SUD Support Newsletter

Authority & Quality Improvement Services

OC health CARE AGENCY

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UPDATES:

Family Therapy can ONLY be provided by a Licensed Practitioner of the Healing Arts (LPHA). Sessions include addressing unhealthy family dynamics that enable the addiction to continue, working on healthy interactions, and can focus on the entire family unit and not just the client.

Billing for completing the discharge summary is permissible ONLY for those clients who are discharged due to loss of contact. Drug Medi-Cal Organized

WHO IS AQIS SUD Support?

Under Authority & Quality Improvement Services (AQIS), the Substance Use Disorder (SUD) Support Team is tasked with providing quality improvement support for the county and county-contracted SUD programs to adhere to State and Federal regulations. The County began providing services under the Drug Medi-Cal Organized Delivery System July 1, 2018, which brings about many changes in our practices. This monthly newsletter will help keep everyone abreast of new or updated information from the State as well as address questions that you come across in this process. Our hope is to learn and grow together in this new venture!

Drug Medi-Cal Organized Delivery System Documentation Training

All staff who will be conducting assessments of clients in need of substance use treatment will be required to have the appropriate American Society of Addiction Medicine (ASAM) training. You can fulfill one of the requirements by attending the AQIS Documentation Training (ASAM-B). Don't forget that the AQIS Documentation Training is required. For county staff: sign-up through Training Partner. For contract staff: For contract staff: email us.

Upcoming AQIS Documentation Trainings (ASAM-B):

- Tuesday, Oct. 23, 2018 and Thursday, Oct. 25, 2018
- Tuesday, Nov. 27, 2018 and Wednesday, Nov. 28, 2018

2019 training dates will be coming out soon!

...More UPDATES:

Delivery System (DMC-ODS) allows us to bill for this activity as a Case Management service. AWOL from a Residential program would not be considered a discharge due to loss of contact. If you are discharging clients for any other reason (i.e., planned, involuntary for other reasons besides loss of contact, voluntary), you may account for your time spent on documenting the discharge summary for the client as a non-billable Case Management note.

*Remember to document your efforts to contact clients for outreach and engagement back into services! There should be a clear trail of documentation of our efforts from the last face-to-face contact to the date of discharge.

Service Time includes only Face-to-Face and Non Face-to-Face minutes. Documentation and Travel minutes do not get included into the Service Time. Documentation and Travel minutes will still be billed to DMC-ODS, but is entered separately into IRIS for billing from the Service Time.

CERTIFICATION REMINDERS

NPI NUMBERS

Please remember that ANY staff who will be billing services under DMC-ODS, must have an NPI (National Provider Identification) number. If there are any staff who are Bachelor's level and are going to be providing services that will be billed, they must be registered or certified as an AOD Counselor. Trainees (those who are currently in school, completing their practicum) would also need to have an NPI number if services are billed under the supervision of an LPHA. Any billing submitted to DMC-ODS for providers who do not have an NPI number will be denied and may be scrutinized as potential fraud.

FAQ's

1. How should I write the intake note?

Keep in mind, if a task can be performed by front office staff, it is not billable. So, stay away from indicating that you had the client simply sign or fill out paperwork. As with other billable notes the documentation must convey the clinical need and how it must be provided by someone with your credentials. Think about the aspects of the intake process that require an explanation from a clinical person: informed consent (risk, benefits, your status as a registered intern, etc.), privacy and limits of confidentiality (how this applies to the clinical relationship, mandated reporting, etc.), program expectations (as it applies to the clinical process of how client will move through the program or from one level of

TRUE or FALSE?

If the treatment plan does not get completed on time, services will never be billable for the client.

False. If medical necessity has been established, then once there is a valid treatment plan, services are billable. If the treatment plan is unable to be completed within the required timeframe, services would be non-compliant until there is a valid treatment plan in place. However, anytime during the assessment period (the length of time you have to complete the initial assessment after the client's admission to treatment), services can be billed as long as each documentation for the service demonstrates the medical need for that service.

care to another, achievement of treatment plan goals rather than completing the entirety of a pre-determined program length). Additionally, if there are any aspects of the intake process that begins to provide you with information that can be incorporated into the initial assessment, this is a billable activity. An example is the use of the CalOMS to begin gathering information about the client's drug use history.

2. How do I write the face-to-face consult between the non-LPHA and the LPHA for assessment?

Both the non-LPHA and the LPHA can do an Individual Counseling note to account for their time. However, one is billable and the other is non-billable.

For the billable note, we are just basically documenting that this interaction took place. To account for or justify the time being billed, the key items to include would be that the client's current and past information was discussed for the purposes of determining the appropriate diagnosis and associated impairments for establishing medical necessity and a suitable level of care placement.

Be mindful of the length of time that this interaction takes to make sure that the documentation looks like it would warrant the amount of time billed. If it is a particularly lengthy consult, consider highlighting a piece of the discussion. For example, perhaps the client's complicated family issues are a deciding factor between whether the client would be better suited for one level of care versus another. Or the presence of a mental health issue that may need to be considered for possible higher level of care referral. No need to repeat any of the information that will be on the assessment form itself, but identify pieces that were discussion points in the interaction. In the GIRP format, the Intervention is for the writer's portion and the response can briefly include the other party's feedback.

The non-billable note can be very brief and general, as long as the person reading it can identify that this was the consult for the assessment and it is non-billable because the other party did the billing and the writer is just capturing the time.

...Continued on page 4

DOC TIPS

Assessment timeframes:

For Intensive Outpatient and Outpatient Drug Free: The initial Substance Use Disorder (SUD) Assessment is due within 30 days from the date of the client's admission to treatment

For Residential Services: The initial SUD Assessment is due within 3 days from the date of the client's admission to treatment.

Keep in mind that the above timeframes include situations where a non-LPHA completes the first 10 pages of the assessment and must pass it on to the LPHA!!

...Continued on page 4

For example, if the client has admitted into the Outpatient Drug Free level of care, the timeframe is 30 days from the date of admission to complete the initial assessment. Therefore, during this 30-day period, services can be billed without a treatment plan in place if documentation supports the medical need. After the 30 days, any services provided would be non-compliant if there is no treatment plan in place. If the treatment plan is completed 50 days from the date of admission, everything between day 30 and day 50 is non-compliant. Billing can start from when the treatment plan is signed by the LPHA.

Remember to document if the assessment and/or treatment plan is unable to be completed within the required timeframe to justify the gap.

FAQ's

Continued from page 2

3. How do I apply the GIRP progress note format for a billable activity with the client's Probation Officer?

G— The purpose of the activity (i.e., provide a weekly progress report in order for continuity of care to help client maintain sobriety.)

I— What did you the provider do? (i.e., discuss drug test results, inquire about court orders or upcoming court dates, etc.)

R— What did the other party do/say? (i.e., PO reported that client has been showing up for all appointments, PO expressed concerns about client's adherence to treatment, etc.)

P— How is this information going to be applied to the client's treatment? (i.e., follow up with client in regards to the PO's concerns about…)

This type of activity could be billed as case management.

4. What additional resources are available to help me with documentation?

In addition to the documentation trainings provided by AQIS, there is a Documentation Manual and an Accompanying Guide to assist you!

The SUD Documentation Guidelines are specific to requirements under the DMC-ODS and covers all documentation from assessment to discharge.

The SUD Assessment Accompanying Guide is detailed information with tips and guidance on completing the initial assessment as well as the Continuing Services Justification.

5. How will I know when my client is ready to discharge?

Based on the client's progress toward achieving treatment plan goals and the reduction of problems or impairments in functioning. The client's progress toward achieving his or her treatment goals should be looked at regularly (it is actually required to be noted on each progress note!). Therefore, you should have some idea of how the client is doing. Additionally, each time you re-assess or complete the Continuing Services Justification, you will be looking to see whether the severity ratings have changed. If there are fewer problems, the risk or severity ratings should be getting lower. We are then looking at whether the client continues to need the current level of care to address those needs.

DOC TIPS

Continue from page 3

SUD Assessment rationales:

The rationale for each dimension of the ASAM criteria should substantiate the risk or severity rating. We want to know what the information gathered from the client tells us about his or her risk in each dimension. The higher the risk, the higher the need for more intensive services. It is not just a summary of the information. This is where you make your case, using evidence from your interaction with the client (and/or other collateral information) to justify your assessment of the level of severity .

Progress notes:

Remember that the purpose is not to write down EVERYTHING that took place. Identify the key interventions that were provided that specifically address the problem related to substance use and/or the treatment goals. Consider what the purpose and intention of your using the particular technique or approach was. Be concise, but descriptive enough to give the reader a good picture of what you did! Don't forget your Evidence-Based Practices!

Treatment plan goals:

If a client says "I just want to stay sober" or "I just want to complete the program," these would be problem statements. To develop goals based on these statements, consider what the client may need to learn or acquire to remain sober. We know that just simply completing the duration of a program is not what is going to sustain one's sobriety. What might be the underlying issues that need to be addressed? What does the client need in order to work towards self-sufficiency and full reintegration back into the community? Perhaps it is the social anxiety that has led the client to use to feel better about interacting with peers. It could be the poor self-image perpetuated by the client's upbringing and abusive relationships that has kept the client using.