Shasta County Health and Human Services Agency
Mental Health Plan
Quality Management Tip Sheet

Access to Specialty Mental Health Services Criteria for Youth

Criteria for Youth Under Age 21 to Access SMHS

For enrolled beneficiaries under 21 years of age, Shasta County Mental Health Plan and its contracted providers shall provide all medically necessary SMHS.

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:
    a. Scoring in the high-risk range under a trauma screening tool approved by the department,
        i. *Shasta county currently uses the CANS trauma section for the trauma rating. This may change based on future DHCS requirements.*
    b. Involvement in the child welfare system,
    c. Juvenile justice involvement, or
    d. 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 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 (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

   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.

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.

Diagnosis Requirements

Although a diagnosis is not a prerequisite for access to covered SMHS, we still must have a mental health ICD-10 diagnosis code for claiming and reimbursement. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to a trauma as noted above, options are available including Z03.89, which is an ICD-10 code we already use for services provided prior to determination of a diagnosis. You can also use codes for "other specified" and "unspecified" disorders, or "Factors influencing health status and contact with health services" (i.e., Z codes).

- There is no longer a restricted "ICD-10 Included Code Sets for Medi-Cal Outpatient SMHS." The list of Medi-Cal covered diagnoses for SMHS was superseded by DHCS Behavioral Health Information Notice No.: 21-073, which established new criteria for access to SMHS detailed in this tip sheet.

- 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.

Medical Necessity for a Service

For youth, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to correct or ameliorate a mental illness or condition. Mental health services don’t have to 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 therefore are medically necessary and covered services.

Services provided must be medically necessary and clinically appropriate to address the **beneficiary’s presenting condition**.

Additional Coverage Requirements and Clarifications

Clinically appropriate mental health prevention, screening, assessment, treatment, or recovery services are covered and reimbursable under the following circumstances:

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