SUD Support Newsletter

Authority & Quality Improvement Services

March 2022

SUD Support Team

Azahar Lopez, PsyD, CHC
Yvonne Brack, LCSW
Angela Lee, LMFT
Beatriz Garcia, LMFT
Emi Tanaka, LCSW
Claudia Gonzalez de Griese, LMFT
Laura Parsley, LCSW
Faith Morrison, Staff Assistant
Oscar Camarena, Office Specialist
Marsi Hartwell, Secretary

CONTACT
aqissudsupport@ochca.com

UPDATES

Patient Education at Outpatient Drug Free (ODF)

As you know, we previously did not have a specific code for billing Patient Education at ODF. Recently, we have been informed by the State that going forward, we will be able to **bill for Patient Education at ODF using the Group Counseling code**.

However, there are some important considerations:

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WHAT'S NEW?

The 2021-2022 **Annual Provider Training (APT)** will be coming out in April. The County is required by the State to provide an annual training on the requirements of the DMC-ODS. Therefore, the APT is required to be completed by all providers in the County's DMC-ODS network each year. The training will contain relevant information about the work that providers do.

Once the APT becomes available in April, providers will have 30 days to complete it. Please begin preparing your staff to ensure this is completed in a timely manner.

This year's APT has a common core with the Mental Health Plan APT, and we welcome your feedback on this new format.

For more information on the APT requirements and who needs to take it, please refer to the P&P here:

https://ochealthinfo.com/sites/hca/files/import/data/files/70039.pdf

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

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!

If only one provider documents, who should document the consultation for establishing the preliminary diagnosis?

a. Non-LPHA
b. LVN
c. LPHA
d. Program Director

…UPDATES (continued)

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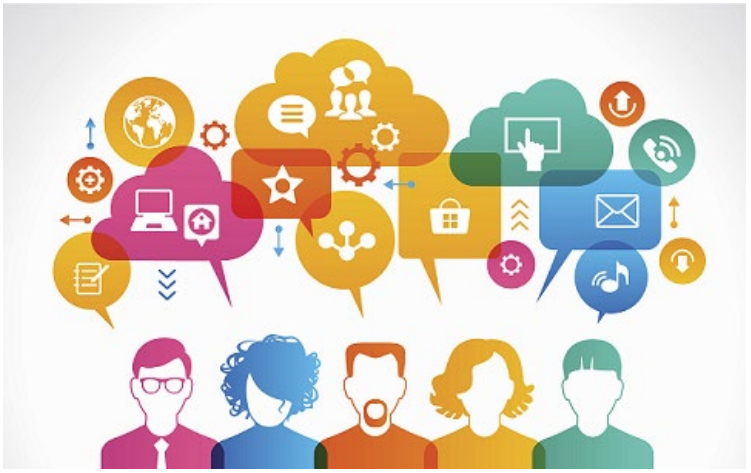
- Patient Education Groups at ODF are limited to 2-12 clients in order to bill using the Group Counseling code. Patient Education Groups at ODF that exceed the 12 clients, should be coded as non-billable.
- Patient Education can be provided by non-LPHA and LPHA, within their scope of practice.
- Patient Education provided by Registered Nurses (RN) must be within scope of practice! This is particularly important: Just because Patient Education is billed as Group Counseling does not mean that an RN is now able to provide any and all Group Counseling services.
- The note should be clearly labeled as "Group/Patient Education", even if the billing code used is for "Group Counseling". Contact your assigned consultant for T/A.

What is Patient Education?

According to the State, it means "providing research based education on addiction, treatment, recovery and associated health risks."

A few examples of Patient Education Groups…

- Providing information about health risks for intravenous drug users, such as HIV
- Presentation on the neurobiological effects of substance use
- Differences in gender-specific physiological effects of long-term substance use based on research



Documentation FAQ

1. What happens to services if an individual who is not credentialed is providing DMC-ODS services?

Services cannot be billed if the staff person is not properly credentialed to be a DMC certified provider. This means that if services have already been provided by an individual without the proper credentials, the services must be made non-compliant. For residential programs, where there are multiple services provided to a client on any given day, if any one of those services is performed by an individual without MCST credentials, the entire day on which that individual provided the service is non-compliant. Please ensure that you have gone through the credentialing process with the Managed Care Support Team!

2. How can I make sure my care coordination (previously known as case management) note is billable?

Remember that we are not able to bill for clerical activities.

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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…

Consultation start and end times not matching

Please remember that billing by both parties for a consultation is permissible when the start and end time of the consultation matches between the two progress notes. Consultation progress notes where the start and end times do not match will result in a disallowance.

Missing documentation of LPHA and non-LPHA consultation

The documentation of the consultation between the LPHA and non-LPHA for the purpose of establishing medical necessity by the LPHA is a requirement. It is a billable service. If it is not billed and documented in a progress note, at minimum, there must be documentation that evidences that the consultation took place (i.e., statement in the Case Formulation). Assessments completed without evidence that a consultation between the LPHA and non-LPHA took place, will result in a disallowance.

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

Documentation FAQ (continued)

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Some examples of clerical activities include, making an appointment, rescheduling, leaving a phone message, allowing a client to use your office telephone, helping the client connect to a telehealth session, observing a client receiving another service, waiting for the client, providing transportation. The activity or intervention must require the provider's credentialing/licensing. Additionally, the documentation needs to be clear to the reader that the activity or intervention provided is medically necessary and relevant to the client's treatment. Be sure to consider how this service will help the client with his/her/their treatment goals.

3. My client is completing Residential treatment and will be attending Outpatient with another provider, but wants to continue with our Recovery Services program. What should I do?

First, you will need to confirm with your program administration that verification has been obtained from the State that your site is permitted to have clients who are no longer in the Residential program (i.e., Alumni) onsite at the same time as those who are enrolled in the Residential program. This is potentially a licensing and certification issue that must be addressed. If not permitted, you will need to make arrangements to link your client to Recovery Services with another provider (such as with the Outpatient program that the client will be transitioning to). If it is permitted by the State for your program to have onsite Residential clients and Alumni simultaneously, there are a few things that will need to happen. If your client was receiving Recovery Services as part of his/her/their Residential treatment, it is likely that there was one Episode of Care (EOC) for Residential services that was opened. Upon the client's discharge from Residential, that Residential EOC should be closed and a new EOC opened for Recovery Services if the client is continuing with Recovery Services. If a discharge Re-Assessment was completed for the client's discharge from Residential with documentation that establishes the justification for the client's need for Recovery Services, this may be used as the Initial Assessment for the new Recovery Services EOC. Timelines will be based off of the newly opened Recovery Services EOC and a new Recovery Plan will need to be created. A new CalOMS record is not required for RS. A discharge CalOMS for Residential is.

RECOVERY SERVICES (RS) TIPS

Now that RS is an available component of each level of care, below are some important considerations when enrolling a client simultaneously in treatment AND RS…

- Use clinical judgement to consider the appropriateness of having the client receive both treatment and RS. What treatment and recovery needs does the client have that cannot be addressed in treatment alone? Be sure to clearly document how the addition of RS is necessary!
- When adding RS to supplement the client's current enrollment in treatment, be sure to document either in a Re-Assessment or as an addendum to the most recent Assessment or Re-Assessment the reasons for the client's need for RS.
- Add RS to the client's existing treatment plan or create a new treatment plan. Either way, obtain updated signatures to indicate client's agreement to this addition.

REMINDERS

Close the Episode of Care (EOC)!

If your program has several levels of care, please be sure that EOC's are being closed in IRIS as your client moves from one level of care to another. We have been noticing an increase in situations where the client has several EOC's open. For example, a client moves from IOT to ODF and has a new EOC at ODF, but the EOC at IOT was never closed. In such cases where the client is going from IOT to ODF, the EOC at IOT needs to be closed and a new one opened at ODF.

LPHA: Did you sign the non-LPHA's treatment plan within 15 calendar days?

Particularly in those cases where the non-LPHA has completed the Treatment Plan early, there will be a period of non-compliance for instances where the LPHA does not sign within 15 calendar days of the counselor's signature.

Is there a corresponding progress note?

Whenever you obtain verbal consent from the client for the treatment plan, be sure to document in the session progress note that the treatment plan was reviewed and that client has given his/her/their verbal consent.

"Test Your DMC-ODS Knowledge" Answer: c

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

CLINICAL SUPERVISION

Supervisor Self-Assessment Report (NEW)

This form will affirm that the licensee is qualified to be a supervisor under the Board of Behavioral Sciences (BBS) authority. Licensees of other boards should consult with their respective boards. New BBS supervisors (a licensee serving as a supervisor for the FIRST TIME on or after January 1, 2022) must submit this form to BBS within 60 days of commencing supervision for the first time. Existing BBS supervisors (a licensee who served as a supervisor PRIOR TO January 1, 2022) must submit this form to BBS by January 1, 2023. This is a one-time submission. Do NOT resubmit upon commencing supervision with a new supervisee.

The MCST will require a copy of the Supervisor Self-Assessment Report to keep on file in order to ensure compliance with the clinical supervisor requirements.

See hyperlink for the Supervisor Self-Assessment Report form:
https://bbs.ca.gov/pdf/forms/supervisor_self_assessment.pdf

Clinical Supervision Reporting Form (REVISED)

This form has been revised to meet the BBS new requirements and must be used effective 2/1/22.

2022 DHCS ENHANCED MONITORING REQUIREMENTS FOR NOABDS AND ACCESS LOGS

Per DHCS, MCST is now required to enhance the tracking and monitoring of all NOABD submissions and Access Log entries:

- ✓ A quarterly report tracking NOABD submissions and Access Log entries will be e-mailed to the appropriate Mental Health and Recovery Services (MHRS) Director, Division Manager and Program Managers to review and disseminate to all County and Contracted providers to assist and discuss with program in order to adhere to the DHCS requirements.
- ✓ The report will identify programs that have zero or a low numbers of submissions and entries.
- ✓ Programs that are determined to be non-compliant could be placed on a Corrective Action Plan (CAP).
- ✓ The MCST can offer NOABD and/or Access Log Training, if necessary.

MANAGED CARE SUPPORT TEAM

REMINDERS (CONTINUED)

GRIEVANCES

- County and County Contracted programs are required to file a grievance on the beneficiary's behalf when there is any expression of dissatisfaction and mail it to AQIS at no cost to the beneficiary. County-Contracted programs that have their agency internal grievance process must also submit a formal grievance to AQIS.
- **(DMC-ODS ONLY)** Per, the Intergovernmental Agreement the DMC-ODS beneficiary has the right to file a grievance with the Health Plan and/or directly with DHCS. The MCST is required to submit the initial grievance and the formal Notice of the Grievance Resolution (NGR) letter to DHCS within 2 business days of completion. DHCS will track, monitor and review the grievance that was submitted by the MCST to determine if any additional action is required (e.g. conduct a site visit for further investigation).

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 Administrative 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)

CONTACT INFORMATION

200 W. Santa Ana Blvd., Suite #100A (Bldg 51-I)
Santa Ana, CA 92701
(714) 834-5601 FAX: (714) 480-0775

E-MAIL ADDRESSES

AQISGrievance@ochca.com (NOABDs/Grievance Only)
AQISManagedCare@ochca.com