SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

March 2024

SUD Support Team

Chiyo Matsubayashi, LMFT
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

You may have noticed that the most recent Behavioral Health Information Notices (BHINs) from the Department of Health Care Services (DHCS) have not included specific guidance on discharge plans and discharge summaries. The State has provided clarification that **there is no longer an explicit requirement for discharge plans and discharge summaries for the DMC-ODS.** Although not required, it is best practice to document a discharge summary for all

continued on page 2…

WHAT'S NEW?

Behavioral Health Information Notice (BHIN) 24-001 established the inclusion of new disciplines that are eligible to provide Drug Medi-Cal Organized Delivery System (DMC-ODS) services, which includes Medical Assistants (MAs). As previously mentioned, we are not able to bill for services provided by the new disciplines at this time (claims must be held or be denied and then resubmitted later). However, there are some important pieces of information that you need to know if you plan on utilizing Medical Assistants in your programs:

- An individual must be at least 18 years of age and meet all applicable education, training, and/or certification requirements.
- They may provide basic administrative, clerical, and non-invasive routine technical support services, within their scope of practice, under the supervision of a licensed physician and surgeon or a nurse practitioner/physician assistant delegated supervisory authority by a physician or surgeon.
- The licensed physician and surgeon, nurse practitioner, or physician assistant must be physically present in the treatment facility during the provision of services by a MA.
- MA training documentation maintained on site must include the following: A) Diploma or certification from an accredited training program/school, or B) Letter/statement

continued on page 2…

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

Update (continued)

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clients who have been admitted. If your program must abide by requirements for other accrediting and regulatory bodies (i.e., AOD Certification Standards, SUBG, etc.), please follow up with your program administrators as you may need to continue completing them. Additionally, keep in mind that your program may have used the discharge summary as part of your internal procedures for closing a client's case or episode of care, which may require you to continue with the practice of completing a discharge summary for all clients who have been admitted. Again, please follow up with your supervisor or program administrator for further guidance.

WHAT'S NEW? (continued)

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from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. C) Evidence of training or attendance at state audiometric training and vision training is documented.

MA Scope of practice DHCS 4493 (07/12) Reviewer Guidelines (ca.gov).

- Administration of medications permissible is the direct application of pre-measured medications orally, sublingually, topically, vaginally, or rectally, by providing a single dose to a patient for immediate self-administration, by inhalation or by simple injection. In every instance, prior to administration of medication by the MA, a licensed physician, or another person authorized by law to do so shall verify the correct medication and dosage.
- Administration of injections or scheduled drugs, including narcotic medications, is permitted only if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular. All medications administered by an MA must be specifically authorized by the supervising physician, which means a specific written order or standing order prepared by the supervising physician. To administer medications by intramuscular, subcutaneous, and intradermal injection, to perform skin tests or venipuncture for the purpose of withdrawing blood, an MA must have completed at least the minimum amount of training hours established in Title 16, section 1366.1.
- MAs are NOT permitted to place an intravenous (IV) needle, start, or disconnect the IV infusion tube, administer medications or injections into an IV line, or administer anesthesia.

Documentation FAQ

1. What billing codes do I use for Recovery Services?

With Payment Reform, there are now specific service billing codes to be used for Recovery Services:

- Community Support Svcs, per 15 Min (70899-121)
- Psychosocial Rehabilitation, Indv, per 15 Min (70899-122)
- Psychosocial Rehabilitation, Group, per 15 Min (70899-123)
- Recovery Svcs, 1 Hr (70899-124)

For all care coordination activities provided to a client in Recovery Services, the Community Support Services code should be used. Assessment, collateral, and individual/family counseling services should be claimed using the Psychosocial Rehabilitation code specific to individual. All groups conducted at Recovery Services should be claimed using the Psychosocial Rehabilitation group code. The State has not provided any guidance on the specific use of the Recovery Services, 1 hour code. It may be used for individual counseling services that are one hour in duration.

2. Are there timelines for the Residential level of care for completing assessments?

Yes, the timeline for completing assessments at the residential levels of care is within 72 hours of the client's admission. However, this is regarding the "multidimensional level of care assessment," which the State indicates does not need to be the full ASAM-based assessment. Rather, it is a brief screening or assessment tool for the purpose of determining whether prior authorization for the residential level of care is appropriate. For example, the Authorization for Residential Treatment (ART) team conducts a brief ASAM assessment for authorizing clients. If a client is coming to your residential program through the ART, with a brief assessment, then the residential provider will be expected to complete a full ASAM-based assessment as quickly as clinically possible after admission. Due to the short length of stay and intensity of level of care needs, it is advised that you document the

Continued on page 3…

Documentation FAQ (continued)

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reason for any delays in the completion of the full ASAM-based assessment. If you are admitting a client directly into your program (not through ART), it is recommended that the full ASAM-based assessment be completed as soon as clinically possible.

3. What does the State mean by, "If information is located elsewhere in the clinical record, it does not need to be duplicated in the progress note?"

This means that if it is already documented, it does not need to be documented again. For example, it is not necessary to document all the assessment information gathered in a session with the client in the session progress note if it is going to be documented in the SUD Assessment form. Or, in the case of the LPHA, the case formulation information does not need to be included in the progress note to account for the time that was claimed to complete it. In this case, the duration of time claimed should be substantiated by what is documented in the actual case formulation. Thus, it is sufficient to simply explain in the progress note that the time spent was for the purpose of synthesizing the assessment information to establish the appropriate level of care placement for the client.

Treatment Planning

Treatment planning is not the same as a treatment plan.

Treatment planning is any activity associated with determining the course of treatment. This includes using the information we have about our clients (either obtained in an encounter or through the completion of an assessment) to identify appropriate and necessary interventions and services. It is a collaborative process that engages the client in a discussion about what they need help with and are desiring to gain from participating in treatment. This requires the provider to find a balance between what the client is looking for and what appears to be needed clinically, based on our professional impressions of the client. What is discussed is then translated into identified problems or issues that are addressed on a treatment plan or problem list.

Even if your program is no longer required to meet treatment plan requirements, you are still going to be doing treatment planning. The DMC-ODS requirement for a problem list still necessitates treatment planning in the sense that there is dialog that will need to happen with the client (and other significant individuals in the client's life) to decipher what will be added or not added to the problem list.

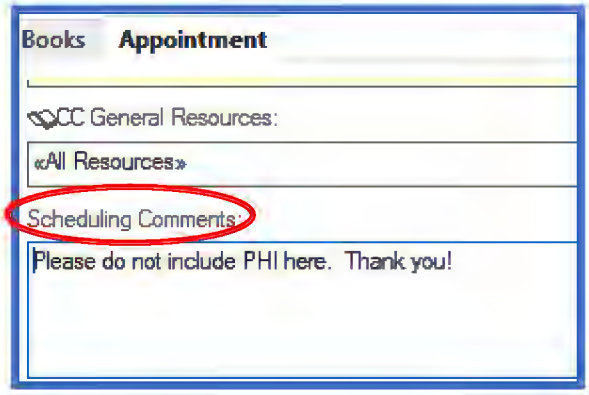
Sessions conducted with the client for these treatment planning activities are billable at the outpatient levels of care using the SUD Treatment Plan Development and Modification (70899-125) code.

Tips & Reminders

- "Supervising" a client: Remember that just supervising a client is a non-billable activity as it does not require someone with a license/credential to provide. We can only bill for those services that are medically necessary.
- *Evidence-based MAT assessment:* Don't forget to document that the assessment to determine the need for a MAT referral has been conducted within 24 hours of the client's admission.
- *Residential providers receiving clients through the ART team:* The required MAT assessment for a referral should be completed once the client enters your program. The 24-hour timeline begins upon admission to the residential program.
- *Problem lists:* Don't forget to indicate the name and credentials of the provider who is adding/resolving an issue and the date on which this is done.
- *Re-Assessments:* Remember, to justify a change in level of care, the LPHA needs to provide documentation (i.e., case formulation) as part of a re-assessment. For the residential levels of care, it is advised that the LPHA confirm the client's need for ongoing care at the residential level with the appropriate documentation.

Protected Health Information (PHI) in Scheduling Comments in SCHED

Please do not enter PHI in the Scheduling Comments in SCHED. The IRIS team has recently found that PHI is occasionally being entered into the Scheduling Comments box in SCHED. This may have been done to either assist front office staff with setting up appointments or for intake clinicians when preparing for sessions. The important thing to know is that the information can be easily viewed by those who may not have a business reason to view this information. In addition, IT is unable to track who may access this information. For these reasons, ***please do not enter PHI in the Scheduling Comments box***.



The Office of Compliance created a helpful guide, "PHI in EHR Scheduling Comments", to assist clinicians on what CAN be entered in the Scheduling Comments, which is in this newsletter for your reference.

Thank you all so much for helping us to continually improve the EHR! If you have any questions or need further information, please contact us at bhsirisliaisonteam@ochca.com.

DEBRA BAETZ, MBA
INTERIM AGENCY DIRECTOR

KELLY K. SABET, LCSW, CHC, CHPC
CHIEF COMPLIANCE OFFICER

405 W. 5th STREET, SUITE 212
SANTA ANA, CA 92701
PHONE:714-568-5614
FAX:714-834-6595
Email:officeofcompliance@ochca.com

OFFICE OF COMPLIANCE

PHI in EHR Scheduling Comments

HIPAA Reminder: Minimum Necessary Standard

- Concept of increased confidentiality
- Define the "need to know," instead of releasing "all" information
- Use, disclose, and request only the minimum amount of PHI necessary to accomplish the purpose intended

Using the Minimum Necessary Standard also applies to scheduling. The purpose of the scheduling comments in the EHR is not to identify PHI, however, there has been an increase in the amount of PHI that is being included in the scheduling comments that warrants additional clarification.

PHI can be in any form: written, spoken, or electronic and includes at least one of the 18 personal identifiers listed below when combined with:

- Information about a patient's
  - health or condition,
  - health care, or
  - payment for health care services.
- Or, genetic information about a patient or their relatives.

Name	Address (all geographic subdivisions smaller than state, including street address, city, county, ZIP code)	All elements (except years) of dates related to an individual (including birth date, admission date, discharge date, date of death and exact age if over 89)
Telephone Numbers	Fax number	E-mail address
Social Security number	Medical Record number	Health plan beneficiary number
Account number	Certificate/license number	Any vehicle or other device serial number
Device identifiers or serial numbers	Web URL	Internet Protocol (IP) address numbers
Finger or voice prints	Photographic images	Any other characteristic that could uniquely identify the individual

The information shared in the scheduling comments is available to view by all who have access to scheduling. What this means is that individuals who do not "need to know" the PHI pertaining to the client being scheduled can now access this information.

Users should utilize the appropriate documentation resources such as the Access Log or Progress Note to document the interaction and purpose of scheduling. When those options are not applicable and the user needs to relay information to the program being scheduled with, they can follow up with an encrypted email, fax, or phone call. This should not be justification to include PHI in the scheduling comments.

Appropriate examples of information that can be included in the scheduling comments include:

- Phone number the client can be reached at if it is not possible to update the client's phone number in the system
- Reminders to obtain an ATD (without the mention of what the ATD is for), complete the Care Plan, obtain intake paperwork, and other general reminders that do not include PHI

For example:
"Obtain ATD"; "Complete intake paperwork"; "Complete Care Plan"; "Begin assessment documents"

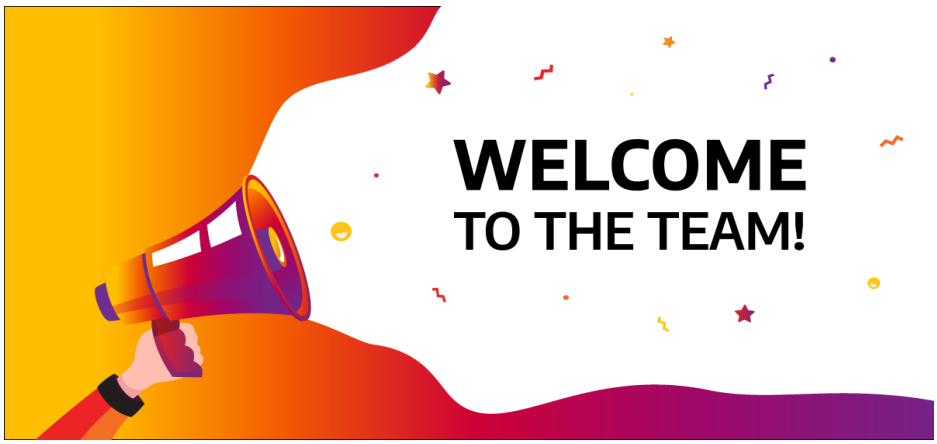
Questions? Please do not hesitate to contact the Office of Compliance at OfficeofCompliance@ochca.com

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



WE'RE SO HAPPY YOU'RE HERE!

Catherine Shreenan, LMFT
Service Chief II

MCST is excited to welcome Catherine Shreenan, LMFT, Service Chief II, to our QMS family. Catherine is a Licensed Marriage Family Therapist and has worked for the County of Orange since 2000. She has worked in several different programs as a clinician and later promoted to a Service Chief I in the Anaheim PACT and then to the Anaheim Clinic. She promoted to a Service Chief II in Adult and Older Adult Mental Health in 2019. She has many years of experience working in County Mental Health and is looking forward to this new opportunity with MCST.

Esther Chung
Office Specialist

Esther, our newest addition to the QMS MCST! Hailing from diverse professional experiences, Esther brings a wealth of expertise as a linguist and project manager in the field of translation. With a heart dedicated to mental health, Esther is passionate about contributing to the well-being of our community. Join us in welcoming Esther as she embarks on her journey to make a positive impact on the health and wellness in Orange County.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

COUNTY CREDENTIALING & RE-CREDENTIALING

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

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 for re-credentialing. It is important to have the provider's respond to the e-mail within **one (1) business day** to confirm their primary e-mail, employer's agency name, direct supervisor name and supervisor's e-mail for the various agencies the provider is currently employed. 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!

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.

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 to 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.

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