SUD Support Newsletter

Authority & Quality Improvement Services

February 2022

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UPDATES

As mentioned in the January 2022 SUD Newsletter, some changes have already started taking root as the State moves towards CalAIM. You likely already have some questions about how this will look and what these changes will mean in practical terms. The State is expected to be issuing further guidance on documentation requirements in the near future and the SST will communicate those updates to you as they become available. It is yet another reminder for us all that we will need to be flexible and

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WHAT'S NEW?

We would like to introduce a new member of the team: Laura Parsley, LCSW. She will be one of your Quality Improvement and Compliance Consultants within the Authority and Quality Improvement Services (AQIS) Substance Use Disorder Support Team (SST) to assist with documentation and billing support as well as participating in the clinical chart reviews. Here is a little bit about Laura so you can get to know her better…

"I grew up in Riverside and have been with the County for many years with the Social Services Agency. I obtained my BA in Sociology from Cal State Fullerton and my MSW from Cal State Long Beach. I finally decided to work on my LCSW a couple of years ago and achieved that in August 2021. I'm married to a wonderful man who is smart in all the ways I am not, so we make a good team, and we have two wonderful kids. My son, Landon, is 5 and is an energy-filled athlete. My daughter, Johana "JoJo", is 4 and loves all things sparkly. I love spinning, hiking, paddle boarding, podcasts, and my dog Lily."

Documentation Training

SST SUD Documentation Training (online):
https://www1.ochca.com/ochealthinfo.com/training/bhs/aqis/SUDDocumentationTraining/story.html

The SUD Case Management Training:
https://www.ochealthinfo.com/about-hca/behavioral-health-services/bh-services/drug-medi-cal-organized-delivery-system-dmc-ods

Test Your DMC-ODS Knowledge!

When should the Individual Intake code be used?

a. For the first encounter with the client to indicate the first service/start of the EOC
b. Whenever assessing or re-assessing a client for medical necessity
c. For all intake and assessment sessions necessary for each client

…UPDATES (continued)

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and ready for ongoing changes.

One area to note is the exception that involves the Alcohol and/or Drug (AOD) Certification Standards. As the requirements for DMC-ODS change, if your program is operating under an AOD Certification, you will need to be mindful of how you can stay in compliance with both.

Please note that the SST does not have authority over the monitoring and adherence to AOD Certification Standards. Therefore, we are unable to provide guidance on specific questions pertaining to how to properly document to the AOD Certification Standards. If you should have any questions or concerns about fulfilling the AOD Certification Standards, please consult with your program's LCD State Analyst.

An example of how the AOD Certification Standards conflicts with the DMC-ODS changes involves the extension of the assessment period for beneficiaries who are homeless and those who are under the age of 21, effective January 1, 2022. As discussed previously, it is permissible under DMC-ODS to now take up to 60 days to assess whether an individual meets medical necessity and the need for a particular level of care if the documentation demonstrates that the client is homeless or under the age of 21. However, if your program is under AOD Certification, the timeline for the AOD Certification Standards must be followed. This means that programs under AOD Certification will not be able to make use of the extension of up to 60 days for the assessment.

If your program is *not* AOD Certified and would like assistance on documenting the need for up to 60 days to assess, please reach out to your SST Consultant!

Documentation FAQ

1. I am a provider at a Residential program and have just received the assessment and approved Treatment Authorization Request (TAR) for a client. What do I need to do with these documents?

It is in your program's best interest for the LPHA to review the received assessment document to confirm that it meets all the requirements for an Initial Assessment as well as sufficiently documents medical necessity. The LPHA should ensure that the documentation clearly explains how the client meets the diagnostic criteria for the given diagnosis and appropriately justifies the residential level of care. The LPHA should also check that all ten psychosocial elements are addressed. The time spent reviewing the assessment document is billable as a care coordination progress note. Whether or not the LPHA makes any changes, he/she should document in a progress note that the review was done and what the outcome was (i.e., whether the information is sufficient as it is or what needs to be updated). If the LPHA determines any changes are needed, either an addendum

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SST Clinical Chart Review Findings & Trends

As the SST QI Consultants continue to conduct Clinical Chart Reviews for fiscal year 2021-2022, here are a few issues we have been seeing most recently that we all need to be careful of…

Missing service and/or documentation start and end times

The service and documentation start, and end times are required components of a progress note. Please be aware that the State could disallow services that do not properly document the service and documentation start and end times. Additionally, be sure to double check that the start and end times are congruent with the total number of service and/or documentation time that is claimed. We are frequently coming across differences between the start and end time and total number of minutes indicated on the progress note as well as with what has been entered into IRIS.

Continuing Services Justification (CSJ) outside of the 5th and 6th month

This is potentially a significant period of non-compliance so please pay close attention to the timeline of every 5th and 6th month from the date of the client's admission. If a CSJ is completed sometime in the 4th month, this means that we are out of compliance for the requirement of a CSJ between the 5th and 6th month and the period of non-compliance would extend until the next CSJ brings the chart into compliance!

If you have questions or need clarification, please be sure to ask your designated Consultant!

Documentation FAQ (continued)

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or a new assessment document should be completed. It is recommended that if there are substantial changes such as change in diagnosis or how the severity of the client's problems warrant the residential level of care, a new assessment document be completed. The time spent interviewing the client to confirm or update information and formulating the new assessment document, are assessment activities billable as an individual counseling progress note. Lastly, please make sure that a copy of the assessment document received from another entity and the TAR are filed in the client's chart. This is especially important if you are intending to use the received document as the Initial Assessment or referencing any of the content elsewhere.

2. I know the Initial Assessment needs to address all 10 psychosocial domains, but what do I do if any of those areas do not apply to my client?

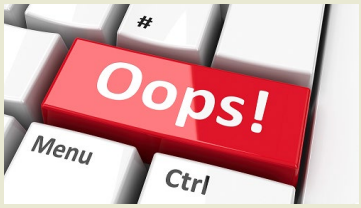
If a particular element does not apply to the client, be sure to document the reason in the assessment. This is to ensure it is clear that you addressed the topic. For example, the assessment may be for an adolescent who has no work history and whose finances depend on their primary caregiver(s). It is sufficient to note that, "Client is a student and has never had a job" or "Employment history: not applicable as client is currently a full-time a student and reports never having a job." If the client is not financially independent, this can be noted as, "Financial status: client is dependent on his mother and father" or "Client reports not having any money of his own and that he mostly steals cash from his uncle to buy weed." There may also be instances where the client is unwilling to provide information on a particular topic. This can also be documented by recording something like, "Client declined to provide information about his employment history."

Care Coordination Billing Tips

We all know how important it is to help our clients with accessing necessary resources like medical/health care and housing. However, when it comes to billing, we need to remember that not everything related to assisting our clients with this is billable in the DMC-ODS.

For example:

- *Transporting a client to a psychiatrist's appointment* – Although the client's mental health needs may be impacted by the substance use disorder, this alone does not allow us to bill for transportation of a client. In fact, under the DMC-ODS, transportation is never billable.
- *Allowing the client to use your office phone to make an appointment for a physical exam* – Although the State expects us to assist the client in getting a physical exam, this alone does not allow us to bill for letting the client use the phone.



As a reminder, administrative activities are not billable to DMC-ODS. Scheduling, making appointments, leaving phone messages, etc. do not require a clinical provider to do. Before you bill an activity as care coordination, make sure that there is medical necessity! As a general rule, if a client is able to do it for themselves, it is probably not billable. Make sure your documentation makes it clear why you needed to assist the client with an activity. If the activity does not require specific credentials/education/experience to provide, it is likely not billable.

Reminders

Did you sign that document?

Don't forget that clinical documents like progress notes, assessments, treatment plans, etc. need to have the provider signature and date of signature. The requirements for these documents include the provider signature. Therefore, without the provider signature, the State can deem the document as incomplete and disallow services. Be sure your signature is adjacent to your printed name.

Does the start and end times for both consult notes match?

Remember, in order for both parties to bill for a relevant consultation that takes place, the start and end times on each respective progress note needs to match. The State can disallow both claims in instances where the times do not match!

Is it time for a Treatment Plan Update?

Your clients' treatment plans are only valid for up to 90 calendar days. Whichever timeline you choose (whether from admit date or from the last treatment plan), be mindful of when it expires! Services beyond the 90 days must be made non-compliant until there is an updated treatment plan.

"Test Your DMC-ODS Knowledge" Answer: a

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

- GRIEVANCES & INVESTIGATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- CLINICAL SUPERVISION
- PAVE ENROLLMENT FOR COUNTY SUD DMC-ODS CLINICS & PROVIDERS
- PAVE ENROLLMENT FOR MHP PROVIDERS
- COUNTY CREDENTIALING
- CAL-OPTIMA CREDENTIALING
- ACCESS LOGS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP)
- MHP/SUD DMC-ODS PROVIDER DIRECTORIES

REMINDERS

COUNTY CREDENTIALING

Expired Licenses, Certification and Registration

- The MCST has the ability to track and monitor expired credentials for providers who have successfully completed the County credentialing process. Over the last several months there has been a significant rise of SUD providers who have not renewed their expired credentials on time.
- VERGE revised their e-mail notifications to providers from 90/60/30 days to 45/30/7 days in advance about expiring licenses, certifications and registrations. Also, they send final notices the day of and the day after expiration.
- After VERGE's multiple attempts to obtain an updated credential, MCST and IRIS intervenes to suspend and deactivate the provider. The provider is then no longer permitted to deliver services requiring licensure, registration or certification for the Orange County Health Care Agency.
- When this occurs the provider must immediately petition for their credentialing suspension to be lifted once their status is updated and provide proof of the license, certification and/or registration renewal to MCST and IRIS. The reinstatement is **NOT** automatic.

CLINICAL SUPERVISION (EFFECTIVE 1/1/22)

Please be advised that LMFT, LCSW, and LPCC Clinical Supervisors have new requirements set by the Board of Behavioral Sciences (BBS). It is the responsibility of the Clinical Supervisors and Supervisees to keep current with changes to regulations. Please review the following link in depth for the detailed changes.

https://bbs.ca.gov/pdf/law_changes_2022/supervision_reg_changes.pdf

New & Revised Clinical Supervision Forms

1. **Supervision Agreement Form,** this will replace the Supervisor Responsibility Statement & Supervisory Plan. The form is to be signed within 60 days of commencing supervision. *(Available on the BBS website)*
2. **Supervisor Self-Assessment Report,** this form will affirm that the licensee is qualified to be a supervisor. *(New form will be posted by BBS soon)*
3. **Written Oversight Agreement (revised),** is used on the letterhead of the employer when a licensed waivered individual is receiving clinical supervision from a licensed clinical supervisor that is **NOT** employed by the same company/organization/agency as the supervisee. *(Available on the BBS website)*
4. **Clinical Supervision Reporting Form,** this form has been revised to meet the BBS new requirements and must be submitted to MCST. It will go into effect 2/1/22.

MANAGED CARE SUPPORT TEAM

REMINDERS (CONTINUED)

COMPLAINTS TO LICENSING BOARDS, SUCH AS BBS:

- ✓ Beginning July 1, 2020, all mental health counselors, whether licensed or unlicensed, were required to provide a notice to each of their clients stating where they can file a complaint. (AB 630, Chapter 229, Statutes of 2019).
- ✓ Effective January 1, 2022, there are some changes to the timing of when you must provide the notice and to documentation requirements.
- ✓ For new clients, the providers are required to provide this notice prior to initiating therapy services, or as soon as practicably possible thereafter. The "as soon as practicably possible thereafter" allowance is new, and is intended to allow a provider to provide services first in an emergency, and then provide the notice once the emergency has passed and it is appropriate to do so.
- ✓ You do not need to distribute the new version of the notice to existing clients. You only need to distribute the new version, to new clients you begin seeing on or after January 1, 2022.

- AQIS Support Teams will **NOT** oversee and audit for the revised BBS requirements regarding filing a complaint with the Board or certifying organization (CO). It is the provider's responsibility to ensure they abide by the BBS or CO requirements when delivering the notice to the new client about where they can file a complaint and documenting it in the client's record. Contact BBS or your applicable licensing board or CO for consultation and/or refer to the BBS link below for further guidance:

https://www.bbs.ca.gov/pdf/law_changes_2022/required_notice_to_consumers_2022.pdf

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- If you and your staff would like a specific or a full training about the MCST's oversight and updates on the State and Federal regulations governing Managed Care please e-mail the Program Manager, Annette Tran at anntran@ochca.com.

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
Leads: Esmi Carroll, LCSW Jennifer Fernandez, MSW

CLINICAL SUPERVISION
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, MSW

PAVE ENROLLMENT FOR MHP & SUD
Leads: Araceli Cueva, Staff Specialist Elizabeth "Liz" Martinez, Staff Specialist

CREDENTIALING AND PROVIDER DIRECTORY
Leads: Elaine Estrada, LCSW Sam Fraga, Staff Specialist (County Credentialing, Cal-Optima Credentialing & Provider Directory)

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