

SUD

Support Newsletter

Authority & Quality Improvement Services

January 2020

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CalOMS Late Submission Rate	
Jan	9.0%
Feb	
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WHAT'S NEW?

Credentialing is rolling out this year. The DMC-ODS Plans must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, registered, waivered, and/or certified.

The uniform credentialing and re-credentialing requirements apply to all licensed, waivered, or registered mental health providers and licensed substance use disorder services **providers employed by or contracting with the Plan to deliver Medi-Cal covered services.**

The following information must be verified from the primary source:

1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

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Upcoming Documentation Trainings

- January 22nd (1 day)*
- February 26th (1 day)*
- March 9th & 11th (2 day)
- March 25th (1 day)*

**Prerequisites: ASAM A and ASAM B*

For both county staff and contract staff: e-mail us at AQISSUDSupport@ochca.com

Increased Cannabis Use in Individuals with Depression

The prevalence of cannabis, or marijuana, use in the United States increased from 2005 to 2017 among persons with and without depression and was approximately twice as common among those with depression in 2017. The findings, which are published in *Addiction*, come from a survey-based study of 728,691 persons aged 12 years or older.

"Perception of great risk associated with regular cannabis use was significantly lower among those with depression in 2017, compared with those without depression, and from 2005 to 2017 the perception of risk declined more rapidly among those with depression. At the same time, the rate of increase in cannabis use has increased more rapidly among those with depression," said corresponding author Renee Goodwin, PhD, MPH, of Columbia University and The City University of New York.

The prevalence of past 30-day cannabis use among those with depression who perceived no risk associated with regular cannabis use was much higher than that among those who perceived significant risk associated with use (38.6% versus 1.6%, respectively). Certain groups appeared more vulnerable to use. For instance, nearly one third of young adults (29.7%) aged 18-25 with depression reported past 30-day use.

In 2017, the prevalence of past month cannabis use was 18.9% among those with depression and 8.7% among those without depression. Daily cannabis use was common among 6.7% of those with depression and among 2.9% of those without.

Retrieved from:
<https://www.sciencedaily.com/releases/2019/12/191209131956.htm>



Documentation

Documentation is essential in maintaining a record of the quality of services provided to SUD clients. All documentation must meet DMC-ODS standards and regulations. The following are some important reminders for appropriate documentation:

Medical Necessity

Clients must meet medical necessity criteria, including:

1. Having one diagnosis from the DSM-5 for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders & Non-Substance Related Disorders
2. Meet the American Society of Addiction Medicine (ASAM) Criteria definition of medical necessity for services based on the ASAM criteria
3. If applicable, must meet the ASAM adolescent treatment criteria

Elements of Assessment

For SUD services, the initial assessment that is completed upon the client's admission is where the documentation of medical necessity begins. The assessments should include information about the following aspects of a client's life/history: Drug and/or Alcohol use, Medical, Family, Psychiatric, Social/Recreational, Financial status, Educational, Employment, Legal status, and previous SUD treatment history

Refer to the SUD Counselor Handbook with Documentation Guidelines:
<https://www.ocgov.com/civicax/filebank/blobdload.aspx?BlobID=773>

NOABD – Termination (New Practice)

Beneficiary informs you that they no longer want your SUD services

- Treatment goals have not been met for this LOC but the beneficiary is deciding to terminate
- NOABD – Termination is issued since the treatment recommendations still exist for this beneficiary (*i.e. beneficiary is leaving AMA / ACA*)
- Discharge the case 10 days after issuing the NOABD - Termination

Mandatory Exclusions

Mandatory exclusions refer to the Office of Inspector General (OIG) prohibition of Federally funded healthcare organizations to employ or contract with individuals or entities that are debarred, suspended or excluded from participating in Federal procurement or non-procurement activities.

Under either section 1128 or section 1128A of the Social Security Act, Managed Care Organizations may not employ or contract with providers excluded from participation in Federal health care programs. Exclusions may result for a variety of reasons, including healthcare fraud and certain drug related offenses.

Because the County of Orange DMC-ODS and the Mental Health Plan (MHP) are Federally funded healthcare plans, no provider or individual who is found on the OIG exclusion list may work within the County system in any capacity. The County and contracted providers perform routine “sanctions screenings” to ensure this requirement is met.

Mandatory Exclusion and Credentialing

Any individual who is excluded from participation in Federally funded health care programs is not eligible to be credentialed by the DMC-ODS or the MHP.

Additionally, managed care credentialing procedures require that the following items also be taken in consideration at the time of re-credentialing

1. A history of grievances against the provider for quality of care reasons
2. A history of inappropriate clinical practices based on records reviews
3. Issues identified through the plan’s quality improvement activities

Stay tuned for more information about credentialing coming soon.



Key Neural Circuit Regulating Alcohol Consumption

Scientists have known that a region of the brain called the central nucleus of the amygdala (CeA) plays a role in behaviors related to alcohol use and consumption in general. It's been less known which precise populations of brain cells and their projections to other brain regions mediate these behaviors. University of North Carolina (UNC), School of Medicine scientists recently discovered that specific neurons in the CeA contribute to reward-like behaviors and alcohol consumption in particular. Published in the *Journal of Neuroscience*, this research pinpoints a specific neural circuit that when altered caused animal models to drink less alcohol.

"The fact that these neurons promote reward-like behavior, that extremely low levels of alcohol consumption activate these cells, and that activation of these neurons drive alcohol drinking in animals without extensive prior drinking experience suggests that they may be important for early alcohol use and reward," said senior author Zoe McElligott, PhD, assistant professor of psychiatry and pharmacology. "It's our hope that by understanding the function of this circuit, we can better predict what happens in the brains of people who transition from casual alcohol use to subsequent abuse of alcohol, and the development of alcohol use disorders."

McElligott, who is also a member of the UNC Bowles Center for Alcohol Studies, set out to investigate if a population of neurons that express a specific neuropeptide (neurotensin or NTS) contributes to reward-like behaviors and alcohol drinking. She was especially interested in these neurons in the context of inexperienced alcohol use, such as when a person first begins to drink alcohol.

Also, NTS neurons are a subpopulation of other neurons in this CeA brain region that have been implicated in anxiety and fear -- known as the somatostatin and corticotropin releasing factor neurons.

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Using modern genetic and viral technologies in male mice, McElligott and colleagues found that selectively lesioning or ablating the NTS neurons in the CeA, while maintaining other types of CeA neurons, would cause the animals to drink less alcohol. This manipulation did not alter anxiety-like behavior. It also did not affect the consumption of other palatable liquids such as sucrose, saccharin, and bitter quinine solutions.

"We found that these NTS neurons in the CeA send a strong projection to the hindbrain, where they inhibit the parabrachial nucleus, near the brainstem," McElligott said.

Using optogenetics -- a technique where light activates these neurons -- the researchers stimulated the terminal projections of the CeA-NTS neurons in the parabrachial, and found that this stimulation inhibited the neurons in the parabrachial. When the scientists stimulated this projection with a laser in one half of the animal's box, animals would spend more time where the stimulation would occur.

Animals also learned to perform a task to get the laser stimulation to turn on, and they would do this repeatedly, suggesting that they found this stimulation to be rewarding.

"Furthermore, when we stimulated this projection, animals would drink more alcohol as compared to when they had an opportunity to drink alcohol without laser stimulation," McElligott said. "In contrast to our study where we ablated the NTS neurons, laser stimulation of this parabrachial pathway also caused the animals to consume caloric and non-caloric sweetened beverages. When the animals were presented with regular food and a sweet food, however, laser stimulation did not enhance the consumption regardless of the mouse's hunger state. This suggests that different circuits may regulate the consumption of rewarding fluids and solids."

McElligott and her graduate student María Luisa Torruella Suarez, the first author of this study, hope to explore how alcohol experience may change these neurons over time.

"Would these cells respond differently after animals have been drinking high quantities of alcohol over time?" McElligott said. "We also want to discover which populations of neurons in the parabrachial are receiving inputs from these neurons. Fully understanding this circuit could be the key to developing therapeutics to help people with alcohol use disorders."

The National Institutes of Health, The North Carolina Translational Clinical Science (NC TraCS) Institute, the Alcohol Beverage Medical Research Foundation, and The UNC Bowles Center for Alcohol Studies funded this research.

Retrieved from:

<https://www.sciencedaily.com/releases/2019/12/191212122550.htm>

The following information does not need to be verified from a primary source but is also part of the credentialing process:

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. **Current malpractice insurance** in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See <https://www.npdb.hrsa.gov/>;
9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: <http://files.medicare.ca.gov/pubsdocs/SandILanding.asp>; and
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

Credentialing is mandatory for all network providers. There are no exceptions or waivers.

