Behavioral Health Documentation Requirements for DMC, DMC-ODS, & SMHS - FAQs

Assessments

Can the American Society of Addiction Medicine (ASAM) Criteria® be used to assess youth and adolescents? Is there an approved ASAM assessment tool for youth and adolescents? - April 17, 2024

Reference ASAM 4th Edition Development and BHIN 23-068

No. As of April 2024, the American Society of Addiction Medicine (ASAM) has not developed an assessment tool for youth and adolescents, but an Adolescent and Transitional Age Youth version of the ASAM Criteria® is anticipated in the future. The Department of Health Care Services (DHCS) will review any forthcoming editions of the ASAM Criteria® and will make necessary updates to state guidance as new developments occur. At this time, counties and providers may continue to use their locally developed assessment tools for adolescents and youth when the new requirements for standardized ASAM Criteria® assessments for adults outlined in BHIN 23-068 go into effect as of January 1, 2025.

Will the Department of Health Care Services (DHCS) approve additional American Society of Addiction Medicine (ASAM) assessment tools?

Reference BHIN 23-068

At this time, DHCS has not approved any additional American Society of Addiction Medicine (ASAM) assessment tools other than the ASAM Criteria Assessment Interview Guide and the ASAM CONTINUUM software. DHCS may choose to evaluate and potentially approve additional tools in the future; if DHCS does so, this decision will be communicated to stakeholders. However, the Department does not anticipate establishing a process to routinely approve new tools submitted by stakeholders, as this would not support the goals of CalAIM.

DHCS' decision to require the use of the above tools aligns with the CalAIM goals to standardize, simplify, and streamline access to Medi-Cal services. The use of tools that have been validated by ASAM will help assure the quality of DMC/DMC-ODS services statewide by ensuring that all Medi-Cal members who receive DMC or DMC-ODS

services receive a comprehensive assessment that appropriately applies ASAM level of care criteria.

Will the American Society of Addiction Medicine (ASAM) Criteria updates be reflected in future Department of Health Care Services (DHCS) guidance?

Reference BHIN 23-068 and BHIN 21-001 Exhibit A

Yes. DHCS plans to update DMC and DMC-ODS policy guidance as needed to align with the most current American Society of Addiction Medicine (ASAM) version. The free ASAM assessment tool will also be updated to reflect the ASAM Criteria Fourth Edition standards. DHCS will provide updates on publication dates for ASAM Criteria Fourth Edition policy guidance as soon as possible.

BHIN 23-054 specifies that a Medications for Addictions Treatment (MAT) assessment must be provided within 24 hours of admission to a licensed and/or certified substance use disorder recovery or treatment facility. How does that guidance align with BHIN 23-068, which eliminates the previous 30/60 timeframe for completing ASAM Level of Care assessments?

Reference BHIN 23-068; BHIN 23-054

Section (a)(3)(ii) of BHIN 23-068 clarifies that "MAT assessments, as described in BHIN 23-054 or subsequent guidance, need not meet the comprehensive ASAM assessment requirements described in this BHIN." The MAT assessments described in BHIN 23-054 serve a specific clinical purpose that is distinct from the purpose of the comprehensive ASAM assessment. As such, the MAT assessment must occur rapidly whereas the comprehensive ASAM assessment may occur over a longer period of time.

The purpose of the MAT assessment is to promptly identify if MAT would be beneficial for the Medi-Cal member, so that MAT can be initiated in a timely manner. A comprehensive ASAM Level of Care assessment may utilize information gathered during the MAT assessment but will likely incorporate other information as well. The comprehensive ASAM assessment may be completed over a longer timeframe and must meet all DMC/DMC-ODS assessment requirements as described in BHIN 23-068.

Part 1

Page 4 of Behavioral Health Information Notice (BHIN) 23-068 discusses existing guidance on Department of Health Care Services (DHCS) Level of Care (LOC) designations that requires providers of residential treatment services to ensure members receive multidimensional level of care assessments. Are these requirements new? Are they duplicative of the comprehensive ASAM assessment requirements described in BHIN 23-068?

Reference BHIN 23-068 & BHIN 21-001

The Medi-Cal guidance set forth in BHIN 23-068 does not supersede the Level of Care (LOC) designation requirements for licensed facilities that were previously set forth in Exhibit A of BHIN 21-001. All licensed adult alcohol or other drug recovery or treatment facilities must receive a DHCS LOC Designation or ASAM Level of Care Certification. Services delivered in facilities that hold a DHCS LOC Designation must be provided and documented consistent with the guidelines for assessment and care planning outlined in BHIN 21-001. Providers of these services that choose to participate in Medi-Cal must follow both the guidance for licensed facilities in BHIN 21-001, and the Medi-Cal guidance in BHIN 23-068.

The initial multidimensional LOC assessment described in BHIN 21-001 need not meet all the requirements for a comprehensive ASAM assessment, as described in BHIN 23-068 (page 4). However, the information collected for the LOC assessment can also be used as part of the comprehensive ASAM assessment. The two BHINs should not be interpreted as requiring duplicative assessments (see below).

Part 2

Does this mean that two different assessments are required? Should residential providers instead be required to complete the comprehensive ASAM within 72 hours?

Reference BHIN 23-068 & BHIN 21-001

No. DHCS is not requiring substance use disorder (SUD) residential facilities to conduct two different assessments. DHCS requires that key pieces of information are collected upon entering treatment to ensure members are receiving services in the correct level of care (BHIN 21-001). Later, the provider may add to the information previously collected by completing the comprehensive ASAM assessment (BHIN 23-068).

BHIN 23-068 does not apply strict assessment timelines for behavioral health services. DHCS' policy asserts that the assessment can happen during multiple encounters and should be done in a timeframe that meets the individual needs of each Medi-Cal member. Medi-Cal behavioral health delivery systems shall not enforce standards for timely initial assessments, or subsequent assessments, in a manner that fails to permit adequate time to complete assessments when such time is necessary due to a member's individual clinical needs (p. 3, BHIN 23-068).

Are seven-domain assessments as specified in Behavioral Health Information Notice (BHIN) 23-068 required for Specialty Mental Health Services (SMHS) crisis intervention or crisis stabilization services? What about SMHS or Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS) mobile crisis services?

Reference BHIN 23-068, BHIN 23-025, & Supplement 3 To Attachment 3.1-A in the California State Plan

Although a Specialty Mental Health (SMH) crisis intervention or crisis stabilization service or SMH, DMC, or DMC-ODS mobile crisis service may include assessment, completion of a comprehensive assessment as described in BHIN 23-068 is not required during the course of an individual SMH crisis intervention or crisis stabilization or SMH, DMC, or DMC-ODS mobile crisis service encounter. If the member receives other SMHS, DMC, or DMC-ODS concurrently or at a later date, then the assessment requirements in BHIN 23-068 would apply.

For additional Medi-Cal Mobile Crisis Services assessment and documentation requirements, please refer to BHIN 23-025.

Do the changes to assessment timelines for Specialty Mental Health Services impact Child and Adolescent Needs and Strengths (CANS) assessment and Pediatric Symptom Checklist (PSC)-35 requirements? What about the Adult Needs and Strengths Assessment (ANSA) (for adults)?

Reference BHIN 23-068

No. The CANS and PSC-35 requirements have not changed. DHCS does not require completion of the ANSA for adults.

If a Mental Health Plan (MHP) has a current assessment template within their electronic health record that captures all seven (7)

Specialty Mental Health Services (SMHS) assessment domains, will the MHP be required to re-structure their assessment so it is categorized by the new domains?

Reference BHIN 23-068

Although the order of the seven domains is not specified, the assessment shall capture all of the required seven uniform assessment domains pursuant to BHIN 23-068.

Are the seven (7) domains for a Specialty Mental Health Services assessment required for psychiatric diagnostic evaluations?

Reference BHIN 23-068

Yes. The seven (7) standardized assessment domains are required for psychiatric diagnostic evaluations.

Should providers document a reason for taking more time than usual to complete an assessment?

Reference BHIN 23-068

It is good practice to document the member's circumstances and the provider's efforts to assess and engage the member, when applicable.

This question and answer has been transitioned to this FAQ from MHSUDS IN 17-040, which was superseded by BHIN 22-019. BHIN 23-068 has since superseded BHIN 22-019.

Care Plans

Can Electronic Health Record (EHR) templates be used for care plans?

Reference BHIN 23-068

The Department of Health Care Services (DHCS) does not regulate how providers or Medi-Cal Behavioral Health Delivery Systems organize their EHRs (or written records) so long as the documentation requirements outlined in BHIN 23-068 are met. A care plan template is an acceptable location for documentation of care planning, as long as all relevant state or federal care planning requirements are met.

Please review the Care Planning Requirements on page 11 of BHIN 23-068 and Enclosure 1a on pages 13 – 14 of BHIN 23-068 for detailed guidance on how care plan

activities must be documented for programs, services, or facilities for which care planning requirements remain in effect under state or federal law.

Do providers of substance use disorder services funded through the Substance Abuse and Mental Health Services' (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) need to complete standalone treatment plans?

Reference BHIN 23-068 & 45 CFR § 96.136

Behavioral Health Information Notice (BHIN) 23-068 describes updated problem list and progress notes requirements and eliminates certain historical requirements for Specialty Mental Health Services client plans and Drug Medi-Cal and Drug Medi-Cal Organized Delivery System treatment plans. DHCS is also in the process of updating the Department's Alcohol and/or Other Drug Program Certification Standards to align with Medi-Cal documentation guidance.

Consistent with these updates, a standalone treatment plan is no longer required for SUBG-funded services. SUBG performance contracts require SUBG-funded programs to observe federal regulations in 45 CFR § 96.136, but do not require treatment planning to be documented in a specified format, e.g., a standalone treatment plan template. As long as SUBG-funded programs observe the federal requirements in 45 CFR § 96.136, they may document consistent with Medi-Cal guidance in BHIN 23-068 or subsequent DHCS documentation guidance .

Problem Lists

Can problem lists be used in place of care plans?

Reference BHIN 23-068

No. Problem lists and care plans serve different purposes within a clinical record and are not interchangeable. For services, programs, and facilities that must observe care planning requirements under state or federal law (see Enclosure 1a on pages 13 – 14 of BHIN 23-068), the problem list does not replace care planning.

As described on pages 7 – 8 of BHIN 23-068, the problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters, and is developed by the provider.

Care plans, which are also called client plans, treatment plans, or service plans, are developed in collaboration with the provider and client to define treatment goals. Care

planning is an ongoing, interactive component of service delivery and is not a one-time event.

A problem list is required for every member receiving Medi-Cal behavioral health services as described in BHIN 23-068. Unlike the problem list, a care plan is only required for specific services, facility types, funding sources, and/or program types as noted in BHIN 23-068, Enclosure 1a.

At the discretion of the provider, elements of the care plan may be documented within the problem list, but a problem list cannot substitute for a care plan when it is required.

What is the difference between the problem list and a billing or primary diagnosis?

Reference BHIN 23-068, BHIN 21-071, BHIN 21-073 & BHIN 23-001

The problem list is a list that may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. It may be updated throughout the course of treatment by members of the care team. Maintaining a comprehensive list of health conditions and issues in one place in the clinical record can support continuity of care between providers.

An individual's primary Diagnostic and Statistical Manual of Mental Disorders (DSM) mental health or substance use disorder (SUD) diagnosis is typically included within the problem list. However, the problem list is a broader list that also includes additional conditions and risk factors. In addition to mental health or SUD diagnoses, the problem list may include other issues that are self-reported by the member or identified by other health care providers.

Medi-Cal claims must include clinically appropriate International Classification of Diseases, Tenth Revision (ICD-10) codes associated with each service encounter, regardless of whether the problem list has been updated to include a primary DSM diagnosis. Per Welfare and Institutions Code section 14184.402(f)(1)(A), a behavioral health diagnosis is not a prerequisite for access to covered Specialty Mental Health, Drug Medi-Cal, or Drug Medi-Cal Organized Delivery System services.

For more information on problem lists, please see:

- BHIN 23-068 (DHCS guidance)
- American Health Information Management Association, “Problem List Guidance in the EHR,"

Can a provider update the problem list to include diagnoses that are outside their scope of practice (e.g., the member reports a cancer diagnosis to a Licensed Marriage and Family Therapist)?

Reference BHIN 23-068

Yes. Providers may add items to problem lists that are outside their scope of practice, including, but not limited to, physical health conditions, if they are reported to the provider by the member or by another qualified professional. For example, a primary care physician may diagnose a chronic physical health condition and share that information with the mental health or substance use disorder (SUD) provider. The mental health or SUD provider may update the problem list to include the physical health diagnosis. The member record may include information on when, by whom, and to whom the issue was reported. The mental health or SUD care team that accesses the problem list throughout the member's treatment can then be aware of a diagnosis that may impact the member's life or engagement in mental health or SUD treatment.

Can providers add problems to the problem list that are not diagnoses?

Reference BHIN 23-068

Yes. Providers can add problems to the problem list that are not diagnoses. The problem list should reflect the member's current presentation and unique needs and should include an International Classification of Diseases, Tenth Revision (ICD-10) Clinical Modification (CM) code for each problem identified. BHIN 23-068, pages 7-8, list the requirements for Specialty Mental Health Services, Drug Medi-Cal, and Drug Medi-Cal Organized Delivery System problem lists.

Does identifying a staff's credential (e.g., Licensed Clinical Social Worker) meet the requirement for “title" of provider in the problem list?

Reference BHIN 23-068

Yes. Listing a credential is sufficient.

Because it is not feasible for all currently opened members to be transferred to having a problem list, what is DHCS' expectation for when members who have been opened prior to 7/1/22 get a problem list?

Reference BHIN 23-068

For members that were receiving Specialty Mental Health Services prior to July 1, 2022, while a problem list is not required to be created retroactively, a problem list should be developed no later than when the member receives a subsequent assessment, or when there is a relevant change to a member condition, whichever comes first. Likewise, for members receiving Drug Medi-Cal or Drug Medi-Cal Organized Delivery System services, a problem list should be created no later than when the member is reassessed because their condition has changed, or when there is a relevant change to a member's condition, whichever comes first.

Progress Notes

Historically, stakeholders have raised concerns regarding burdensome requirements for progress note documentation. What sources did the Department of Health Care Services (DHCS) review to ensure DHCS' progress note documentation requirements outlined in Behavioral Health Information Notice (BHIN) 23-068 align with current industry standards? - April 17, 2024

Reference Simplified Outpatient Documentation and Coding Toolkit, Ethical Standards for Clinical Documentation Integrity (CDI) Professionals, Medicaid Documentation for Behavioral Health Practitioners, Record Keeping Guidelines, Mental Health Provider Manual, and BHIN 23-068

DHCS looked to national and local industry leaders such as the American Medical Association's (AMA) Simplified Outpatient Documentation and Coding Toolkit, American Health Information Management Association's Ethical Standards for Clinical Documentation Integrity (CDI) Professionals, Centers for Medicare & Medicaid Services (CMS) Medicaid Documentation for Behavioral Health Practitioners and Medicare Documentation for Behavioral Health Practitioners, as well as Carleon's Behavioral Health Provider Handbook to guide the development of BHIN 23-068.

How should progress notes be completed for group services if two providers conduct the group session?

Reference BHIN 23-068

One progress note is required for each member that participates in the group session, and only one provider needs to sign the progress note. Per footnote 15 on page 10 of BHIN 23-068, "...if a group service is rendered by more than one provider, one

progress note shall be completed for each member that participates in a group session and the note shall be signed by at least one provider. The progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity."

Do digital signatures meet the signature requirements for completing progress notes?

Reference BHIN 23-068, in DMH Letter No. 08-10, and ADP Bulletin No. 08-13

Yes. Assessments shall include a typed or legibly printed name and must also include a signature of the service provider as outlined in BHIN 23-068. DHCS does not establish specific requirements for how providers organize their Electronic Health Records. As long as the required information set forth in BHIN 23-068 is accurately represented in the member record, including a provider signature, digital or physical, documentation is considered to be in compliance.

More information on the use of electronic signatures and related requirements can be found in DMH Letter No. 08-10 and ADP Bulletin No. 08-13.

Will the Department of Health Care Services (DHCS) be adjusting the progress note timeframes outlined in Behavioral Health Information Notice (BHIN) 23-068? How does this timeframe apply when notes are completed by providers practicing under supervision?

Reference BHIN 23-068

No. DHCS does not plan to update the progress note timeframes that appear in BHIN 23-068. Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0). Timely completion of progress notes supports quality clinical care.

Some provider types work under direct supervision of a licensed professional. In these instances, the treating provider shall complete progress notes in accordance with the timeframes outlined in BHIN 23-068. Any required review of the progress notes by a supervising professional should then be completed in accordance with clinical best practices, but need not occur within the progress note timeframes specified in BHIN 23-068.

How do the progress note requirements in Behavioral Health Information Notice (BHIN) 23-068 apply to bundled services such as per diem rates for residential treatment?

Reference BHIN 23-068 & SMHS, DMC, and DMC-ODS billing manuals

DHCS requires providers to complete at minimum a daily progress note for services that are billed on a daily basis (i.e. bundled services). The progress note must support the services rendered and include all progress note requirements outlined in BHIN 23-068. For example, Therapeutic Foster Care (TFC) is claimed based on 24-hour increments, and a progress note is required for each unit of service delivered. Weekly or periodic progress notes cannot be used in lieu of individual progress notes for each unit of service.

There are some (relatively rare) scenarios where a bundled service may be delivered concurrently with a second service that is not included in the bundled rate and may be claimed separately. In these cases, there must also be a progress note to support the second, unbundled service. For example, Medi-Cal Peer Support Specialist services may be claimed on the same day as, and separately from, residential or day services. In this scenario, DHCS would require one progress note for the bundled residential or day service and a separate progress note to support the additional, unbundled claim for Medi-Cal Peer Support Specialist services.

These requirements apply regardless of whether the bundled and unbundled services are delivered by the same provider or by different providers.

How should providers document a group service if it is provided as a component of a bundled service? For example, members receiving residential treatment may participate in group services as well as other services or activities during the course of a single day.

Reference BHIN 23-068 & Supplement 3 To Attachment 3.1-A in the California State Plan

Some Specialty Mental Health (SMH), Drug Medi-Cal (DMC), and Drug Medi-Cal—Organized Delivery System (DMC-ODS) services include group therapy as a component of a service that is billed daily or as a bundled service. DHCS does not require separate or distinct progress notes for all service components included within a bundle. However, the note for the bundled service that is claimed should accurately represent the services or activities delivered. When group therapy is provided as a service component of a bundled service, the progress note for the bundled service shall support the service components provided within the bundled service, including the group service.

Can a group participant list substitute for an individual group progress note in the member record?

Reference BHIN 23-068

No. While a list of participants is required to be documented and maintained by the provider when a group service is rendered, a group participant list cannot substitute for an individual group progress note. The participant list does not contain the individualized information needed to support continuity of care or demonstrate program integrity. Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed on pages 9-10 of BHIN 23-068. The progress note for the group service encounter shall also include a brief description of the member's response to the service.

Are the progress note requirements stated in Behavioral Health Information Notice (BHIN) 23-068 what is minimally required by DHCS?

Reference BHIN 23-068

Yes. The progress note requirements stated in BHIN 23-068 are the minimum requirements.

Do progress notes need to include the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) descriptor in addition to the International Classification of Diseases, Tenth Revision (ICD-10) code?

Reference BHIN 23-068

No. While progress notes do not need to include a DSM-5 descriptor, it may be a best practice to include the additional descriptor. For valid Medi-Cal claims, appropriate ICD-CM diagnostic codes, as well as HCPCS/CPT codes, must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note. However, current ICD-CM codes and HCPCS/CPT codes are not required to be included in the progress note narrative. For further guidance on use of ICD-10 codes during the assessment process, refer to BHIN 22-013: Code Selection Prior to Diagnosis.

Are member signatures required for group service progress notes?

Reference BHIN 23-068

No. Member signatures are not required for a group service progress note.

Service, Program, & Facility Requirements

Some Medi-Cal behavioral health providers contract with Managed Care Plans (MCPs) that offer Enhanced Care Management (ECM). Do these providers need to follow two different sets of documentation requirements for Medi-Cal behavioral health services and ECM? - April 17, 2024

Reference CalAIM Enhanced Care Management Policy Guide and BHIN 23-068

Where possible, DHCS has worked towards aligning ECM and behavioral health documentation standards and has provided guidance to MCPs on this topic. See, in particular, pages 28 – 29 of the CalAIM Enhanced Care Management Policy Guide:

- **On assessment requirements:** Page 28 of the Policy Guide notes that MCPs *"…must avoid imposing assessment requirements that are duplicative of the SMHS/DMC/DMC-ODS screening [assessment] domain requirements."* The Policy Guide further notes that county agencies and/or contracted providers can make use of already documented assessment requirements to avoid duplication of efforts, and thus only document in any required section that is missing. MCPs may need to update their documentation policies to allow for the use of existing assessment documentation.
- **On care planning requirements:** Pages 28 and 29 of the Policy Guide state that MCPs "…must not impose care planning documentation requirements that duplicate existing SMHS/DMC/DMC-ODS Provider processes, but instead work with the county behavioral health agency and/or their subcontracted SMHS/DMC/DMC-ODS Providers to meet both ECM and SMHS/DMC/DMC-ODS care planning requirements in a way that leverages existing documentation processes" MCPs are directed to work with county agencies and/or contracted providers to "leverage existing documentation processes" as a means for both ECM and SMHS/DMC/DMC-ODS providers to meet documentation requirements with undue burden.

DHCS directs Medi-Cal behavioral health delivery systems and MCPs to work together to avoid duplicative documentation requirements while still achieving the goals of Medi-Cal behavioral health and ECM policies. For further instruction on streamlining and standardizing documentation requirements for ECM, please refer to the CalAIM

Enhanced Care Management Policy Guide.

DHCS will consider updates to the CalAIM Enhanced Care Management Policy Guide to more explicitly align with the revised Medi-Cal behavioral health documentation requirements in BHIN 23-068, and will communicate any updates to ECM policy to stakeholders.

Can you clarify what the requirements listed in Enclosure 1a of BHIN 23-068 mean? For example, do Adult Residential treatment providers that are licensed by CDSS and certified by DHCS need to continue creating treatment plans? What about SUD residential providers that hold Level of Care designations?

Reference BHIN 23-068

Wherever possible, the Department of Health Care Services (DHCS) eliminated detailed care plan requirements for mental health and substance use disorder services. In some instances, due to existing state or federal requirements, DHCS was unable to completely remove these requirements. Enclosure 1a of BHIN 23-068 notes care planning requirements that remain in effect for programs, services, and facility types where DHCS was unable to remove existing state or federal requirements. This includes several program or facility types that are required to comply with program/facility-specific regulations or policies in addition to Medi-Cal policies. Licensed and certified Social Rehabilitation Programs, and providers of SUD residential treatment, are among the programs/facilities that must observe care planning requirements that appear elsewhere in state law or policy.

To determine whether a care plan is required for a particular behavioral health service, follow these steps:

1. Does the program, service, or facility type have state or federal care planning requirements that remain in effect (see Enclosure 1a for a non-exhaustive list)?
    - If yes, continue to step 2.
    - If no, there are no care planning requirements to follow. DHCS will not monitor or enforce the use of a formal care plan, or documentation of specific care planning activities.
2. Review the relevant state and/or federal guidance to identify specific requirements, e.g. care planning activities, included in Enclosure 1a of BHIN 23-068. Some of these care planning requirements are more detailed/specific than others.

3. Providers shall document the required care plan/care planning activities within the member record. DHCS allows providers to choose where within the member record to document care planning information required by state or federal law (e.g., within a care plan template, in progress notes, or in a combination of locations or formats).
4. Providers must be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems as needed to facilitate coordinated, high-quality care for Medi-Cal members.

Do members receiving Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services need to have a diagnosis and evaluation completed within 30 days of admission to treatment?

Reference BHIN 23-068

No. BHIN 23-068 superseded 22 CCR § 51341.1, subd. (h)(1)(A)(v)(a-b) (see Enclosure 2). This removes the requirement for DMC and DMC-ODS members to receive a diagnosis and evaluation within 30 calendar days of admission to treatment. While the 30 calendar day timeframe for documenting a diagnosis has been superseded, members should still receive a comprehensive assessment and documented diagnosis in a timely manner that is aligned with current standards of practice, consistent with the assessment guidance in BHIN 23-068.

Can you clarify the requirements for Specialty Mental Health Services (SMHS) Targeted Case Management (TCM) care planning? Is the policy different from the policy that was in BHIN 22-019 (now superseded)?

Reference BHIN 23-068 and 42 CFR § 440.169(d)(2)

Behavioral Health Information Notice (BHIN) 23-068 updated the Department of Health Care Services' (DHCS) previous policy for documenting TCM care plans to allow additional flexibility in the way care plans may be documented. DHCS no longer requires TCM care plans to be documented within a member's progress notes. However, DHCS' Medi-Cal guidance does not supersede federal requirements for TCM care planning. SMHS TCM care plans shall be documented as outlined on page 11 of BHIN 23-068, and must meet the federal requirements outlined in 42 CFR § 440.169(d)(2).

Please note that federal regulations at 42 CFR § 440.169(d)(4) and 42 CFR § 441.18(a)(7) also discuss provider requirements related to care planning for members who are

receiving TCM. These regulations are not listed as care plan requirements in BHIN 23-068 Enclosure 1A but remain in effect. (As noted in the BHIN, the tables in the BHIN Enclosures are not exhaustive lists of applicable state and federal policy for each program, service, or facility type.)

As noted in footnote 22 on page 14 of BHIN 23-068, DHCS consulted the Centers for Medicare and Medicaid Services (CMS) on this policy update. CMS approved the DHCS request for a waiver of 42 CFR § 440.169(d)(2) and affirmed that care plans may be documented in various formats, as long the required TCM care plan elements outlined in 42 CFR § 440.169(d)(2) are incorporated into the clinical record. (Application: Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CalAIM), Amendment Submitted November 4, 2022, Updated June 23, 2023, (pg. 18) and Approval: CalAIM 1915(b) Approval Letter Revised STCs).

What are the differences between Targeted Case Management (TCM) and Intensive Care Coordination (ICC)? Is care planning required for ICC?

References: BHIN 23-068, 42 CFR § 440.169(d)(2), 42 CFR § 441.18(a)(7), & Medi-Cal ICC, IHBS, & TFC Manual

ICC is a TCM service, provided to those under age 21 as described on page 26 of the Medi-Cal ICC, IHBS, & TFC Manual. ICC services must meet federal TCM care planning requirements in 42 CFR § 440.169(d)(2) as described in Enclosure 1a of BHIN 23-068.

Please note that federal regulations at 42 CFR § 440.169(d)(4) and 42 CFR § 441.18(a)(7) also discuss provider requirements related to care planning for members who are receiving TCM, or ICC. These regulations are not listed as care plan requirements in BHIN 23-068 Enclosure 1A but remain in effect. (As noted in the BHIN, the tables in the BHIN Enclosures are not exhaustive lists of applicable state and federal policy for each program, service, or facility type.)

Are weekly summaries still needed for substance use disorder (SUD) residential levels of care?

Reference BHIN 23-068, BHIN 21-001 Exhibit A, & DHCS AOD Certification Standards (October 2023)

The Department of Health Care Services (DHCS) Certification for Alcohol and Other Drug (AOD) Programs Certification Standards (October 2023) require that residential programs document each member's progress on a weekly basis.

BHIN 23-068 (pages 8-10) describe requirements for Medi-Cal behavioral health progress notes. Providers must complete at minimum a daily progress note for services that are billed on a daily basis (e.g., Drug Medi-Cal/Drug Medi-Cal Organized Delivery System Residential treatment) (BHIN 23-068(d)(6) (page 10)). A daily progress note fulfills the AOD Certification Standard requirement to document each member's progress on a weekly basis, and an additional, weekly progress note is not required.

Is Drug Medi-Cal Organized Delivery System (DMC-ODS) care coordination the same as Targeted Case Management (TCM)?

Reference BHIN 23-001, BHIN 23-068, Supplement 1 to Attachment 3.1-A in the California State Plan, & 42 CFR § 440.169(d)(2)

No. The DMC-ODS Care Coordination service (formerly known as "case management") is not the same as Targeted Case Management (TCM) and does not require a care plan. TCM is a distinct Specialty Mental Health service. Federal requirements for TCM (including, but not limited to, 42 CFR § 440.169(d)(2)) do not apply to DMC-ODS care coordination, regardless of what billing code is used for the DMC-ODS service.

Can Targeted Case Management (TCM) services be provided prior to an assessment and completion of a TCM Care Plan?

Reference BHIN 23-068

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

Other

Do I still need to follow documentation requirements for specific Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology® (CPT) codes, such as Evaluation and Management (E/M) CPT codes?

Reference BHIN 23-068

Yes. Behavioral Health Information Notice 23-068 does not supersede HCPCS or CPT documentation standards. HCPCS documentation standards are produced by the Centers for Medicare and Medicaid Services, and CPT documentation standards are produced by the American Medical Association. Records should be compliant with both these standards, and BHIN 23-068.

For additional resources on CPT and HCPCS coding and documentation, please see:

- American Medical Association CPT and HCPCS Resources
- Centers for Medicare and Medicaid Services HCPCS Resources

Is the justification for continuing services still a requirement for substance use disorder (SUD) services still in effect?

Reference BHIN 23-068 and CCR 22 § 51341.1(h)(5)(A)(i-iii)

No. BHIN 23-068 (Enclosure 2) has superseded the requirements to provide a justification for continuing SUD services, set forth in CCR 22 § 51341.1 (h)(5)(A)(i-iii). Previously, this was to occur no later than six months after the member's treatment start date. Per BHIN 23-068, re-assessments for SUD services should now be conducted based on a member's needs and clinical discretion.

Are physical exams required for outpatient and residential substance use disorder (SUD) programs?

Reference BHIN 23-068 and 22 CCR § 51341.1, subd. (h)(1)(A)(iv)(a-c)

Yes, physical examinations are required for members receiving Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC-ODS) services per 22 CCR § 51341.1, subd. (h)(1)(A)(iv)(a-c). BHIN 23-068 notes that 22 CCR § 51341.1, subd. (h)(1)(A)(iv)(c)'s requirement related to updated treatment plans are superseded by the BHIN.

Are member sign in sheets required for group services? What about member signatures?

Reference BHIN 23-068 & 22 CCR § 51341.1 subd. (g)(2)(A-E)

Behavioral Health Notice (BHIN) 23-068 superseded 22 CCR § 51341.1 sub. (g)(2)(A-E) (Enclosure 2), removing requirements for member sign-in sheets and signatures for Drug Medi-Cal (DMC)/Drug Medi-Cal Delivery System (DMC-ODS) when providing group services. Providers must maintain participant lists for all DMC/DMC-ODS and Specialty Mental Health group services, as noted on pages 9-10 of BHIN 23-068, but signatures are not required as part of participant lists.

Why are Narcotic Treatment Programs (NTPs) exempt from the guidance in Behavioral Health Information Notice (BHIN) 23-068?

Reference BHIN 23-068, CCR Tit. 9 §§ 9995 – 10425[HT1] & 42 CFR § 8

NTPs are subject to program-specific state and federal regulations under 42 CFR § 8, which include standards for care delivery and documentation. NTPs in California must operate in compliance with Cal. Code Regs. Tit. 9 §§ 9995 – 10425[HT2] and must

continue to meet the standards for patient treatment plans specified in Cal. Code Regs. Tit. 9 § 10305. To avoid complexity or conflict with these existing standards, at this time, DHCS has chosen to exempt NTPs from the documentation standards in BHIN 23-068.

Have the requirements for medication consents changed? This section was removed from the Specialty Mental Health Services Triennial Protocol and the Mental Health Plan Contract and Behavioral Health Information Notice 23-068 doesn't touch on medication consent requirements.

Reference WIC § 5325.3

California Senate Bill (SB) 184 was chaptered on 6/30/22. This health budget trailer bill legislation updated and superseded state regulations (Cal. Code Regs. Tit. 9, § 852) that required mental health facilities to obtain patient signatures to demonstrate informed consent for antipsychotic medications delivered in specified community mental health settings. SB 184 eliminated the requirement to obtain patient signatures, and instead requires that facilities maintain written consent records that contain both of the following:

- A notation that information about informed consent to antipsychotic medications has been discussed with the patient; and
- A notation that the patient understands the nature and effect of antipsychotic medications, and consents to the administration of those medications.

Please refer to WIC § 5325.3 for complete statutory language.

If Mental Health Plan (MHP) providers can now deliver co-occurring treatment and focus on a member's substance use disorder (SUD) needs as clinically appropriate, does that mean the member's clinical record with the MHP will now be governed by 42 CFR Part 2?

Reference BHIN 23-068

Confidentiality of SUD patient records as required by 42 CFR Part 2 would apply to any records which identify a patient as having or having had an SUD and contain information about the SUD obtained through a federally assisted SUD program. If the SUD information was obtained through the MHP or a Specialty Mental Health Service provider, these restrictions would likely not apply.

Are Medicare requirements being taken into consideration since counties must bill to Medicare first? Do members who have Medicare and Medi-Cal need treatment plans?

Reference BHIN 23-068

Documentation requirements set forth in BHIN 23-068 do not change or supersede any federal requirements, including Medicare requirements.

To reduce documentation time, is it acceptable to use checkboxes except where “narrative" is required?

Reference BHIN 23-068

Checkboxes are allowable as long as the note narrative is individualized, provides sufficient detail to support the service code selected, and all other progress note requirements outlined in BHIN 23-068 are met.

Is there still a Drug Medi-Cal Organized Delivery System requirement to document the diagnosis as a narrative summary based on the Diagnostic and Statistical Manual of Mental Disorders criteria?

Reference BHIN 23-068

No. BHIN 23-068 did not retain the requirement to document a narrative summary in the American Society of Addiction Medicine (ASAM) assessment. Please see section (c) starting on page 7 of BHIN 23-068 for the requirements of the documentation of diagnosis/reason for service encounter in the problem list.

How may providers document the member's involvement in the treatment process?

Reference BHIN 23-068

DHCS encourages strength-based, person-centered treatment. Under the documentation requirements outlined in BHIN 23-068, the member's perspective and involvement in treatment may be noted in the member record, e.g., the progress notes.