County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**QM**
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Title: **Determination for Medical Necessity and Access to Specialty Mental Health Services**	Functional Area: **Access**

Approved By: (Signature on File) **Signed version available upon request**

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BACKGROUND/CONTEXT:

Sacramento County Mental Health Plan (MHP) is dedicated to serving people with psychiatric disabilities from various target populations, ages, cultural and ethnic communities. The goal is to promote recovery and wellness for adult and older adults with severe mental illness, and resiliency for children with serious emotional disorders and their families.

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care to ensure that all Medi-Cal beneficiaries receive coordinated services in support of improved health outcomes. The goal is to ensure access to the right care in the right place at the right time.

To achieve this aim, DHCS has clarified the responsibilities of Mental Health Plans (MHPs), including updating the criteria for access to SMHS, for both adults and beneficiaries under age 21, except for psychiatric inpatient hospital and psychiatric health facility services. BHIN 21-073 supersedes California Code of Regulations (CCR), title 9, sections 1830.205 and 1830.210 and other guidance published prior to January 1, 2022, regarding medical necessity criteria for MHP reimbursement of SMHS (other than psychiatric inpatient hospital and psychiatric health facility services), including components of BHIN 20-043.

DEFINITIONS:

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.

Homelessness: The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act. Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who 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) children and youths who 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) children and youths who 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).

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 child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Juvenile Justice Involvement: The beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. 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, are included in the "juvenile justice involvement" definition. 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 also meets the "juvenile justice involvement" criteria.

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).

Medical Necessity: The criteria that identify service need based on inclusion of specific signs, symptoms, and conditions and proposed treatment associated with mental illness. Determination of medical necessity requires inclusion of a covered diagnosis; an established level of impairment; an expectation that specialty mental health treatment is necessary to address the condition; and the condition would not be responsive to physical health care based treatment. Medical necessity is defined by the California Code of Regulations and is contained in a variety of State Department of Health Care Services (DHCS) notices and letters delineating requirements for county mental health services**.**

Medically Necessary Services: Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or 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.

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. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not 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 EPSDT services.

Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition

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.

PURPOSE:

This policy and procedure updates Sacramento County guidelines and criteria for accessing Specialty Mental Health Services (SMHS) as described in the Department of Health Care Services' (DHCS) Behavioral Health Information Notice (BHIN) 21-073. Under this BHIN, access criteria and medical necessity criteria are separated and redefined.

DETAILS:

A. **Process to Determine Medical Necessity:** All Staff conducting the initial assessment meet the qualifications for Licensed Professional of Healing Arts (LPHA) and function as part of the MHP Access Team or specifically designated entry points of services. The process to determine Medical Necessity is as follows:
   i. The Access Team will make an initial determination of Medical Necessity criteria for outpatient services. The Access Team will document their determination and refer to the appropriate provider based on said determination.
   ii. The Access Team designates additional specified points of entry for vulnerable population in order to provide presumptive determination of eligibility to prevent barriers to care.
   iii. Service providers receiving assignments from the Access Team are required to confirm medical necessity and to complete the appropriate assessment upon contact with referred individuals.
   iv. Service providers will continue to review and confirm medical necessity annually at minimum.

B. **Criteria for Adult Beneficiaries to Access the SMHS Delivery System:** For beneficiaries 21 years of age or older, a county MHP shall provide covered SMHS for beneficiaries who meet both of the following criteria, (1) and (2) below:
   1. The beneficiary has one or both of the following:
      a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
      b. A reasonable probability of significant deterioration in an important area of life functioning.

   AND

2. The beneficiary's condition as described in paragraph (1) is due to either of the following:
    a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnosis and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems.
    b. A suspected mental disorder that has not yet been diagnosed.

C. **Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System:** For enrolled beneficiaries under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

1. 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 the department,[1] involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

2. The beneficiary meets both of the following requirements in a) and b), below:
    a. The beneficiary has at least one of the following:
        i. A significant impairment
        ii. A reasonable probability of significant deterioration in an important area of life functioning
        iii. A reasonable probability of not progressing developmentally as appropriate.
        iv. 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.

AND

    b. The beneficiary's condition as described in subparagraph (2) above is due to one 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[2] and the International Statistical Classification of Diseases and Related Health Problems.
        ii. A suspected mental health disorder that has not yet been diagnosed.
        iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.[3]

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

[1] MHPs are not required to implement a trauma screening tool until DHCS issues additional guidance regarding approved tool(s) for the purposes of SMHS access criteria.

[2] 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 disorders not yet diagnosed) and meet criteria for SMHS as described above.

[3] Welf. & Inst. Code, § 14184.402(d)

Additional Coverage Requirements and Clarifications

This criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth 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:

- Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.[4]
- The beneficiary has a co-occurring substance use disorder.

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-10 diagnosis code.[5] In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS-approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes). DHCS may provide additional clarification and technical assistance regarding the use of Z codes.

The portion of BHIN 20-043 that limits SMHS to a list of DHCS included ICD-10 diagnoses is superseded by BHIN 21-073, effective January 1, 2022 (except for psychiatric inpatient hospital and psychiatric health facility services.)

Non-Specialty Mental Health Services

Non-Specialty Mental Health Services (NSMHS) are delivered by Medi-Cal Managed Care Plans (MCP) and Medi-Cal Fee-for-Service (FFS) providers and include the following:[6]

- Mental health evaluation and treatment, including individual, group and family Psychotherapy[7]
- 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, supplies and supplement

MHPs also provide these types of services; however, the level of impairment is typically identified as "moderate to severe" versus the "mild to moderate" level of impairment that supports the provision of NSMHS.

BHIN 21-073 does not change the respective responsibilities of MHPs, Medi-Cal MCPs and the Medi-Cal FFS delivery systems. 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.

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[4] Some SMHS may still require an individual plan of care, such as Targeted Case Management (42 C.F.R. § 440.169.). DHCS will issue forthcoming guidance regarding documentation.

[5] The ICD 10 Tabular (October 1st thru September 30th) at https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

[6] Welf. & Inst. Code, § 14184.402(b)(1)

[7] Dyadic services will be provided effective 7/1/22.

Criteria for Beneficiaries to Access Non-Specialty Mental Health Services

MCPs are required to provide or arrange for the provision of NSMHS for the following populations:[8]

- Beneficiaries 21 years of age and over 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;[9]
- Beneficiaries under age 21, to the extent eligible for services through the Medicaid EPSDT benefit as described above, regardless of level of distress or impairment or the presence of a diagnosis;
- Beneficiaries of any age with potential mental health disorders not yet diagnosed.

REFERENCE(S)/ATTACHMENTS:

- California Code of Regulations, Title 9
- BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req

RELATED POLICIES:

- All MHP P&P's
- All MHTC P&P's

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff		
X	Mental Health Treatment Center		
X	Adult Contract Providers		
X	Children's Contract Providers		
X	Substance Use, Prevention, and Treatment Services		
	Specific grant/specialty resource		

CONTACT INFORMATION:

- Quality Management Program
  QMInformation@saccounty.net

[8] Welf. & Inst. Code, § 14184.402(b)(2)

[9] 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 NSMHS delivery system. However, MCPs must cover NSMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.