NOVEMBER 2019 | VOL. 1 | NO. 7

QRTips

Behavioral Health Services
Authority and Quality Improvement Services
AOABH / CYPBH / Managed Care
Support Teams

Timely Access NOABD

Timely Access NOABDs are issued to a Medi-Cal beneficiary or the representative when the Mental Health Plan (MHP) fails to provide services within the required time frame as follows:

- Routine: 10 days
- Urgent: 24 hours
- Emergent: 4 hours

Please note the following important details:

- Timely Access NOABDs are issued by Program ONLY after consultation and verification with AQIS.
- Timely Access NOABDs are NOT downloadable on the AQIS internet site, in order to ensure consultation and verification with AQIS.
- Program is responsible to ensure that IF a Timely Access NOABD may need to be issued they have consulted with and verified this with the AQIS Managed Care Support Team (MCST) immediately, as issuance of this NOABD needs to be done within 2 business days. Program must also communicate this decision to any Provider (if there is one) within 24 hours of the determination. This can be a phone call prior to the written notice.
- AQIS MCST will continue to run reports weekly to ensure compliance with access regulatory requirements.
- **Please note that IF AQIS has determined that a Timely Access NOABD has to be issued, the Program will be placed on an immediate Plan of Correction per DHCS requirements.**

If you have any additional questions regarding Timely Access NOABDs, please contact AQIS MCST.

TRAININGS & MEETINGS

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AOABH
New Provider Training
(Documentation & Care Plan)

This training is now only available online on AQIS AOABH Support Team website!
Here is the link:
AOABH New Provider Training

AOABH Core Trainers Meetings

County Core Trainers Meeting

Canceled

Contract Core Trainers Meeting

Canceled

CYPBH Trainings

**Please see CYPBH Support Team website for online trainings.*

HELPFUL LINKS

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AQIS AOABH Support Team

AQIS CYPBH Support Team

BHS Electronic Health Record

Medi-Cal Certification

REMINDERS

*When submitting documents for the Final Rule requirements to AQISManagedCare@ochca.com, please identify the requirement (e.g., Clinical Supervision, Provider Directory, etc.) in the subject line to ensure timely processing.

*Collateral Services: Please authorize on the Care Plan when deemed clinically necessary for client's care. For County EHR clinics, please remember that it still appears as "MHS Family" and that it must be authorized in order to bill.

*Service Chiefs and Supervisors, when submitting Provider Directory updates, please ensure that you are updating information on the individual providers at your clinic.

*Service Chiefs and Supervisors, please document the review of QRTips in staff meetings. Thank you!

ANNOUNCEMENTS

Here are the dates for the upcoming 2019 - 2020 MHP external audits:

- **CalEQRO**: 11/19/2019 – 11/21/2019
- **DHCS Triennial**: 12/10/2019 – 12/12/2019

Medi-Cal Certification/Re-Certification Reminders

Per MHP/DHCS contract, MHPs must notify DHCS when a provider makes major staffing changes, makes organizational and/or corporate structure changes (example: conversion to non-profit status), adds medication support services when medications are administered or dispensed from the provider site, there are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance), there is a change of ownership or location, there are complaints regarding the provider, and/or there are unusual events, accidents, or injuries requiring medical treatment for clients, staff or members of the community. When in doubt, please consult with AQIS at AQISmccert@ochca.com.

CalEQRO FY 19-20 On-Site Review

The Fiscal Year 19-20 EQRO sessions will take place from 11/19/19 to 11/21/19. The review will be carried out by Behavioral Health Concepts, Inc. (BHC), the External Quality Review Organization for Specialty Mental Health Services for California (CalEQRO). As in previous years, the review will emphasize the MHP's systems, procedures, activities, and data that are designed to improve access, timeliness, quality, and outcomes of services.

Information along with the final agenda has been sent to the leads for recruitment and participation. Please refer to the email for details such as the participation criteria, date/time/location, etc. Here is a list of group interviews and focus groups:

- One-on-One Peer: 11/19/19, 10:45am – 12:00pm
- Clinical Providers (County Operated): 11/19/19, 1:00 – 2:30pm
- Clinical Supervisors (County Operated): 11/19/19, 2:45 – 4:15pm
- Contract Providers ED/COO/Administrator Level: 11/20/19 9:00 – 10:30am
- Wellness Center Site Visit: 11/20/19, 9:00 – 9:45am
- Consumer Family Member Focus Group #1 – Caregivers of School Age Children: 11/20/19, 10:45am – 12:00pm
- Clinical Providers (Contract Providers): 11/20/19, 2:30 – 4:00pm
- Consumer Family Member Focus Group #2 – Adults: 11/20/19, 2:30 – 4:00pm
- Consumer Family Member Focus Group #3 – TAY: 11/21/19, 9:00 – 10:15am
- EHR – Hands On Session: 11/21/19, 9:00 – 10:15am

CYPBH ONLY

Pathways to Well Being / Intensive Service Reminders and Clarifications

Here are a few reminders and clarifications regarding Pathways to Well Being (PWB) or Intensive Services (IS). The Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries (3rd Edition -January 2018) says that ICC and IHBS are provided through EPSDT benefit to all children and youth who:

- Are under the age of 21
- Are eligible for the full scope of Medi-Cal services; and
- Meet medical necessity criteria for Specialty Mental Health Services (SMHS)
- Have an open child welfare case (PWB only)

If services are still medically necessary after the client turns 21, the provider can bill for Case Management or Rehabilitation Services provided that that the care plan has been revised, these services (Case Management and Individual/Collateral Rehab) have been added to the plan, and the client is still eligible for the full scope of Medi-Cal services. The client must meet the criteria for medical necessity before he or she can be eligible for PWB or IS classification and receive ICC and IHBS services. What is required to establish medical necessity? The client must have an included DSM5/ICD10 diagnosis, an impairment(s) as a result of the mental health diagnosis, and the likelihood that he or she would benefit from the services provided. As a reminder, a licensed or waivered clinician practicing within their scope of practice must establish the mental health diagnosis and resulting impairment(s) through an assessment.

Frequently Asked Questions (FAQs)

Question # 1: "Does that mean that I have to complete a full assessment and care plan before I can establish eligibility for PWB or IS?" The answer is "Not necessarily, depending on whether or not you have established medical necessity." Remember that we use the Interim Care Plan (ICP) in a similar manner. We have completed a "mini" assessment, which is usually documented in a progress note that demonstrates medical necessity of the included diagnosis and resulting impairment(s) and the reason(s) that treatment needs to be initiated before completion of a full assessment. Then, we complete the ICP with the services that we need to provide to decrease the immediate problem. For establishing PWB or IS eligibility prior to the full assessment and care plan being completed, you would need the same process of an assessment note by a licensed or waivered clinician documenting the criteria for medical necessity and the ICP authorizing ICC and IHBS services.

Question #2: "What if the client hasn't been assessed by a licensed or waivered clinician? Can I still complete the eligibility form?" The answer is no. We should not give the impression that we have established medical necessity for any treatment services including ICC and IHBS without the licensed or waivered clinician's direct assessment or review of the assessment and ICP.

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Question # 3: "When do I start using the ICC or IHBS codes?" Once the client has been made eligible for PWB or IS services, all assessment (with the exception of psychological testing or clinical interview to establish medical necessity for SMHS) and case management services are to be coded ICC even if the full assessment has not been completed. All rehab services (individual and collateral) are to be coded as IHBS.

Question # 4: "Can I still use assessment codes to bill for completing the full assessment and care plan?" The answer is that you shouldn't need to use assessment codes unless you are doing psychological testing. The clinical interview to establish medical necessity for SMHS shouldn't be necessary since you already documented the medical necessity in the "mini" assessment progress note.

Finally: "What happens if I'm a secondary provider and didn't know that the client was made PWB or IS eligible?" If you billed case management or assessment by mistake instead of ICC or rehab services instead of IHBS, then for future billings, be sure to change your future notes and billings to the appropriate ICC and IHBS codes.

If you have any questions, please call AQIS at 714.796.0332.

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