SECTION 5, CHAPTER 7, POLICY 009

MEDICAL NECESSITY AND ACCESS CRITERIA FOR OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES (SMHS)

POLICY NUMBER:	5-7-009
SYSTEM OF CARE:	Mental Health
FINALIZED DATE:	3-30-2022
EFFECTIVE:	January 1, 2022
SUPERSEDES # :	Supersedes Policy #'s: PP 500 Medical Necessity Criteria *Partially* Supersedes Policy #: 5-7-008 Medical Necessity – Policy 5-7-009 (NOTE: only supersedes portions of policy 5-7-008 that pertain to outpatient services).

A. PURPOSE: To define medical necessity and the criteria for access to outpatient Specialty Mental Health Services (SMHS) covered by the Yolo County Mental Health Plan (MHP). These requirements are set forth by the Department of Health Care Services' (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) initiative outlined in Behavioral Health Information Notice (BHIN) 21-073.

B. RELATED DOCUMENTS: N/A

C. DEFINITIONS:

1. **Mental Health Plan (MHP)**: Yolo County HHSA Behavioral Health (BH) and Network Providers of SMHS.

2. **Network Providers:** Any provider, group of providers, or entity that has a network provider agreement with Yolo County HHSA BH and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract (Title 42 Code of Federal Regulations [42 CFR] § 438.2).

3. **Specialty Mental Health Service (SMHS):** Specialty mental health service includes but is 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 in California through County MHPs. The MHP can provide services through its own employees or through contract providers.

4. **Involvement in Child Welfare**: The beneficiary has an open child welfare services case, or the beneficiary is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system.
    a. A child has an open child welfare or prevention services case if:
        i. The child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or
        ii. The child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement.
    b. A child can be involved in child welfare, whether the child remains in the home or is placed out of the home. Involvement in child welfare also includes a child whose adoption occurred through the child welfare system.

5. **Homelessness:** The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act. Specifically:
    a. This includes individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and
    b. This includes children and youths who:
        i. Are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;
        ii. Have a primary nighttime residence that is a public or private place not designed for, or ordinarily used as a, regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));
        iii. Are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

iv. Migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

6. **Juvenile Justice Involvement:** The beneficiary has ever been detained or committed to a juvenile justice facility or is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. This includes:
    a. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps.
    b. Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency.

D. POLICY:

Medical Necessity

1. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition (42 C.F.R. §§ 456.5 and 440.230 (b)).

2. For beneficiaries 21 years of age and 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 as set forth in Welfare and Institutions Code section 14059.5.

3. For beneficiaries 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. For behavioral health, this section requires provision of all Medicaid-coverable SMHS necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services (CMS) 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, and are thus medically necessary and covered as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

E. PROCEDURE:

Criteria for Beneficiaries to Access the SMHS Delivery System

1. For beneficiaries 21 years of age or older, the MHP shall provide covered SMHS for beneficiaries who meet both (a) and (b) criteria below:
    a. The beneficiary has 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.
        ii. A reasonable probability of significant deterioration in an important area of life functioning

    AND

    b. The beneficiary's condition as described in subparagraph (a) above is due to either of the following:
        i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
            a. Note: 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 for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS.
        ii. A suspected mental disorder that has not yet been diagnosed.

2. For beneficiaries under age 21, the MHP shall provide covered SMHS for beneficiaries who meet either criteria (a) or (b) below:
    a. The beneficiary has 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

    b. The beneficiary meets both of the following requirements in (i) and (ii) below:
        i. At least one of the following:
            a. A significant impartment
            b. A reasonable probability of significant deterioration in an important area of life functioning

c. A reasonable probability of not progressing developmentally as appropriate
d. 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

ii. The beneficiary's condition as described in subparagraph (i) above is due to one of the following:
a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
b. A suspected mental health disorder that has not yet been diagnosed
c. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional (Welf. & Inst. Code, § 14184.402(d)).

Additional Coverage Requirements and Clarifications

1. The criteria above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:
   a. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
   b. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
   c. The beneficiary has a co-occurring substance use disorder.

2. Per Welfare and Institutions Code section 14184.402(f)(1)(A), a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS-approved ICD diagnosis code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma, a CMS-approved ICD diagnosis code list shall be utilized.
   a. While DHCS does not specify a time limit on the use of Z codes for SMHS, diagnosing providers shall utilize their clinical judgement and clinical best practices to update the beneficiary's diagnosis in the medical record to accurately reflect the beneficiary's need as soon as clinically appropriate.

3. The respective responsibilities of MHPs, Medi-Cal Managed Care Plans (MCPs), and the Medi-Cal Fee for Service (FFS) delivery systems has not changed. For additional information on access criteria for and types of *non*-specialty mental

health services delivered by MCPs and FFS providers, please refer to DHCS BHIN 21-073.

4. Services for symptoms or conditions solely due to a medical condition (e.g., traumatic brain injury) remain the responsibility of the MCP or the FFS delivery system. However, SMHS are reimbursable for beneficiaries with medical diagnoses if they also have mental health conditions and meet criteria for SMHS as described above. Coordination of care between the MHP and the MCP may be necessary to address beneficiaries' needs.

F. REFERENCES:

1. DHCS BHIN 21-073: Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements
2. Welfare and Institutions Code (WIC) § 14184.402
3. WIC § 14059.5
4. 42 C.F.R § 1396d(r)(5)
5. 42 C.F.R § 456.5
6. 42 C.F.R § 440.230 (b)

Approved by:

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Karleen Jakowski, Interim Mental Health Director **Date**
Yolo County Health and Human Services Agency