



City and County of San Francisco  
London N. Breed  
Mayor



San Francisco Health Network  
Behavioral Health Services

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## FAQ: Medical Necessity Questions Related to CalAIM (Non-Hospital/Outpatient SMHS)

### A. Diagnosis

#### 1. Is the State changing the documentation requirements?

Yes. As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to reform behavioral health documentation requirements for the following reasons: improve the beneficiary experience; facilitate payment reform; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate and effective beneficiary care; address equity and disparities; and ensure quality and program integrity. ([Behavioral Health Information Notice: 21-073](#))

#### 2. When will these changes take effect?

The changes will take effect over several years. Currently, the only change that has been in effect since January 1, 2022 was communicated in DHCS' BHIN #21-073 (Medical Necessity, access, the use of diagnosis for Non-Hospital/Outpatient SMHS). Additional changes will come into effect on July 1, 2022, but DHCS has not provided a final BHIN yet.

Regarding BHSIN #21-073 and the changes effective January 1, 2022, a new Welfare and Institutions Code section 14184.402(f)(1)(A) clarifies that a mental health diagnosis is not a prerequisite for access to covered Specialty Mental Health Services (SMHS). **This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 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, 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. (Behavioral Health Information Notice: 21-073, page 6).

At this time, before additional changes take place, please continue to follow the documentation standards and workflow set forth in our documentation manual.



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**3. Do I still have to enter a diagnosis for every new SMHS case I open?**

Yes. This practice will continue until further notice. Provider must insert diagnostic code as admission diagnosis in Avatar or write a diagnosis in the episode opening form.

**4. Is the list of mental health conditions that are excluded still valid?**

Please refer to CMS approved ICD-10 diagnosis code list. (See [Behavioral Health Information Notice: 20-043](#) and [Enclosure 1 - ICD-10 Inpatient/Outpatient Diagnosis Codes and Descriptions](#).)

**5. Can providers bill for “planned services” with a suspected diagnosis?**

Yes. The SMHS provided during assessment period can be reimbursable (when appropriately delivered within the scope of practice; when appropriately documented; when delivered to address a suspected mental health disorder/impairment) whether or not the client ends up meeting criteria for SMHS at the time of the completion of the assessment. Providers can bill for planned services with a suspected diagnosis.

**6. Can I use a "rule out" diagnosis for opening an episode? At what point do I need to enter a primary diagnosis?**

Yes, ICD-10 code Z03.89, “Encounter for observation for other suspected diseases and conditions ruled out,” may be used by an LPHA or LMHP during the assessment phase of a beneficiary’s treatment when a diagnosis has yet to be established. ([Behavioral Health Information Notice: 22-013: https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf](https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf))

**7. Can we open an episode with a Z code or deferred diagnosis and claim to Medi-Cal? Can we implement the Z code now?**

Yes, an episode or clinical record may be opened with a deferred diagnosis (Z03.89), other Z code or any other valid ICD 10 diagnosis code. All claims must have a valid ICD-10 diagnosis code. ([Behavioral Health Information Notice: 22-013: https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf](https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf))



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- 8. For clients with co-occurring medical or substance use diagnoses, would there be any audit concerns if the assessment process culminates in the finding that the medical or substance use diagnosis is primary and the mental health diagnosis is secondary?**

No. This has been allowable. Placing the substance use or medical diagnosis as the primary diagnosis is not a cause for audit disallowance because this is what your assessment identified. Claims will not be denied if the ICD-10 diagnosis code associated to the claim is a substance use or medical diagnosis.

- 9. If someone drops into the clinic in crisis (no open case) and we do a risk assessment or institute an involuntary hold, do we have to put a diagnosis for billing like we have done prior to the implementation of CalAIM? Or we can just bill without a diagnosis?**

Based on current practice, provider would need to open an episode and establish an admission diagnosis. A mental health diagnosis is not a prerequisite for accessing covered SMHS. However, according to the Behavioral Health Information Notice No: 21-073, **this does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code.**

## **B. Assessment**

- 1. Are Specialty Mental Health Services (e.g., therapy, rehabilitation, collateral) provided during the assessment period reimbursable when it is determined at the end of the assessment that the client does not meet criteria to access specialty mental health services?**

Yes, this is similar to #4 (above in section A), which emphasizes that appropriate clinical documentation supports why billed services was rendered during the assessment period.

The SMHS provided during assessment period are reimbursable whether or not the client ends up meeting criteria for SMHS at the time of the completion of the assessment. After determining the client does not meet criteria to access SMHS, the client should be referred to the appropriate service delivery system, including non-specialty mental health services, if applicable. This is the basis for the CalAIM No Wrong Door policy which is coming later this year.



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**2. Will CalAIM Medical Necessity intersect, or diverge, from the 11 Elements of Medical necessity (Assessment) for documentation?**

We have not received updated information from DHCS on how best to implement the changes yet. More information will follow.

**3. For children and youth beneficiaries 21 and under, how should we document homelessness and trauma for Medical Necessity?**

We have not revised our documentation forms. There are no check boxes in the CANS Assessment to indicate homelessness or trauma in the same way that child welfare involvement and juvenile justice involvement are captured. Note that DHCS has defined homelessness and trauma in [Behavioral Health Information Notice: 21-073](#).

Providers can document trauma and homelessness in multiple places in the narrative sections of the CANS Assessment:

Trauma	Homelessness
Section 2: Trauma/Abuse: Abuse History narrative, Trauma Events scores, Trauma Symptoms scores	Cultural Factors Narrative (under the prompt “living environment”).
Section 12: Development History. Significant Events narrative for both prenatal/Birth/Early childhood stages, as well as the Adolescent stages narrative section.	Section 7 & 8 Caregiver Strengths and Needs: Describe Family and Community Supports AND Caregiver/foster Strengths and Needs narrative. This is a section where concrete needs and resources often surface.
Sectional 15. Clinical formulation narrative.	Section 12: Developmental History. Significant Events narrative for both prenatal/birth/Early childhood stages, as well as the Adolescent narrative section.



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## C. Treatment Plan of Care

- 1. Do I still have to obtain the client signature for the treatment plan as evidence of the client's participation/agreement (or, if the client is unavailable, noting in a progress note that describes the lack of signature)?**

Yes. We have not changed our practice. Please follow the current protocols for documentation.

- 2. Do I still have to finalize a Treatment Plan of Care once I have completed the assessment for my client?**

Yes. We have not changed our practice. Please follow the current protocols for documentation.

- 3. If a new client is opened last week and does not have a completed treatment plan yet, can clinicians start billing for SMHS?**

Yes. The SMHS provided during the period of completing assessment and treatment plan can be reimbursable (when appropriately delivered within the scope of practice; when appropriately documented; when delivered to address a suspected mental health disorder/impairment) whether or not the client ends up meeting criteria for SMHS at the time of the completion of the assessment or treatment plan of care. Providers can bill for planned services with a suspected diagnosis.

## D. Utilization Management

- 1. Do we need to issue an NOABD if the client does not meet criteria to access SMHS and/or if it is determined SMHS would not be medically necessary?**

Yes. If SMHS will not be provided, a Notice of Adverse Benefit Determination will need to be issued.

***END OF DOCUMENT***