SUD Support Newsletter

Authority & Quality Improvement Services

October 2020

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UPDATES

- In the September SUD Newsletter, under Telehealth Reminders, there was a statement about indicating that the provider is physically present in CA. If this is the case, please continue to document it in the progress note. However, **there is no requirement for the provider to be physically present in CA in order to provide telehealth services,** as

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WHAT'S NEW?

It's time for Treatment Perception Surveys! Many of you will recall that around this time each year, we are required to gather data as part of the Centers for Medicare and Medicaid Services' (CMS) evaluation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration. It also fulfills the External Quality Review Organization (EQRO) requirement related to conducting a client satisfaction survey using a validated tool. The purpose of the surveys is to obtain feedback for quality improvement efforts. We thank you all for your efforts to ensure that this year's collection of surveys goes as smoothly as possible!

Please join us in congratulating Annette Tran, who has been promoted to the manager position of the Managed Care Team! Although we were only able to have her with the Substance Use Disorder Support Team (SST) for a very short amount of time, we appreciate all that she has done and wish her the very best!

Upcoming Documentation Trainings

- October 28th*

**Prerequisites: ASAM A and ASAM B*

Until further notice, all SST Documentation Trainings will be provided via online to ensure the health and safety of all.

To sign up, e-mail us at AQISSUDSupport@ochca.com. For county staff, Training Partner is no longer in use. Please send an e-mail.

Coming soon…

We are working on posting the SST Documentation Training online for easier access!

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as long as he/she is licensed in CA and is associated with a program that is enrolled in the Medi-Cal **program that is physically present in CA**.

- We have received direction from the State in regards to clients who present with an "in remission" substance use disorder (SUD) diagnosis as their primary diagnosis, but have a secondary SUD diagnosis. **Clients who present with any active diagnosis at all, even secondary, cannot be enrolled in Recovery Services.** He or she should instead be in treatment. Going forward, please be sure to determine placement accordingly.

- In past SST Clinical Chart Reviews, it was acceptable for providers to indicate the client's need for a physical exam as either a treatment goal or action step. The focus had been on making sure that it was addressed on the treatment plan. However, with the State placing a greater emphasis on the physical exam requirement, **please make sure that the need to assist the client with obtaining a physical exam is a stand-alone goal with its own action steps.** This will clearly demonstrate how we have fulfilled the requirement.

Documentation FAQ

1. Due to the COVID-19 public health emergency and telecommuting, I am not able to provide a physical signature on progress notes within the 7 days, even though I complete it on time. How should I document the late signature?

For those that do not have e-signature capabilities to sign documents on the completion date and it is known at the time of writing that you will be unable to provide a signature within 7 days from the date of service, the reason should be documented in the body of the progress note. As long it is clear to an outside reader why the signature is late, it does not matter how it is documented or phrased. One example might be: "Counselor unable to provide signature at this time due to shelter-in-place restrictions of COVID-19, despite completing note on 10/1/2020. Wet signature to be provided upon Counselor's return to office."

2. I was early and completed the Continuing

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Updates to SST's Monitoring Process

The SST clinical chart review findings report identify "quality comments" that are not recoupments by the County, but are advisements provided based on our understanding of the requirements. As a reminder, please note that these "quality" items may be recouped by the State. Since we are in the third year of implementation of DMC-ODS, the State will be looking to the County to demonstrate how we are helping providers improve compliance. Therefore, going forward, if consecutive reviews of the same provider results in the same "quality" issues, you will now begin to see that we will be informing you that these "quality" issues will be recoupments by the County if the trend continues to be seen.

An example of a "quality" issue that is often observed in progress notes is when interventions do not demonstrate an explicit connection to the client's SUD or recovery efforts. If Provider A had 10 services identified with this issue on the last review and continue to exhibit the same number of issues in the current review, the provider will be notified that if the trend continues to the subsequent review, the services will be recouped at that time.

For more on the SST's approach to monitoring, stayed tuned to the next QIC meeting!

Documentation FAQ (continued)

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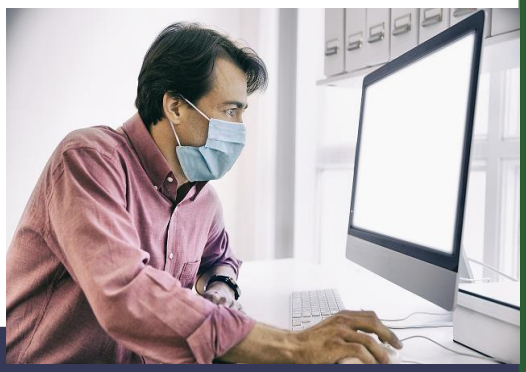
Services Justification (CSJ) in the 4th month instead of between the 5th and 6th month…Is it still valid?

No. The requirement is explicit that there must be a CSJ between the 5th and 6th month. If there is no CSJ between the 5th and 6th month, the chart is out of compliance as of the end of the 6th month (when the CSJ would have been due). Services cannot be billed until there is a valid CSJ in place. Once a CSJ that appropriately establishes ongoing medical necessity for services is complete, the billing can resume. If there is no other CSJ until the next 6th month, this means that services are non-compliant for that entire period.

3. For the SUD Re-Assessment form, under the "Level of Care/Service Accepted" section, in what instances would I check off the option "None"?

You may check off the "None" option in this section in instances where the client has not accepted the counselor's recommended level of care and is unwilling to accept even a lower level of care than what is recommended. For example, if a client is recommended by the counselor, based on the ASAM Criteria, to need Residential level of care, but the client declines, the counselor may begin exploring the client's willingness to engage in even the Outpatient levels of care. The client may decline again and state that he or she has decided to not engage in any treatment. This is a situation in which the "Level of Care/Service Accepted" would be checked as "None." It is advised that the counselor clearly document in a progress note that the client has declined despite the counselor's efforts to educate and explain the benefits of treatment and the risks of declining. Another scenario is if the "Level of Care/Service Indicated by Assessment" is "None" because the counselor has determined that the client no longer meets medical necessity and does not qualify for any and all services. The "Level of Care/Service Accepted" would then be "None." Remember that both scenarios require issuing a NOABD. Please check with MCST for details.



Verifying DMC Eligibility

One of the deficiencies identified in the last State audit of the County involved the requirement for network providers to verify Medi-Cal eligibility for each beneficiary in their program, for each month of service. Please be sure that you are checking eligibility and placing a print out of the verification page in the beneficiary's chart each month. It is important that at any point in time, a reviewer is able to easily locate the print outs for each month that the beneficiary was receiving DMC services.

Are you forgetting something…

Everyone is well aware of medical necessity being two components: the SUD diagnosis and impairments based on the ASAM criteria. But the documentation needs to demonstrate not just medical necessity in general, but ***medical necessity for the recommended level of care***.

For example: How do the client's problems with mental health symptoms and risk of relapse make him or her appropriate for the Intensive Outpatient level of care?

What problems in each of the dimensions demonstrate that the client should be receiving Residential treatment services?

Even those clients in Recovery Services must meet medical necessity, so what areas of the dimensions must be monitored for maintenance to help the client sustain the work that was done in treatment?

The documentation needs to speak to the ***severity*** of the problems, not just that they ***have*** problems.

Look to the reason behind the risk ratings for each dimension, but also remember that the overlap of problems in one dimension with another (e.g., mental health issues on the potential for relapse) can be used to help strengthen the case for the intensity of services needed.

Entering Telehealth Services

Some tips, reminders, and clarification as it relates to billing for telehealth services:

What is considered telehealth?
Whenever a provider utilizes video to conduct a service and visually "sees" the individual on the screen. If you visually see the client for the entire telehealth service, Face-To-Face minutes would equal service time (FTF=ST).

Does telehealth affect the CPT code?
No. The CPT code is the same as what would have been selected if the client was receiving the same service in the clinic.

What encounter type do I select?
In the registration conversation in IRIS, select Encounter type "Site Visit" and the Place of Service "Telehealth." (Regardless of where the provider is physically located in the community).

If I visually "see" the client for only a portion of the session (client hiding, shutting down video, moving off camera) or if the video connection is lost and part of the session is telehealth and the other part is telephone, how do I bill?
If both telehealth and telephone is utilized, the provider should still select Telehealth as Place of Service. Just because the client turns off the camera does not mean that the telehealth service stopped. The provider would continue to use the telehealth medium to deliver the service and have it available to the client. Differentiate the number of Face-To-Face (telehealth) vs. Non-Face-to-Face (telephone) minutes and clearly document what occurred in the progress note. Be clear about what portion of the service was conducted Face-To-Face and what portion was not. Remember to note that the telehealth service was available to the client for the entire session time.

What if the client comes into the clinic but uses a computer to do telehealth in a different office from the provider for the purpose of physical distancing?
This is a telehealth service. Choose the Encounter type "Site Visit" and Place of Service "Telehealth."

What if I contact the client by telehealth platform, but the client is off screen or turns the camera off for the entire session?
If you can only "hear" the client for the entire session, the encounter type is "Telephone," even if video is an option or you are using the telehealth platform with no video. There would be no Face-To-Face time (FTF= 0).

What if the client is initially present by video, leaves the session, and the authorized representative (e.g. parent, probation officer, social worker, etc.) remains on the screen?
If the service type provided both to the client and to the representative are the same (e.g. case management), one progress note may be written. The Face-To-Face minutes will equal the time that you could see the client. The service time is the total time you spent doing the session. The Non-Face-To-Face minutes is also indicated along with what happened during the time spent with the collateral resource without the client present. If the service types are different, two separate notes are needed.

What if I used video for a service where the client is not present?
If you met with other individuals who are relevant to the client's treatment, (i.e., parents, Probation officer, Social Worker, Recovery Residence manager, primary health care provider, etc.), you would choose telehealth, with no Face-To-Face (FTF=0).

Please refer to the "Telehealth FAQ 2020.09.30 DMC" memo for more helpful information!
Contact the AQIS IRIS Team and/or the AQIS SUD Support Team with any questions or concerns:
SUD Support at AQISSUDSUPPORT@ochca.com
IRIS Team at bhsirisliaisonteam@ochca.com or 714.347.0388

This newsletter was established to help communicate any changes or updates as well as to reinforce our current understanding of requirements related to the provision of services under the DMC-ODS. You can access additional resources and previous issues of this newsletter (SUDsies) by visiting the "Providers" tab of the DMC-ODS website, here: http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods/providers

Do you have suggestions for questions or information you would like to see addressed in a SUD Newsletter? E-mail us your thoughts at AQISSUDSUPPORT@ochca.com