SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

February 2024

WHAT'S NEW?

The Department of Health Care Services (DHCS) has issued **Behavioral Health Information Notice (BHIN) 24-007** in January, that emphasizes the federal and state requirements regarding communications with individuals with disabilities. The main points include:

- A DMC-ODS program must provide a member who is blind or visually impaired, and other individuals with disabilities (such as impaired sensory, manual, and speaking skills), with communication materials in the individuals' requested alternative format(s).
- Alternative format requests for Braille, audio format, large print, and accessible electronic format, such as a data CD, as well as requests for auxiliary aids and services must be accommodated.
- Provision of qualified interpreters is required, free of charge and in a timely manner, when such aids/services are necessary to ensure that individuals with disabilities have an equal opportunity to participate in programs.
- "Primary consideration" must be given to an individual's request of a particular aid or service.
- Providers must also furnish aids/services to a family member, friend, or associate of an individual or someone with whom it is appropriate for the provider to communicate.

Access the BHIN here:

https://www.dhcs.ca.gov/Documents/BHIN-24-007-Effective-Communication-Including-Alternative-Formats-for-Individuals-with-Disabilities.pdf

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

Coming Soon!

Updated DMC-ODS Documentation Manual

SUD Support Team

Chiyo Matsubayashi, MFT
Yvonne Brack, LCSW
Claudia Gonzalez de Griese, LMFT
Ashlee Al Hawasli, LCSW
Caroline Roberts, LMFT
Crystal Swart, LMFT
Emi Tanaka, LCSW
Susie Choi, MPH
Faith Morrison, Staff Assistant
Oscar Camarena, Office Specialist

CONTACT
aqissudsupport@ochca.com
(714) 834-8805

UPDATE

With CalAIM, the State has shifted to focusing on fraud, waste, and/or abuse to determine the need for disallowances and recoupments. You may have experienced that there are some issues that pose a situation that simply does not allow us to claim for services. The SST has updated the list of potential disallowances and recoupments to include information from recent findings. Please keep in mind that the list is not exhaustive.

continued on page 2...

Update (continued)

…continued from page 1

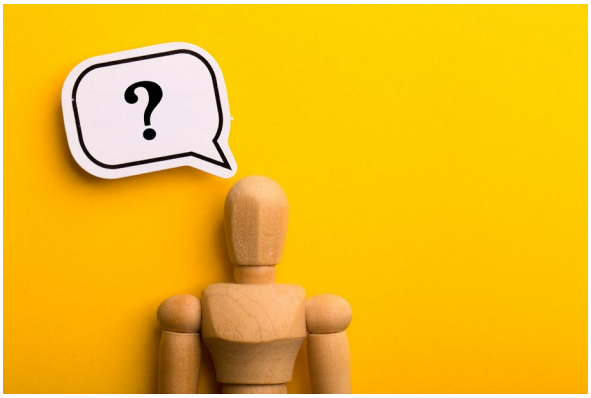
Potential Reasons for Recoupment:

1. Missing or invalid Assignment of Benefits Authorization to Disclose (AOB/ATD)
2. Services provided out of scope of practice
3. Services provided by a non-DMC certified provider
4. Services provided under a lapsed/expired license/credential/registration
5. Assessment services provided without the completion of required trainings (i.e., ASAM A and B)
6. Missing appropriate documentation of clinical supervision
7. No medical necessity established
8. Level of care determination not substantiated
9. A pattern or egregious instance of there being no initial assessment completed to justify the access criteria
10. A pattern or egregious instance of there being no problem list (or treatment plan, if applicable) when it is clinically appropriate and reasonable to expect that it be completed
11. No progress note for the date of service claimed
12. A pattern of templated documentation
13. Patterns in billing without appropriate substantiation (either of time or interventions provided)

Note: Depending on the issue, it is possible that a single service, multiple services, or all services in an entire treatment episode may be impacted. In most instances, the scale of the issue will need to be considered on a case-by- case basis.

One or Two Assessment Progress Notes??

Due to the time restrictions for some of the assessment services billing codes, there may be instances where two billing codes must be used to account for the entire duration of the service. For example, a 73-minute assessment service with the client to conduct the ASAM-based assessment where 30 minutes is claimed using the SUD Structured Assessment code and the remaining 43 minutes is claimed using the SUD Screening code. The State indicates that a progress note should be completed for each billing code. Therefore, it is advised that two separate progress notes are completed in these situations. Please be sure that there is one progress note per service billing code utilized. This also applies to different service types (e.g., individual counseling and care coordination) provided on the same day by the same provider.



Documentation FAQ

1. I work in a Residential program, why do I have to include the start and end times for progress notes?

Due to the State's licensing and certification requirements, providers at residential treatment programs are required to include the start and end times for the service on the progress notes. It also requires that the topic of the session or service is included for each progress note. If you are in the practice of completing a daily note, it is advised that start and end times as well as the topics for the services that will be included in the daily note be indicated to demonstrate compliance with this requirement. Historically, the start and end times for services being included in the documentation were implemented to address the rampant fraud across substance use treatment programs. Including the start and end times for all services is one way we can continue to actively promote the legitimacy of the services we provide!

2. Is there a billing code that can be used to claim care coordination services that are less than 8 minutes?

No. The Targeted Case Management (70899-120) code is "each 15 minutes." This means that the minimum number of minutes expected for the service is 15. The State allows for flexibility by allowing us to bill when the midpoint (half of 15) is met. Services that are 8 minutes or more should be coded using 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. If I provide transportation to a client so they can complete the required physical exam, is that billable?

No. Transportation alone, for any reason, is not a reimbursable activity – even if the purpose of the transportation is to help the client address problems on their problem list. It still remains that if a billable service is provided during the transportation, the time may be claimed.

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

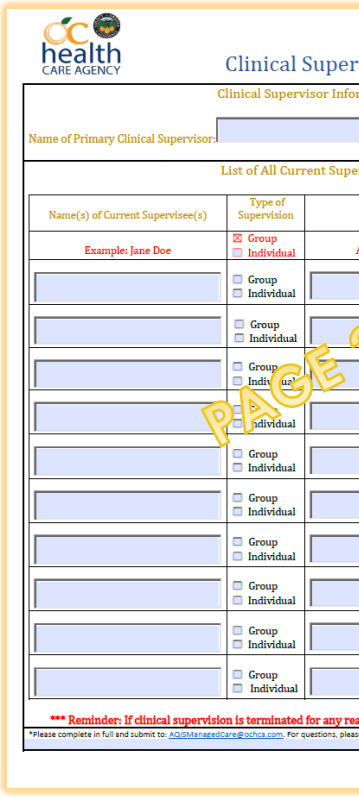
- EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- PAVE ENROLLMENT (MHP PROVIDERS ONLY)
- CHANGE OF PROVIDER/2ND OPINIONS (MHP/DMC-ODS)
- CAL-OPTIMA CREDENTIALING (AOA COUNTY CLINICS)
- GRIEVANCES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

REMINDERS, ANNOUNCEMENTS & UPDATES

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



Mental Health and Recovery Services
Quality Management Services

Clinical Supervision Reporting Form

Clinical Supervisor Information

Name of Primary Clinical Supervisor:

List of All Current Supervisees

Name(s) of Current Supervisee(s)	Type of Supervision	Program Name	Supervisee Classification
Example: Jane Doe	☒ Group ☐ Individual	AOA: Anaheim Clinic	ASW
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		

PAGE 2

*** Reminder: If clinical supervision is terminated for any reason, a CSRF with the end date is required.

*Please complete in full and submit to: AQSManagedCare@ochca.com. For questions, please contact QMS main line: 714-834-5601.

QMS Managed Care Support Team (Revised 8/2023)

- ✓ A supervisee who has individual and group supervision with two different clinical supervisors must submit **two** CSRFs.
- ✓ If the supervisee has the same clinical supervisor for both individual and group, then **one** CSRF is only required.
- ✓ Page 2 of the CSRF requires the Clinical Supervisor to list out their supervisees and re-submit when there is an update.
- ✓ All old versions of the CSRFs are invalid and will not be accepted. Be sure to use the newest version of the Clinical Supervision Report Form.
- ✓ Newest version of the Counselor Supervision Reporting Form.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

COUNTY EMPLOYEES ONLY

AUDITING TIMECARD CODING FOR CLINICAL SUPERVISORS

It is important for Clinical Supervisors to maintain proper supervisee documentation as part of the County requirement. Clinical supervision notes, weekly logs and/or records are subject to review and/or audit upon request (i.e., Human Resources, QMS, Auditor Controller, Program, etc.).

QMS and Human Resources recently conducted an audit of the clinical supervision hours claimed using the Clinical License Services (CLS) pay code on the timecards. As a reminder, it is important for Managers and Service Chiefs to maintain current records for clinical supervision, an updated Clinical Supervision Agreement (CSA) and/or the Clinical Supervision Reporting Form (CSRF) and reconcile the hours coded on the timesheet prior to approving it. This will assist MCST with concluding an accurate reconciliation when reporting the findings to Human Resources.

Remember, the CLS pay code shall only be coded for the hours dedicated to clinical supervision and that a Clinical Supervisor is certifying the Clinical Supervision Hours for a supervisee. Chart review, consultation, preparation, documentation review or other activities outside of the regularly scheduled individual and/or group supervision is **NOT** eligible to be claimed and coded to CLS. Clinical Supervision of interns and volunteers is **NOT** eligible for CLS, as well.

Refer to the 09.03.01 2003 Clinical Supervision Requirements P&P for more detailed information.

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 offering open training sessions effective **1/1/24** for new and existing providers. The 2-hour training will be on NOABDs, Grievances, Appeals, 2nd Opinion/Change of Provider and Access Logs.

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

2nd Tuesdays of the Month @ 1 p.m. MCST Training (MHP)
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.

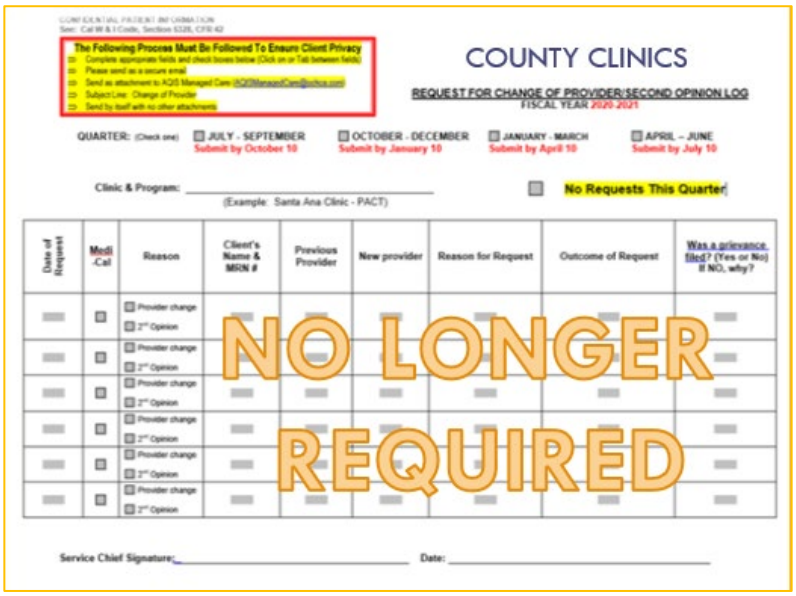
REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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 went 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.



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)

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 attests and provides the required documents needed to initiate the re-credentialing process.

There is a trend of providers 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!**

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: Ashley Cortez, LCSW

COMPLIANCE INVESTIGATIONS
Lead: Ashley Cortez, LCSW

CONTACT INFORMATION

400 W. Civic Center Drive., 4th floor
Santa Ana, CA 92701
(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