# Monterey County Behavioral Health Quality Improvement CalAIM Implementation Memo: 005

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| Re: | Documentation Reform: CalAIM Assessment and Diagnosis Clarification for Specialty Mental Health Services |
| Form Reference | Behavioral Health Information Notice No.: 22-019: Documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services<br>Additional reference:<br>Behavioral Health Information Notice No.: 22-013: Coverage Requirements Code selection during assessment period for outpatient behavioral health (BH) services |
| Effective | 7/22/2022 |

**Topic**

In the spirit of California Advancing and Innovating Medi-Cal (CalAIM), Monterey County Behavioral Health (MCBH) has moved forward with implementing the new documentation requirements for Specialty Mental Health Services (SMHS). These new documentation requirements were established by the Department of Health Care Services (DHCS).

The purpose of this memo is to clarify the assessment and diagnosis requirements for specialty mental health services.

**Procedure**

1. **Effective 7/22/2022**.
2. The new **CalAIM Assessment** shall be used starting 7/22/2022.
    a. The Universal Psychosocial Assessment form is no longer available.
    b. The 138 Professional Psychosocial report will continue to be available for the Universal Psychosocial Assessment and the CalAIM Assessment.
3. Completing the CalAIM Assessment:
    a. The time period for clinicians to complete an initial assessment and updated 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. **An initial assessment must be completed 365 days from the original date of coordination and shall be completed annually there after to correspond with the anniversary month.**
    b. Additionally, the initial and/or annual assessment must be completed prior to transferring to another system of care (i.e. ASOC, CSOC).
    c. Furthermore, assessments must be completed prior to referring persons in care to systems that require authorization (i.e. adult residential, crisis residential, STRTPs, IHBS, etc.) to establish medical necessity for SMHS.
4. Completing the Diagnosis:
    a. All persons in care receiving clinically appropriate and covered mental health services are eligible to receive reimbursement.
    b. **An appropriate ICD-10 diagnosis code is required at intake and annually thereafter** and all behavioral health staff and contracted provider shall submit the

Diagnosis form in the Electronic Health Record ensure claims are reimbursed timely and accordingly.

c. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether Non-SMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the person does not meet criteria for SMHS.
d. Behavioral health staff and contracted provider may use the following options during the assessment phase:
    i. ICD-10 codes Z55-Z65, “Persons with potential health hazards related to socioeconomic and psychosocial circumstances” may be used by all providers as appropriate.
    ii. ICD-10 code Z03.89, “Encounter for observation for other suspected diseases and conditions ruled out,” may be used by an LPHA or LMHP.
    iii. In cases where services are provided due to 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, which may include Z codes. For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.”