



7.2.4 No Wrong Door

Issue Date: 8/29/2022

Revision History: Not Applicable

References: BHIN 22-011; BHIN 21-073; W&I Code section 14184.402(f); Section 1396d(r)(5) of Title 42 of the U.S.C.; Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)).

Policy Owner: BHD-QAPI, MHP QA Manager

Director Signature: Signature on File

I. Policy Statement

It is the policy of Sonoma County Department of Health Service - Behavioral Health Division (DHS-BHD) county Mental Health Plan (MHP) to provide or arrange for clinically appropriate, covered Specialty Mental Health Services (SMHS) to include prevention, screening, assessment, and treatment services. With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHS-BHD MHP (the MHP) aims to address Medi-Cal beneficiaries' needs across the continuum of care, ensure that all beneficiaries receive coordinated services, and improve beneficiary health outcomes. The goal is to ensure that beneficiaries have access to the right care in the right place at the right time.

II. Scope

This policy applies to all DHS-BHD staff and contractors who conduct outpatient SMHS assessments to make service determinations for Sonoma County Medi-Cal beneficiaries.

III. Definitions

- A. Drug Medi-Cal (DMC): Drug Medi-Cal is a treatment funding source for eligible Medi-Cal members. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal members must receive substance use disorder (SUD) services at a Drug Medi-Cal certified program. SUD services funded by Drug Medi-Cal are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6). Title 9 and Title 22, CCR govern DMC treatment.
- B. Drug Medi-Cal Organized Delivery System (DMC-ODS): The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and

- accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021 to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and Specialty Mental Health Services (SMHS).
- C. **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.
 - D. **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).
 - E. **Mental Health Plan (MHP):** MHP means an entity that enters into a contract with DHCS to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly, or another governmental or non-governmental entity.
 - F. **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.
 - G. **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 the county mental health or behavioral health departments and the MHP can provide services through its own employees or through contract providers.

IV. Policy

- A. MHPs are required to provide or arrange for the provision of medically necessary SMHS for beneficiaries in their counties who meet access criteria for SMHS as described in BHIN 21-073 and any subsequent state or federal guidance. As such, it is the policy of the MHP to provide or arrange for clinically appropriate, covered Specialty Mental Health Services to include prevention, screening, assessment, and treatment services.
- B. These services are covered and reimbursable even when:
 - 1. Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether Non-Specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS) access criteria are met;
 - 2. The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
 - 3. NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated.

V. Procedures

- A. SMHS Provided During the Assessment Period Prior to Determination of a Diagnosis or Prior to Determination of Whether SMHS Access Criteria Are Met
 - 1. The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
 - 2. NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated.
- B. Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS.
- C. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.
- D. The MHP shall not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that

- the beneficiary does not meet criteria for SMHS or meets the criteria for NSMHS.
- E. Likewise, Managed Care Plans (MCPs) must not disallow reimbursement for NSMHS services provided during the assessment process if the assessment determines that the beneficiary does not meet criteria for NSMHS or meets the criteria for SMHS.
- F. The MHP, Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs and providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established¹⁰:
1. ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
 2. 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.
 3. In cases where services are provided due for a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMHP in the CMS-approved ICD-10 diagnosis code list, which may include Z codes.
- G. LPHA and LMHP may use any clinically appropriate ICD-10 code¹². For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."
- H. Co-occurring Substance Use Disorder
1. Clinically appropriate and covered SMHS delivered by the MHP providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring SUD.
 2. The MHP shall not deny or disallow reimbursement for SMHS provided to a beneficiary who meets SMHS criteria on the basis of the beneficiary having a cooccurring SUD, when all other Medi-Cal and service requirements are met.
 3. Similarly, clinically appropriate and covered DMC services delivered by DMC providers and DMC-ODS services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the beneficiary has a co-occurring mental health condition.

4. Likewise, clinically appropriate and covered NSMHS are covered Medi-Cal services via the Fee For Service (FFS) and MCP delivery systems whether or not the beneficiary has a cooccurring SUD.
 5. Similarly, clinically appropriate and covered SUD services delivered by MCP providers [e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; Medication-Assisted Treatment (MAT)] are covered by MCPs whether or not the member has a cooccurring mental health condition.
- I. Concurrent NSMHS and SMHS
1. Beneficiaries may concurrently receive NSMHS via a FFS or MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative.
 2. When a beneficiary meets criteria for both NSMHS and SMHS, the beneficiary should receive services based on individual clinical need and established therapeutic relationships.
 3. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary on the basis of the beneficiary also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.
 4. Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a beneficiary on the basis of the beneficiary also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.
 5. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure beneficiary choice.
 6. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for beneficiaries receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. Such decisions should be made via a beneficiary centered shared decision-making process.
 7. Beneficiaries with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from an MHP provider (billed to the MHP), as long as the services are coordinated between these delivery systems and are non-duplicative (e.g., a beneficiary may only receive psychiatry services in one network, not both networks; a beneficiary may only access individual therapy in one network, not both networks).

8. Beneficiaries with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if they simultaneously receive NSMHS from a FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are nonduplicative.
9. The MHP shall utilize DHCS provided statewide tools (effective in 2023 pursuant to future guidance) to facilitate screenings and care transitions for the SMHS, NSMHS and FFS systems.

VI. Forms

None

VII. Attachments

None