorders not yet diagnosed.

Specialty Mental Health Services (SMHS): Specialty mental health services include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, Medication Support Services, Targeted Case Management, Crisis Intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). All the MHPs are part of county mental health or behavioral health departments and the MHP can provide services through its own employees or through contract providers.

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Forms /Attachments	None
Revision History	N/A (First Version)
Acknowledgement	This policy and procedure is courtesy of California Mental Health Services Authority (CalMHSA).
Related Policy or Procedure	DBH Standard Practice Manual and Departmental Forms: • Service Delivery Definition Policy (QM6036) • Timely Access Policy (QM6041) • Service Availability Policy (QM6046) • Criteria for Beneficiary Access to Specialty Mental Health Services (SMHS), Medical Necessity and Other Coverage Requirements (QM6054)
Reference(s)	CMS federal EPSDT guidance: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf Department of Health Care Services (DHCS), Behavioral Health Information Notice (BHIN) No.: 22-011; BHIN 21-071; BHIN 21-073; BHIN 21- 075; All Plan Letter (APL) 22-005 ICD 10 Tabular: https://www.cms.gov/medicare/icd-10/2022-icd-10-cm Title 22 of the California Code of Regulations (CCR) Section 53855 Welfare and Institutions Code section 14184.402(b)(1), 14059.5 and 14184.402: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14184.402)