OC health CARE AGENCY

SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

January 2024

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Important

In order to bill Medi-Cal for services rendered to a client, there must be an **Assignment of Benefits (AOB) Authorization to Disclose (ATD)** on file. This document should be one of the components of the intake process for all admitting clients. Without this completed form, services cannot be billed to Medi-Cal. In a clinical chart review by the SUD Support Team, services discovered to have been claimed without an AOB ATD

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WHAT'S NEW?

Happy New Year!

In case you may have missed it, the Department of Health Care Services (DHCS) has issued **Behavioral Health Information Notice (BHIN) 24-001** in December, which updates the Drug Medi-Cal Organized Delivery System (DMC-ODS) requirements for the period 2022-2026. A few noteworthy points include:

- Residential treatment facilities licensed by DHCS offering ASAM Levels 3.1, 3.3, 3.5 must also have a DHCS LOC Designation and/or an ASAM LOC Certification
- The CalAIM Justice-Involved Reentry Initiative is Intended to build a bridge to community-based care for Justice-Involved (JI) Medi-Cal clients by offering "pre-release services" for up to 90 days prior to their release to stabilize their health conditions and plan for their community-based care. As part of the initiative, DMC-ODS plans will be required to coordinate with the pre-release case manager and be able to receive referrals from correctional facilities by October 1, 2024.
- New provider qualifications with the addition of the Clinical Trainee (unlicensed individual enrolled in a graduate program and participating in a practicum or internship); Licensed Vocation Nurse (LVN); Licensed Occupational Therapist (LOT); Licensed Psychiatric Technician (LPT); Medical Assistant (MA); and other trained staff (O) under the supervision of an LPHA.

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Training & Resources Access

UPDATED DMC-ODS Payment Reform 2023 - CPT Guide:

https://www.ochealthinfo.com/sites/healthcare/files/2023-11/DMC-ODS%20Payment%20Reform%202023-1115.pdf

UPDATED MAT Documentation Manual

https://www.ochealthinfo.com/sites/healthcare/files/2023-11/CalAIM_MAT_Documentation_Manual_v2_11.8.23_FINAL.pdf

The SUD Documentation Training:

http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods/providers

SUD Documentation Manual:

https://www.ochealthinfo.com/sites/healthcare/files/2023-02/DMC-ODS%20CalAIM%20Doc%20Manual.pdf

Important (continued)

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must be recouped. Likewise, an AOB ATD that is not properly completed will also lead to recoupment because services will not be able to be billed to the State.

How to fill out an AOB ATD:

- **All sections must be completed in its entirety!**

ochealth CARE AGENCY

Client Name: ____________________

Client MRN: ____________________

SUBSTANCE USE DISORDER SERVICES

ASSIGNMENT OF INSURANCE BENEFITS / SIGNATURE ON FILE and AUTHORIZATION TO DISCLOSE for FINANCIAL REIMBURSEMENT

I hereby authorize the County of Orange Health Care Agency (HCA) to disclose information about substance use disorder diagnoses and related progress notes about me to:

Medi-Cal ADP Drug ____ ____ (____) ____

Name of Insurance | Insured ID/Policy Number | Insurance Company Phone #

The purpose for this disclosure is to allow Orange County Health Care Agency to obtain the necessary payments for the substance use disorder services Orange County DMC-ODS System has provided to me. I request that payment of authorized insurance benefits, including government benefits, be made on my behalf to the County of Orange Health Care Agency for any substance use disorder services provided to me.

This assignment and authorization will remain in effect until my discharge from Orange County DMS-ODS System, or until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original and from the initial date I received the services from Orange County DMC-ODS System.

I understand that I may be denied services if I refuse to sign this authorization. 42 CFR Part 2 prohibits unauthorized re-disclosure of the records disclosed pursuant to this authorization by the recipient. I acknowledge hereby that I have been provided a copy of this form.

I have read and understand the contents of this form.

____

Name of Insured or authorized representative

____________________ ____________________

Signature of Insured or authorized representative *Date*

PLEASE CONTACT YOUR FINANCIAL EVALUATOR WITH ANY QUESTIONS YOU HAVE REGARDING THIS FORM

IF THE CLIENT HAS INSURANCE COVERAGE, COPY FRONT & BACK OF INSURANCE CARD AND GIVE TO THE FINANCIAL EVALUATOR.

BHS AOB/ATD SUD (Revised 01-09-24)

For any questions or concerns regarding how to fill out an AOB ATD, please reach out to the Front Office Coordination Team at bhsirisfrontofficesupport@ochca.com.

WHAT'S NEW?
(continued)

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- Note that we are awaiting the update of the DMC Billing Manual for information on what services these new providers can bill.
- Claims can be submitted for outpatient DMC-ODS day services (such as NTP dosing) where an LVN/LPT/MA may be providing a service.

Access the BHIN here:

https://www.dhcs.ca.gov/Documents/BHIN-24-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf

Documentation FAQ

1. The doctor can no longer bill for the time it takes to review the physical exam; do we still have to document that this was done?

Since it continues to be required that the physician review a copy of the client's physical exam, it will need to be documented. There needs to be some kind of evidence that points to this having been completed. A few examples of how physicians can evidence that this review took place are:

- Document a non-billable care coordination progress note
- Make a brief note on the copy of the physical exam that it was reviewed (include the physician's printed name, signature, date of signature).
- If a consultation with other members of the client's treatment team is needed as a result of the review, mention the completion of the review of the physical exam in the corresponding progress note.

2. Some billing codes indicate "per 15 minutes." Can I bill for a service if it is less than 15 minutes?

The minimum number of minutes needed to use the billable code in these cases is 8 minutes. This is because the midpoint (half of 15) must be met in order to use the billable code. Services that are less than 8 minutes should be coded using the corresponding non-billable code. This is not applicable for those service codes with a specified time range (i.e., 5-14 minutes, 26-50 minutes, etc.).

3. Who can bill in a Peer Support Services Program?

Only a Peer Support Specialist who has obtained a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and meet ongoing education requirements may claim for services in a Peer Support Services Program. The following are the required qualifications to be a Peer Support Specialist:

1. Be at least 18 years of age;

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Documentation FAQ (continued)

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2. Possess a high school diploma or equivalent degree;
3. Be self-identified as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver, or family member of a consumer;
4. Be willing to share their experience;
5. Have a strong dedication to recovery;
6. Agree, in writing, to adhere to a code of ethics;
7. Successfully complete the curriculum and training requirements for a Medi-Cal Peer Support Specialist; and
8. Pass a Medi-Cal Peer Support Specialist certification examination provided by a DHCS-approved certification program.

Medi-Cal Peer Support Specialists must provide services under the direction of a Behavioral Health Professional.

4. I'm an LPHA and will write up the Case Formulation with the non-LPHA in the consultation meeting. How do I bill for that?

The primary service in this scenario is the consultation between the LPHA and the non-LPHA. The Case Formulation is being completed during the consult, based on the content of the consultation, so it will be billed as part of the consult. This service would be billed as Targeted Case Management (70899-120).

Group Progress Note Documentation

The State has updated the requirements for the documentation of group counseling services. It is no longer required to include a description of how the service addressed the client's SUD needs. However, the State has made no change in requiring all claims to demonstrate medical necessity. One of the ways that we can clearly substantiate medical necessity is by explaining how the service addressed the client's SUD. Therefore, it is recommended that you continue to include this information. A clear statement or two about how the group will contribute to the client's recovery, such as what it will teach the client or help them to practice so they can maintain sobriety, may be sufficient.

The State suggests including information on the effectiveness of the intervention in documenting the client's response to the service. One way to do this could be to start with the intended purpose of the topic or content presented in the group session and to look at how the client did with that objective. For example, if the relapse prevention group was about the importance of identifying triggers, we may want to say how the client was or was not able to identify their triggers. We can use actual client quotes, comments, and reactions ("In response to the discussion about group members' experiences and common triggers, client stated not really knowing as he mostly just wants to use all the time."). Then, we can make a statement about why this is important or necessary for the client's SUD treatment ("Client seemed attentive as peers shared. It was important for client to hear examples from peers of their triggers and experiences so that he can reflect on potential triggers for himself and begin to pay greater attention to changes in the intensity of his cravings/urges to use.").

Billing Code Clarification

Patient Education groups are coded as Skills Training and Development, which the State has categorized as a Treatment Planning activity. As a result, the CPT Guide instructs for the use of the Non-Billable Treatment Planning code. However, going forward **when using the Non-Billable code for Skills Training and Dev, Group (70899-114) and Perinatal Skills Training and Dev, Group (70899-214), please use the NB SUD Group Counseling (70899-310)** so that it can be entered accurately in IRIS (with the number of clients and therapists).

Beneficiary Handbook Updated!

Please use the updated version, effective January 1, 2024.

Access it here:
https://www.ochealthinfo.com/providers-partners/authority-quality-improvement-services-division-aqis/quality-assurance-18

Remember, all clients accessing DMC-ODS services must be provided with a Beneficiary Handbook.

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

- EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- PAVE ENROLLMENT (MHP PROVIDERS ONLY)
- CHANGE OF PROVIDER/2ND OPINIONS (DMC-ODS)
- CAL-OPTIMA CREDENTIALING (AOA COUNTY CLINICS)
- GRIEVANCES & INVESTIGATIONS
- COUNTY CREDENTIALING
- ACCESS LOGS
- CLINICAL/COUNSELOR SUPERVISION
- MHP & DMC-ODS PROVIDER DIRECTORY

REMINDERS, ANNOUNCEMENTS & UPDATES

EXPIRED LICENSES, WAIVERS, CERTIFICATION AND REGISTRATIONS

When a provider's license has expired, the MCST sends an e-mail notification suspending the provider from delivering any Medi-Cal covered services. The e-mail requires an **immediate response** by the provider and/or administrator by the end of the business day to explain the reason for the lapse with the provider's credential. This is important information for the MCST to track and monitor. Be sure to respond promptly upon receiving the e-mail notification.

COUNTY RE-CREDENTIALING

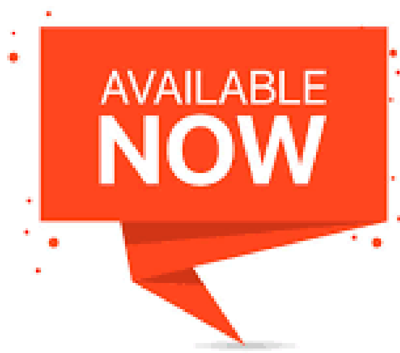
Providers are required to be re-credentialed every 3 years. The Credentialing Verification Organization, Verge/RLDatix sends e-mail notifications to providers 90 days in advance and then every week until the provider attest and provides the required documents needed to initiate the re-credentialing process.

There is a trend of provider's who have failed to complete the re-credentialing process upon the expiration and were suspended from delivering any Medi-Cal covered services. Once you receive a re-credentialing approval letter from MCST you must contact IRIS to petition for your credential suspension to be lifted to begin delivering Medi-Cal covered services. Your reinstatement is not automatic. **Be sure to re-credential your providers on-time by promptly responding to the Verge/RLDatix e-mail notifications!**

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

PROVIDER DIRECTORY

The provider directory template has been revised effective 10/27/23 to incorporate the new programs that joined the DMC-ODS network. All new programs are required to use the new template file name: Orange County Provider Directory Rev. 10.27.23.xlsm. All existing programs may continue using the prior provider directory template filename: Orange County Provider Directory Rev. 6.29.23.xlsm since the changes have no impact, at this time.



MONTHLY MCST TRAININGS – NOW AVAILABLE

MCST is now offering open training sessions effective **1/1/24** for new and existing providers. The 2-hour training will be on NOABDs, Grievances, Appeals and Access Logs.

Please e-mail AQISGrievance@ochca.com with Subject Line: MCST Training for MHP or DMC-ODS and a MCST representative will send you an e-mail invitation to attend the training via Microsoft Teams.

4th Tuesdays of the Month @ 1 p.m. MCST Training (DMC-ODS)

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **NEW** DMC-ODS programs are required to schedule a full-day training to comply with the MCST oversight and DHCS requirements. It is recommended to have the Directors, Managers, Supervisors and Clinical Staff participate in the training to ensure those requirements are met and implemented. Please contact MCST to schedule the training at least a month prior to delivering Medi-Cal covered services.
- If you and your staff would like a refresher on a specific topic or a full training about the MCST's oversight please e-mail the Health Services Administrator, Annette Tran at anntran@ochca.com and/or the Service Chief, Catherine Shreenan at cshreenan@ochca.com

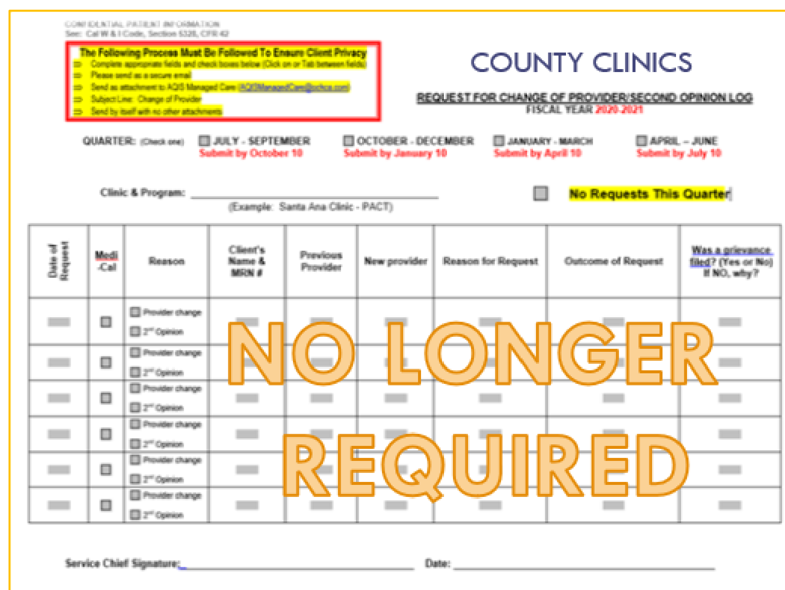
REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

CHANGE OF PROVIDER/2ND OPNION (COUNTY CLINIC PROVIDERS ONLY)

The Change of Provider/2nd Opinion PowerForm has been updated to help streamline the data collection for the DMC-ODS County Clinics and it will go into effect **1/1/24**. Some of the new changes include:

1. Reason for why there was a change of provider request (Required Field)
2. Was a grievance submitted? YES or NO (Required Field). If NO, an explanation as to why a grievance was not filed, is required.
3. Consolidating two of the nine categories for the primary reasons for request. The "Care & Treatment" and "Therapeutic Approach" categories were combined due to several items overlapping. The combined category is now renamed to **Care & Treatment Approach**.

Adding item #1 and #2 to the PowerForm eliminates the DMC-ODS County Clinic providers from having to submit the quarterly "Request for Change of Provider/2nd Opinion Log" (see example below). The additional data being collected in IRIS will help eliminate the reporting duplication.



The Following Process Must Be Followed To Ensure Client Privacy

COUNTY CLINICS

REQUEST FOR CHANGE OF PROVIDER/SECOND OPINION LOG

FISCAL YEAR 2020-2021

QUARTER: (Check one) ☐ JULY - SEPTEMBER Submit by October 10 ☐ OCTOBER - DECEMBER Submit by January 10 ☐ JANUARY - MARCH Submit by April 10 ☐ APRIL – JUNE Submit by July 10

Clinic & Program: ____________ (Example: Santa Ana Clinic - PACT) ☐ No Requests This Quarter

Date of Request	Medi-Cal	Reason	Client's Name & MRN #	Previous Provider	New provider	Reason for Request	Outcome of Request	Was a grievance filed? (Yes or No) If NO, why?
	☐	☐ Provider change ☐ 2nd Opinion						
	☐	☐ Provider change ☐ 2nd Opinion						
	☐	☐ Provider change ☐ 2nd Opinion						
	☐	☐ Provider change ☐ 2nd Opinion						
	☐	☐ Provider change ☐ 2nd Opinion						
	☐	☐ Provider change ☐ 2nd Opinion						

Service Chief Signature: ____________ Date: ____________

NOTE: County-Contracted Providers are **still** required to continue to submit the "Request for Change of Provider/2nd Opinion Log" every quarter since this feature is not available to non-IRIS users.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

CLINICAL/COUNSELOR SUPERVISION

Any of the status changes list below requires an updated Clinical/Counselor Supervision Reporting Form (CSRF) to be submitted to MCST.

- ✓ Change in Supervisor
- ✓ New Supervisee Registration #
- ✓ Termination in Supervision
- ✓ Name Change

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

Leads: Araceli Cueva, Staff Specialist Elizabeth "Liz" Fraga, Staff Specialist

CREDENTIALING AND PROVIDER DIRECTORY

Credentialing Lead: Elaine Estrada, LCSW
Cal Optima Credentialing Lead: Sam Fraga, Staff Specialist
Provider Directory Lead: Paula Bishop, LMFT

COMPLIANCE INVESTIGATIONS

Lead: Ashley Cortez, LCSW

CONTACT INFORMATION

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(714) 834-5601 FAX: (714) 480-0775

E-MAIL ADDRESSES

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

MCST ADMINISTRATORS

Annette Tran, LCSW
Health Services Administrator

Dolores Castaneda, LMFT
Service Chief II