SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

June 2024

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Updates

Updates to IRIS to allow for the new provider disciplines eligible to provide DMC-ODS services, are not yet ready. **Services must be held for the following providers:**

- **LVN**
- **LOT**
- **LPT**
- **MA**
- **Clinical Trainees**

Be sure to refer to the CPT Guide for the service billing codes that are permitted to be

continued on page 2…

WHAT'S NEW?

The Department of Health Care Services (DHCS) has released version 2 of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Billing Manual. Most changes apply to the Outpatient levels of care (or, in some cases, for Residential/Withdrawal Management/NTP programs if a treatment day or dosing service is not claimed on that day).

Below is a summary of the most relevant changes that take effect July 1, 2024:

- Some duration/minute range changes
- Some changes to charge descriptions
- Changes to the prolonged service codes
- **H0001 Alcohol and/or drug assessment, 15 min (70899-103)** will now be used to account for time spent administering assessment activities, including the ASAM-based assessment (initial and re-assessment).
- **G2011/G0396/G0397 Alcohol and/or substance (other than tobacco) abuse structured assessment, 5-14/15-30/31-1440 min (70899-102/70899-100/70899-101)** will now only be used for brief screenings or assessments, such as the evidence-based MAT assessment.
- **H0049 Alcohol and/or drug screening, 15 min (70899-105)** should be used primarily for the Brief SUD LOC Screening Tool (applies also to the ART Team's use of the modified ASAM) or intake sessions where there may be minimal assessment activities due to time spent predominantly on legal intake paperwork.
- **90791/90792 Psychiatric diagnostic**

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Training & Resources Access

NEW! By 07/11/24, the Updated DMC-ODS Payment Reform 2024 - CPT Guide (version 2) will be posted on the DMC-ODS For Providers website under DMC-ODS Documentation Training:

DMC-ODS For Providers | Orange County California - Health Care Agency (ochealthinfo.com)

MAT Documentation Manual

CalAIM_MAT_Documentation_Manual_v2_11.8.23_FINAL.pdf (ochealthinfo.com)

NOTICE: Until there is an updated SUD Documentation Manual and Training, please refer to the most recent Documentation Manual, CPT Guide, and the monthly newsletters for the most recent changes! If you are unsure about the current guidance, please reach out to aqissudsupport@ochca.com

WHAT'S NEW? (continued)

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evaluation, 60 min (90791-1/90792-1) has changed from 15 to 60 minutes, which means a minimum of 31 minutes is needed to use these codes. H0001 Alcohol and/or drug assessment, 15 min (70899-103) should be used for services 30 minutes or less. For services 68 minutes or more, there is now a **T2024 Assessment substitute, 15 min (to be built in IRIS)**. Until this code is built in IRIS, services of 68 minutes or more should be coded using H0001.

- **T2021 Family therapy substitute, 15 min (to be built in IRIS)**. This new code is specific to family therapy code (90846, 90847) services that are 58 minutes or more and multi-family therapy code (90849) services that are 92 minutes more. Until this code is built in IRIS, family therapy services that exceed the maximum should be coded using T1006 SUD Family Counseling (70899-116).

For details on the above codes and the rest of the changes, please refer to the updated CPT Guide!

Please note:

- Charge descriptions may not reflect the new/updated charge descriptions. The changes needed in IRIS are being worked on. You can still select the service code in IRIS or enter the service code in Charge Entry.
- For services provided prior to July 1, 2024, you can select the new charge description (if it has been changed). The system will apply the correct rate calculation based on the date of service.

Updates (continued)

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used by the new provider groups.

The **2024-2025 Annual Provider Training (APT)** is now available! The deadline to complete this is July 25, 2024. Remember that even if you have just recently taken last year's APT, it is required for you to take the new one. Medical Directors, Physicians, and Program Administrators are required to take the APT. Please reach out to aqissudsupport@ochca.com for any questions.

Documentation FAQ

1. How should I document that the evidence-based MAT assessment was administered?

There is no specific place where the evidence-based MAT assessment must be documented. The important part is that it is documented somewhere in the chart to demonstrate that we have fulfilled this requirement. If the evidence-based MAT assessment was part of the intake process, the documentation in the intake progress note should include that this was completed. The time spent would be claimed as part of the intake service in this case. If the evidence-based MAT assessment has been administered as a standalone service (separate from an intake or other assessment service), this can be documented in the progress note to claim for the time. If the evidence-based MAT assessment is part of the ASAM-based assessment service, the documentation in the progress note to account for the time spent should also reflect that some of the time was spent administering this.

2. I consulted with my supervisor about my client's lack of progress in treatment. Is this billable?

A good rule of thumb is if the nature of the discussion is something that should and can be addressed in a clinical supervision meeting, it is not billable. Discussing a client's lack of treatment progress is an issue that should be discussed in clinical supervision. For urgent or time-sensitive situations that require consultation outside of regularly scheduled clinical supervision, it is possible that this may be a billable service. In such cases, it is important to justify the appropriateness of billing the consultation by emphasizing in the documentation the reason(s) the consultation is needed. It is also important to consider that if you are going to bill for the encounter, it cannot count towards your clinical supervision hours. Please be advised that if it is discovered that consultations claimed where the documentation appears to

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Documentation FAQ (continued)

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indicate the service is more appropriate as clinical supervision may need to be disallowed.

3. What kind of documentation is needed for drug testing?

All services claimed must have a corresponding progress note that demonstrates medical necessity. Each drug test administered must be documented, at minimum, with the type of service provided, date of service, duration of the service (direct client care), location of the service, description of the service (i.e., type of test administered, relevance to the client's SUD treatment, results, or outcome), next steps, rendering provider's name/credentials/signature, and date of signature. In addition to the documentation for each drug test performed, it is vital that there be documentation in the chart that speaks to the client's need for drug testing. Historically, drug testing in the substance use disorder treatment industry has been a significant source of fraud, waste, and/or abuse. Given this, along with the State's emphasis on recoupments based on fraud, waste, and/or abuse, we should exercise caution and diligence in our documentation. A few examples of where this documentation can be included is in the Case Formulation or LPHA write-up where an explanation of the client's service needs for the level of care indicated is explained or in progress notes for treatment planning services where the anticipated course of treatment is discussed with the client. If at some point in the treatment episode, a change in the frequency of the drug testing becomes necessary, there must be documentation on file to support this modification. Without this documentation of medical necessity, please be advised that drug testing services that appear to be excessive may be disallowed due to the potential for the appearance of fraud, waste, and/or abuse.

4. Can I bill for setting up a doctor's appointment for my client?

If it is for the purpose of care coordination, it may be billable. First and foremost, it is important that the documentation shows how this service addresses the client's SUD treatment needs. Remember, in general, scheduling an appointment does not require any clinical skills or credentials to perform and is typically considered a non-billable activity. Therefore, the documentation needs to clearly demonstrate the medical necessity for this service. This also means identifying the clinical need for you as the provider to assist the client in performing an activity that they are unable to do for themselves. Additionally, be sure that the amount of time claimed is proportional to what is described as provided.

Tips & Reminders

- *Re-Assessments at Residential:* For clients staying beyond the initial 30 days (and every subsequent 30 days), be sure there is documentation by the LPHA (i.e., Case Formulation as part of the re-assessment) that explains how the client continues to need the residential level of care.
- *Non-LPHA scope of practice:* For non-LPHA conducting the intake, it is important that the documentation does not appear as though the non-LPHA is making any determinations about the client's diagnosis or level of care placement. If the diagnosis or level of care placement is based on a preliminary consultation with an LPHA, this should be clearly indicated in the non-LPHA's documentation, so it is clear the non-LPHA is not practicing out of scope of practice. Remember that non-LPHAs can claim for assessment services using Z codes until the LPHA has established an SUD diagnosis.
- *Intake progress notes:* Make sure there is an intake progress note for every admit, for all levels of care. Transitions across levels of care at the same program should, in most cases, involve a standalone intake progress note.

For additional support...

County Clinics: For questions on billing in IRIS, such as correcting charge entries, contact the IRIS Liaison Team at bhsirisliaisonteam@ochca.com

Contract Providers: For questions about entering billing into IRIS or correcting charge entries, contact the Front Office Coordination Team at bhsirisfrontofficesupport@ochca.com.

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

COUNTY CREDENTIALING & RE-CREDENTIALING

new Department of Health Care Services (DHCS) recently indicated when a provider is hired for a provider type that does not require credentialing [e.g., Mental Health Rehabilitation Specialist (MHRS) or Other Qualified Providers (OQP)], then there is no requirement to follow the credentialing process as stated in the BHIN 18-019, established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214. This mean, even if the provider also happens to have a license, certification or registration in a discipline that is not what they were hired for, then they no longer need to be credentialed by the County.

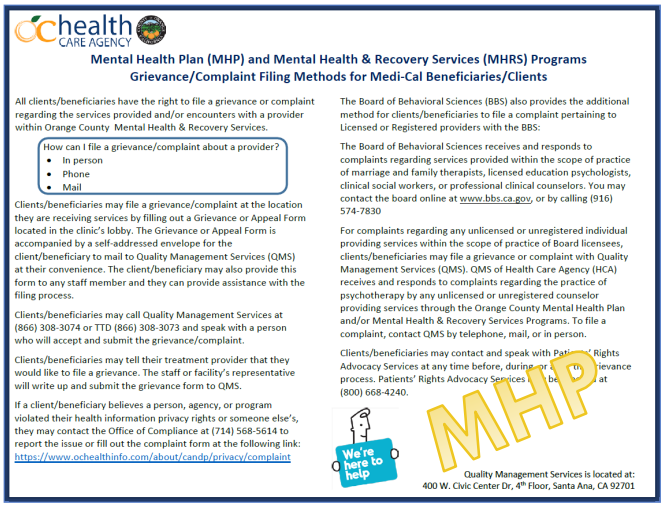
new AOD Counselors in the Mental Health Plan (MHP) are **NOT** permitted providers in the network. They do **NOT** need to be credentialed and will **NOT** be able to accrue hours towards their certification. If the provider meets the qualification for either a MHRS or OQP, then they may work within the MHP program under that limited scope. To determine if the provider meets either of those qualifications, please consult with your division QMS Support Team.

- All **new providers** must submit their County credentialing packet within 5-10 business days of being hired to the MCST. The newly hired provider must **NOT** deliver any Medi-Cal covered services under their license, waiver, registration and/or certification until they obtain a letter of approval confirming they have been credentialed by the MCST. This means the new hire must **NOT** provide direct treatment or supportive services to a beneficiary on their own nor document any services. The IRIS team will not activate a new provider in the IRIS system without proof of the credentialing approval letter. It is the responsibility of the direct supervisor to review and submit the new hire credentialing packet to the MCST.

- New employee who transferred from a non Medi-Cal site to a Medi-Cal site and requires a licensed, waiver, registration or certification for their job classification need to be credentialed, prior to delivering any Medi-Cal covered services.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

GRIEVANCES & APPEALS MATERIALS



ochealth CARE AGENCY

Mental Health Plan (MHP) and Mental Health & Recovery Services (MHRS) Programs
Grievance/Complaint Filing Methods for Medi-Cal Beneficiaries/Clients

All clients/beneficiaries have the right to file a grievance or complaint regarding the services provided and/or encounters with a provider within Orange County Mental Health & Recovery Services.

How can I file a grievance/complaint about a provider?
- In person
- Phone
- Mail

Clients/beneficiaries may file a grievance/complaint at the location they are receiving services by filling out a Grievance or Appeal Form located in the clinic's lobby. The Grievance or Appeal Form is accompanied by a self-addressed envelope for the client/beneficiary to mail to Quality Management Services (QMS) at their convenience. The client/beneficiary may also provide this form to any staff member and they can provide assistance with the filing process.

Clients/beneficiaries may call Quality Management Services at (866) 308-3074 or TTD (866) 308-3073 and speak with a person who will accept and submit the grievance/complaint.

Clients/beneficiaries may tell their treatment provider that they would like to file a grievance. The staff or facility's representative will write up and submit the grievance form to QMS.

If a client/beneficiary believes a person, agency, or program violated their health information privacy rights or someone else's, they may contact the Office of Compliance at (714) 568-5614 to report the issue or fill out the complaint form at the following link: https://www.ochealthinfo.com/about/candp/privacy/complaint

The Board of Behavioral Sciences (BBS) also provides the additional method for clients/beneficiaries to file a complaint pertaining to Licensed or Registered providers with the BBS:

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists, licensed education psychologists, clinical social workers, or professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830

For complaints regarding any unlicensed or unregistered individual providing services within the scope of practice of Board licensees, clients/beneficiaries may file a grievance or complaint with Quality Management Services (QMS). QMS of Health Care Agency (HCA) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services through the Orange County Mental Health Plan and/or Mental Health & Recovery Services Programs. To file a complaint, contact QMS by telephone, mail, or in person.

Clients/beneficiaries may contact and speak with Patients' Rights Advocacy Services at any time before, during or after the grievance process. Patients' Rights Advocacy Services can be reached at (800) 668-4240.

We're here to help

Quality Management Services is located at:
400 W. Civic Center Dr, 4th Floor, Santa Ana, CA 92701

MHP

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Drug Medi-Cal Organized Delivery System
Grievance/Complaint Filing Methods for Medi-Cal Beneficiaries

All Beneficiaries have the right to file a grievance or complaint regarding the services provided and/or encounters with a provider within the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS). This includes all services at all levels of care through the Orange County DMC-ODS

How can I file a grievance/complaint about a provider?
- In person
- Phone
- Mail

Beneficiaries may file a grievance at the location they are receiving services by filling out a Grievance or Appeal Form located in the program's lobby or other conspicuous location. The Grievance or Appeal Form is accompanied by a self-addressed envelope for the sender to mail to Quality Management Services (QMS) at their convenience. The beneficiary may also provide this form to any staff member, and they can provide assistance with the filing process.

Beneficiaries may call Quality Management Services at (866) 308-3074 or TTD (866) 308-3073 and speak with a person who will accept and submit the grievance/complaint

Beneficiaries may tell their treatment provider that they would like to submit a grievance. The staff or facility's representative will write and submit the grievance to QMS

If a beneficiary or participant believes a person, agency, or program violated their health information privacy rights or someone else's, they may contact the Office of Compliance. Beneficiaries and participants may call the Office of Compliance at (714) 568-5614 to report an issue or fill out the complaint form at the following link: https://www.ochealthinfo.com/about/candp/privacy/complaint

The California Board of Behavioral Sciences (BBS) also provides the additional method for the public to file a complaint pertaining to Licensed or Registered providers with the BBS:

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists, licensed education psychologists, clinical social workers, or professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830

For complaints regarding any unlicensed or unregistered individual providing services within the scope of practice of Board licensees, beneficiaries may file a grievance or complaint with Authority and (QMS). QMS of Health Care Agency (HCA) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services through the Orange County Drug Medi-Cal Organized Delivery System. To file a complaint, contact QMS by telephone, mail, or in person.

Complaints regarding Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities and Alcohol and other Drug (AOD) counselor complaints may be made by contacting the Substance Use Disorder (SUD) Compliance Division of the California Department of Health Care Services (DHCS) by telephone toll free at (877) [illegible]-8333. The Complaint Form is available and may be submitted online at the following link: https://www.dhcs.gov/[illegible]/Pages/SUD-Complaints.aspx

We're here to help

Quality Management Services is located at:
400 W. Civic Center Dr, 4th Floor, Santa Ana, CA 92701

DMC-ODS

- The Grievance/Complaint Filing Methods for Medi-Cal Beneficiaries can be given upon intake. Be sure to check your program's process and provide it to the beneficiary upon their initial entry into services and when they are inquiring about the various filing methods to complete a grievance.
- This form along with some of the threshold languages can be found on the QMS website.

PROVIDER DIRECTORY

- There is a trend of programs not accurately reflecting the staffing pattern of the provider's listed on the monthly Provider Directory. Program Administrators must review and ensure the accuracy of the information on the spreadsheet prior to submitting it on the 15th of the month. Inaccurate reporting results in reconciliation errors and potential compliance issues. Please double check your submission before sending it to MCST!
- Another trending issue, is with programs not submitting their provider directory every month or submitting it past the 15th of the month deadline. The Provider Directory is a DHCS network and accessibility requirement indicated in the BHIN18-020. If the program has three consecutive months of missing or late submissions it will result in a formal Notice of Deficiency to correct the issue.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

PROVIDERS TYPES NEWLY ELIGIBLE TO CLAIM FOR SERVICES EFFECTIVE 7/1/23:

MHP	DMC-ODS
• Medical Assistant* • Nurse Practitioner/Clinical Nurse Specialist Clinical Trainee** • Psychologist Clinical Trainee** • Clinical Social Worker (LCSW) Clinical Trainee** • Marriage and Family Therapist (MFT) Clinical Trainee** • Professional Counselor (LPCC) Clinical Trainee** • Psychiatric Technician Clinical Trainee** • Registered Nurse Clinical Trainee** • Vocational Nurse Clinical Trainee** • Occupational Therapist Clinical Trainee** • Pharmacist Clinical Trainee** • Physician Assistant Clinical Trainee** • Medical Student in Clerkship (Physician Clinical Trainee)**	• Medical Assistant* • Occupational Therapist • Licensed Vocational Nurse • Licensed Psychiatric Technician • Nurse Practitioner Clinical Trainee** • Psychologist Clinical Trainee** • Clinical Social Worker (LCSW) Clinical Trainee** • Marriage and Family Therapist (MFT) Clinical Trainee** • Professional Counselor (LPCC) Clinical Trainee** • Psychiatric Technician Clinical Trainee** • Registered Nurse Clinical Trainee** • Vocational Nurse Clinical Trainee** • Occupational Therapist Clinical Trainee** • Pharmacist Clinical Trainee** • Physician Assistant Clinical Trainee** • Medical Student in Clerkship (Physician Clinical Trainee)**

* **Medical Assistants** must be under the supervision of a licensed physician or surgeon, or to the extent authorized under state law, a nurse practitioner or physician assistant that has been delegated supervisory authority by a physician and surgeon. The licensed physician or surgeon, nurse practitioner, or physician assistant **MUST** be physically present in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant, per the State Plan Amendment (SPA) 23-0026. If, the Medical Assistant does **NOT** have the required supervision on-site they will **NOT** be able to deliver any Medi-Cal covered services within that scope of practice.

** **Clinical Trainee** is an unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Practitioner of the Healing Arts; is participating in a practicum or internship approved by the individual's school/program; and meets all relevant requirements of the school/program and/or the applicable licensing board to participate in the practicum or internship and provides rehabilitative mental health services or substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements.

CLINICAL/COUNSELOR SUPERVISION REPORTING FORM

The State Plan Amendment (SPA) 23-0026 has added more rendering provider types (see above). Therefore, DHCS expects the County to account for tracking, logging and determining the type of supervision required for these newly eligible providers claiming for services. This requires MCST to revise the supervision reporting forms to include clinical trainees, medical professionals and other qualified provider types. MCST is working on revising the forms and will have it available, as soon as possible.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

CHANGE OF PROVIDER/2ND OPINION

When a beneficiary is requesting a change of provider or a 2nd opinion a grievance should be filed based on the situations listed below:

DO FILE A GRIEVANCE

If the beneficiary reports:

- ✓ Personality Conflict (e.g., not a good fit, rude, disrespectful, didn't feel heard, discriminated against, etc.)
- ✓ Quality of Provider Service (e.g., saw me for 5 minutes, didn't give me the medication I need, not able to reach provider, etc.)

Do's

DON'T FILE A GRIEVANCE

If the beneficiary reports:

- ✓ Language preference
- ✓ Gender preference
- ✓ Requesting a provider with a specific license, certification or registration
- ✓ Requesting a specific modality of treatment

Don'ts

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 or 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** MHP and DMC-ODS programs are required to schedule a full 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 MCST's oversight please e-mail the Health Services Administrator, Annette Tran at anntran@ochca.com and the Service Chief II, Catherine Shreenan at cshreenan@ochca.com.

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS

- When the provider's license, certification or registration expires MCST immediately sends a notification e-mail suspending the provider from delivering any Medi-Cal covered services. If the provider still has not renewed their license within 3 months a follow-up e-mail will be sent to inquire on the status and if the expired credentials continues beyond 6 month the provider's County Credential will become deactivated. This will require the provider to undergo the credentialing process all over again upon receiving their renewed or newly issued credentials from their certifying organization.

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

CLINICAL SUPERVISION
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, LCSW

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 Leads: Elaine Estrada, LCSW Sam Fraga, Staff Specialist

COMPLIANCE INVESTIGATIONS
Lead: Catherine Shreenan, LMFT

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

Catherine Shreenan, LMFT
Service Chief II