SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

April 2024

SUD Support Team

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Update

(More) Changes are coming! We are anticipating that the State will be announcing updates to their billing manual in the next few months. Please note that this will likely lead to changes in how and what billing codes can be used. There is nothing different that needs to be done at this time – please continue with our current understanding. We will provide guidance as soon as possible when it becomes

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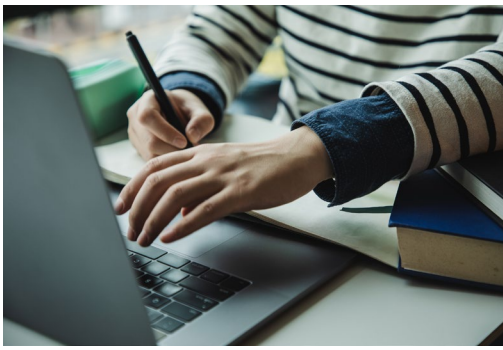
WHAT'S NEW?



Welcome aboard, Erika!

Erika Hayden has joined the Substance Use Disorder (SUD) Support Team as a Quality Improvement and Compliance Consultant. You will be seeing Erika participate in the Clinical Chart Reviews to assist in monitoring activities. She will also be assigned to some of our County and County-contracted providers to offer support for our compliance with State and Federal regulations. Here is some information about Erika to get to know her:

"I am a licensed Marriage and Family Therapist. Most recently I worked with Children Youth Services Outpatient Programs North Region. Previously I also worked with CYS Specialized Programs CEGU Probation and Youth Reporting Center. I obtained my Bachelor's Degree in Psychology and Master's Degree in Counseling from California State University, Fullerton. I enjoy spending time with my family and friends, watching my boys play soccer and baseball and reading love stories. I look forward to working with our providers and building collaborative relationships."

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

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

Update (continued)

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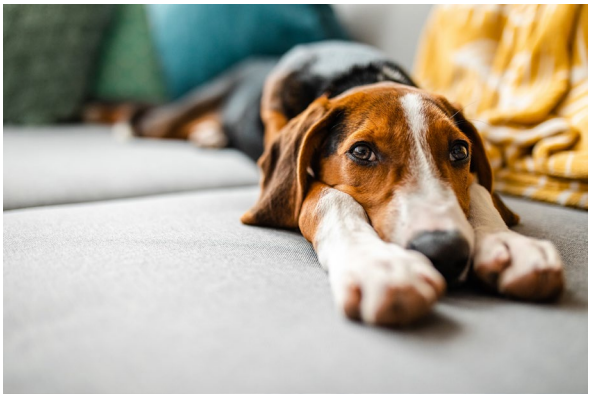
available.

For County EHR-users ONLY: You may have noticed that when you complete a SUD Re-Assessment document in the EHR and wish to document a change in the level of care without a diagnosis change, it does not allow you to enter information in the Case Formulation section. The issue has been rectified and any future Re-Assessment documents will allow you to complete the Diagnosis and Case Formulation when you choose "Change in LOC." Any Re-Assessment forms opened or started prior to 4/22/24 will not allow you to fill in the Case Formulation section when you select "Change in LOC." As a reminder, the Case Formulation is not required when changes are only necessary for a client's diagnosis and not the level of care. Any modifications solely to a client's diagnosis can be documented in a session progress note where this was discussed, addressed, or determined.

Collateral vs. Care Coordination

Although we may provide resources, referrals, and linkages to significant individuals in the client's life, such services are considered collateral services and should not be billed as care coordination. All services claimed involving family or significant individuals in the client's life must center around the client and their treatment needs. Oftentimes, such activities are provided as part of discharge planning and supporting the client's preparation to leave treatment, return home, or simply reinforce what the client is gaining from treatment. It is likely that part of the discussion with the individuals in the client's life involves the ways that those individuals can aid in the client's ongoing recovery efforts outside of treatment. Be sure that the documentation makes clear how the encounter is medically necessary for the client's SUD treatment. The SUD Family Counseling (70899-116) code can be utilized for such encounters. For the residential and withdrawal management levels of care, family and collateral work is included in the daily bundle of services with no additional billing on top of the treatment day.



Documentation FAQ

1. What is the assessment timeline for the Withdrawal Management levels of care?

Due to licensing and certification requirements, the timeline for the assessment at Withdrawal Management is within seventy-two (72) hours of the client's admission. However, a full assessment is not required. A brief screening or assessment tool, such as the County's SUD Brief LOC Screening Tool is sufficient. This may be completed by a non-LPHA or LPHA. However, if completed by a non-LPHA, there must be a consultation with an LPHA to establish the diagnosis and level of care placement. This consultation must be documented. To bill for the consultation, a progress note is required. Additionally, the LPHA must also document a narrative that explains how the level of care placement was determined. This may be done in a progress note or another standalone document. Be sure it is clear in the chart documentation that it was the LPHA who diagnosed the client. The documentation by the LPHA is necessary because the LPHA is the only provider able to diagnose and determine the level of care placement. Please also be mindful of the scope of practice of the LPHA as there are some disciplines (such as the Registered Nurse or Licensed Vocational Nurse) who are not eligible to diagnose and determine the level of care placement in the ODS.

2. Is a consultation between a non-LPHA and LPHA regarding a client's problem list or treatment plan billable?

If the consultation is medically necessary, it is billable. Time spent in the consultation is billable by both parties if each provider documents in a progress note. The billing code that should be used to claim for consultations is the Targeted Case Management (70899-120) code. The documentation needs to clearly indicate why the consultation was medically necessary and what the result of the consultation was. Remember, review of documents is not a billable activity, so simply reviewing a problem list or treatment

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Documentation FAQ (continued)

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plan is not billable. Therefore, the consultation documentation must reflect what the discussion involved about the need to review or discuss the problem list or treatment plan that is pertinent to the client's course of treatment, such as how the problems will be addressed, what interventions or services may be necessary, etc.

3. I completed an assessment session for my outpatient client that was 78 minutes...how do I bill for this?

At this time, the SUD Structured Assessment codes have been designated by the State for use in claiming time spent on conducting the ASAM Assessment. However, the SUD Structured Assessment, 30 Minute (70899-101) code for assessment services that are 31 minutes or more, is limited to a maximum of one unit by the State. This means that whether the service is 31 minutes or 91 minutes, the reimbursement is the same. Therefore, to account for the entire duration of an assessment service, two codes will need to be used. The first 31 minutes can be claimed using the SUD Structured Assessment, 30 Minute (70899-101) code and the minutes beyond 31 minutes can be claimed using the SUD Screening (70899-105) code (or in the example above, 47 minutes). In such cases, there will need to be two progress notes completed because two separate billing codes are used.

4. If two counselors meet with a client together for a service, can both bill the total time?

Both parties billing for the total service time is only applicable for general consultations. Clinician Consultations can only be claimed by the rendering provider. For all other types of services, the total time cannot be claimed by both providers. If, for example, there are two providers meeting with a client for an individual counseling service, each provider may document their own progress note, however, each may only account for part of the total time. The time should be split so that the time claimed by each provider is for the part of the service that they contributed to. The documentation should clearly show what the provider did or the interventions that were provided. It is also important to include in the documentation the reason or the need for the service to be conducted by two providers, such as how it benefits or addresses the client's treatment needs.

Are there questions or topics that you'd like to see addressed in the monthly SUD Newsletter? Feel free to reach out to your assigned consultant or let us know at aqissudsupport@ochca.com.

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

Tips & Reminders

- ***Excessive documentation time:*** Even though documentation time is not billable to the State, contract providers are getting reimbursed this fiscal year for documentation time. Please keep in mind that the time needs to be justified by the amount of writing evident in the progress note.

- ***Multiple encounters in one day:*** The State requires one claim for multiple instances of a service type provided on the same day (except for groups) by the same provider. Thus, one progress note is sufficient. However, keep in mind that we cannot provide duplicative services, which means that each encounter must meet medical necessity as a standalone service. This will need to be clear in the documentation.

- ***Review of documents:*** This is not billable for non-LPHA, regardless of whether it is medically necessary or not. For LPHA to bill for the time spent reviewing documents, the purpose must be for establishing, confirming, or changing a client's diagnosis. Be sure the purpose is clearly documented in the progress note.

- ***Don't forget to sign:*** Although there is no disallowance for simply missing the provider's signature, it remains an important part of documentation. The provider's signature is their attestation of what is documented. This is particularly important for assessment documents that include the contributions of multiple providers (i.e., non-LPHA and LPHA). The LPHA's signature is confirmation of their determination of a diagnosis and/or level of care placement.

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

MCST REQUIREMENTS FOR PROGRAMS THAT ARE CLOSING OR MERGING

When a program plans on closing or merging, Quality Management Services (QMS) must be notified. The MCST requires the program to complete the following:

- ✓ Clinical Supervision Report Form (CSRF) – a CSRF must be completed by the clinical supervisor to terminate supervision or change to a new clinical supervisor.
- ✓ NOABDs – submit any pending NOABDs issued to the beneficiary. An NOABD Termination is not required if the beneficiary is transferring within the network to continue services.
- ✓ Access Log – enter any pending access log entries and run the Access Log report to correct all errors and issue NOABD Timely Access (if applicable). Existing beneficiaries transferring within the network to continue services do not require an access log entry.
- ✓ Provider Directory – submit the spreadsheet that will identify all the staff separating and/or transitioning to other locations within the entity. The MCST will utilize the updated provider directory to deactivate credentialed providers who have separated from the program or update the providers information for those that have transitioned to a new location within the entity.
- ✓ Credentialing – submit an updated Insurance Verification Form and New Application Request Form (NARF) for the sites that will be taking on the existing providers at the new locations within the entity.
- ✓ Change of Provider/2nd Opinion – submit the quarterly log prior to the closure of the County-Contracted program only.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

PROVIDER DIRECTORY

Friendly reminder, do NOT tamper with the provider directory spreadsheet formulas and validations. We will require the program to resubmit their information using the correct spreadsheet. MCST and IRIS require accurate data collection to track and monitor all the providers information.

- If a provider is dually licensed, they should be listed consecutively on the **Providers tab** and indicate whether the license is "primary" or "secondary" under the column **New or Inter-Agency Transfer Comments**. See example below:

PROGRAM NAME: _____ PROGRAM ADDRESS: _____

Provider Name Last Name, First Name	Provider Status	Effective Date	New or InterAgency Transfer Comments	Is this Provider accepting new beneficiary referrals?	Provider Type	License Number #####	Certifying Organization Name	License Expiration Date
Example: Smith, John	LOA End	04/01/2023	Provider returning from LOA that started 2/1/23	Yes	APCC - Associate Professional Clinical Counselor	12345	Board of Behavioral Sciences (BBS)	04/01/2024
Jones, Sam	Active		Primary License		APCC - Associate Professional Clinical Counselor	12234345	Board of Behavioral Sciences (BBS)	01/01/2024
Jones, Sam	Active		Secondary License		ASW - Associate Clinical Social Workers	23442522	Board of Behavioral Sciences (BBS)	01/01/2024

Program | Providers | Student Interns, MHS, MHW

- If a provider is transferring from within the same agency to another location, it would be identified as **Interagency Transfer** (not as "separated"). Also, in the column **New or Inter-Agency Transfer Comments**, you must enter the site location the provider is transferring from and to. Both sites would indicate the interagency transfer on the monthly provider directory. See example below:

PROGRAM NAME: _____

Provider Name Last Name, First Name	Provider Status	Effective Date	New or InterAgency Transfer Comments	Is this Provider accepting new beneficiary referrals?
Example: Smith, John	Interagency Transfer	04/01/2023	CRP Telecare South to CRP Telecare North	Yes

CLINICAL SUPERVISION (COUNTY ONLY)

Service Chiefs can now reach out to Behavioral Health Training Services (BHTS) to find someone to clinically supervise a license-waivered staff. Please e-mail Michael Mullard at mmullard@ochca.com or Giselle Rocha at grocha@ochca.com to help you find a clinical supervisor. Remember, all license-waivered staff must receive weekly supervision and be in clinical supervision until they become licensed.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

COUNTY CREDENTIALING & RE-CREDENTIALING

- 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.

- **Certified Peer Support Specialists** registered with the certifying organization, CalMHSA, must be credentialed. Be sure to submit a credential packet to the MCST to be County credentialed.

CalMHSA
California Mental Health Services Authority

- The County's Credentialing Verification Organization, VERGE/RLDatix, will be sending e-mail notifications **120 days** prior to re-credentialing. The request is to obtain the most current e-mail addresses on file upon the initial credentialing which occurred three years ago. It is important to have the providers respond to the e-mail within **one (1) business day** to confirm their primary e-mail, employer's agency name, direct supervisor's name and supervisor's e-mail for the various agencies the provider is currently employed with. Updating this information will help with the re-credentialing process and prevent any delay or suspension with the re-credentialing process.

- Providers are required to be re-credentialed every 3 years. The Credentialing Verification Organization, Verge/RLDatix, sends an e-mail notification 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. Be sure to re-credential your providers on-time by promptly responding to the Verge/RLDatix e-mail notifications!

NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)

Department of Health Care Services (DHCS) requires a Termination NOABD to be mailed to the last known address of the deceased beneficiary within two (2) business days.

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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 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 the Service Chief II, Catherine Shreenan, at cshreenan@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
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

Catherine Shreenan, LMFT
Service Chief II