SUD Support Newsletter

Authority & Quality Improvement Services

March 2021

SUD Support Team

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UPDATES

- In the February 2021 Newsletter, clarification was provided on the same day billing issues between Residential and Outpatient programs. However, additional clarification is needed for same day billing issues between Outpatient and Recovery Services. **The State does not allow for treatment services to be billed on the same day at Intensive Outpatient**

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WHAT'S NEW?

The moment you have all been waiting for has arrived! The Substance Use Disorder (SUD) Support Team's Documentation Training is now available in a pre-recorded, online format. The benefit is that there is no need to register ahead of time and staff can access the trainings at a time that is most convenient for them. This also means that the training can be taken at your own pace and information can be reviewed as many times as desired. This is also a great way to freshen up your documentation skills if you have attended a live training in the past.

Are you sad to see the live trainings go? Don't worry, we will continue to offer the live, video conferenced trainings on a quarterly basis. These will be beneficial for those who may be more comfortable in being able to ask questions as they receive the information or those who may do better with a structured and dedicated time to complete the training. It is also a great refresher as well.

Upcoming Documentation Training

- July 28th*

**Prerequisites: ASAM A and ASAM B*

All SST Live Documentation Trainings will continue to be provided via online to ensure the health and safety of all.

To sign up, e-mail us at AQISSUDSupport@ochca.com.

The following are the links to the online format -

Website to access training:
Orange County, California - For Providers (ochealthinfo.com)

Direct link to training:
https://www1.ochca.com/ochealthinfo.com/training/bhs/aqis/SUDDocumentationTraining/story.html

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Treatment (IOT) or Outpatient Drug Free (ODF) and Recovery Services. This means that a termination session for the client's discharge from ODF cannot be claimed on the same day as the intake session for the client's admission to Recovery Services. It would be considered duplicate billing as both of those services are considered Individual Counseling services.

For those providers who have multiple levels of care within the same legal entity, it may have been the workflow that there was one session that encompassed both the discharge and the admission.

For these situations, the provider can split the time. It is recommended that the discharging program not bill any treatment services for the day so that the client's intake and admission to the receiving program can be claimed. The discharging program can do a non-compliant service note to document that the service (termination session) took place.

In some cases, it may be more appropriate for the individual discharge session at ODF to be billed (with the admission note to Recovery Services coded as non-compliant). This may occur if more time was spent on the discharge process than the admission.

Use your clinical judgement to make the best determination; just make sure that BOTH are not billed!

Documentation FAQ

1. I had to attend a meeting at the court for my client. Is this a billable service?

To bill for such a service as Case Management, the question you will want to ask yourself is whether your attendance at the meeting was medically necessary. How is attending the meeting at court for your client going to benefit the client's treatment? If you determine that it is medically necessary, it will be important to keep in mind that you cannot claim the entire duration of the meeting. You can only bill for the time you played an active role in that meeting to provide relevant and necessary information. So, if you only spoke for 10 minutes during a 2-hour meeting, you can only claim those 10 minutes. Travel time to and from the location is also billable for a billable service. In your progress note, it will be

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Managed Care Support Team (MCST)

GENERAL REMINDER:

- Formal Grievance and Appeal Forms must be available in all the threshold languages in the lobby. It must be accessible for the client to pick-up without having to make a request.
- All registered/waivered mental health professionals, interns and volunteers are required to submit their Clinical Supervision Reporting Forms and BBS Responsibility Statement for Supervisors Form to MCST when the provider is a new hire or when there is a change in status (e.g. termination, change in Clinical Supervisor).
- Every access point should be entering an Access Log in IRIS for Medi-Cal beneficiaries upon the initial request to access Substance Use Disorder (SUD) Drug Medi-Cal Organized Delivery System (DMC-ODS) services.
- All Medi-Cal Certified Sites are required to provide an updated provider list to maintain a current Provider Directory for the County to MCST every month by the 15th.

MCST OVERSIGHT

- GRIEVANCES & INVESTIGATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- CLINICAL SUPERVISION
- MHP/SUD DMC-ODS PROVIDER DIRECTORIES
- CREDENTIALING
- ACCESS LOGS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP)

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Documentation FAQ (continued)

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important to be clear about why you needed to attend (medical necessity) and what role you had or what you contributed to that meeting. Also, indicate what the outcome of that meeting was. If it resulted in a change in the client's course of treatment, such as offering 3x/month individual counseling instead of 1x/month to focus on a new area of need, this should be documented and the changes should be reflected on the client's treatment plan.

2. I want to bill for the Non-Face-To-Face Time I spent working on the Initial SUD Assessment (dimensions 1 – 6). Do I have to repeat what I have on the Assessment form in my progress note?

No, not all of the information that you obtained for the Assessment form needs to be included in your progress note. Repeating all of the information that will go in the Assessment does not explain HOW you spent the time, which is what your progress note is for. This is particularly important if you are also billing for the time you spent meeting with the client to gather the information. You will want to make sure there is a clear distinction between what you are billing for the Face-to-Face session with the client (to interview him/her) and what you are billing for Non-Face-to-Face time without the client (determining what the risk ratings for each dimension are and what the client's combination of risks say about his/her need for treatment). Remember, the dates you indicate with your initials at the bottom of each page of the SUD Assessment must correspond with the progress note for the Non-Face-to-Face time you are billing. Those dates help support the amount of time you are billing. If you are billing 2 hours for your work on developing a comprehensive assessment, but the Assessment form shows that you only worked on one page (based on your initials and date), it becomes questionable as to whether it truly took 2 hours to formulate and is at risk of appearing fraudulent.

3. My client needs to schedule an appointment with her primary care physician for a physical exam and I let her use the phone in my office. Can I bill Case Management for that?

No. Although it is fulfilling a requirement (to obtain a physical exam), the act of simply letting the client use the telephone for this purpose is not billable. Remember, to bill an activity, it must be medically necessary and require an individual with the appropriate credentials to perform. Allowing a client to use the telephone requires no clinical skills/interventions and would be considered clerical or administrative. Similarly, it would not be billable to allow the client to use your computer for completing an assignment, sending an email, or researching information – even if the purpose is related to a treatment plan goal (i.e., researching jobs, filling out job applications).

Telehealth Verbal Consent for Treatment Plans

During the COVID-19 public health emergency, it is permissible for clients to provide a verbal consent in lieu of a physical signature to indicate agreement with his or her treatment plan.

However, there must be corresponding documentation…

1. Indicate on the treatment plan that the client provided verbal consent due to not being physically available as a result of COVID-19.
2. The corresponding session progress note clearly indicates that the treatment plan was reviewed with the client and the client has verbally consented to the contents of the treatment plan.

The date of service must match the date of signature on the treatment plan.

What's the problem if the dates don't match?

The risk is the appearance of fraud –

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AUTHORIZATION TO DISCLOSE (ATD) REMINDER

If you are using the County's ATD that lists the various providers within the ODS network, please keep in mind that this ATD is only to be used for the initial linkage. Information that can be disclosed is for the purpose of coordinating the beneficiary's access to DMC-ODS services. Once a beneficiary is appropriately linked to a provider, a standard authorization to disclose (ATD) protected health information specific to that entity should be obtained if any additional disclosures are necessary.

For contract providers: As with all County forms, it is not required that you use the County's ATD.

RE-ASSESSMENTS AT RESIDENTIAL

Clients at the Residential level of care are only authorized for "up to" 90 days per episode of care. They are not guaranteed the 90 days, so we must demonstrate that the client continues to meet medical necessity for the Residential level of care throughout their entire stay. The Re-Assessment form is where this is documented.

Re-Assessments are due every 30 days from the date of admission at the Residential level of care.

As you know, the LPHA only needs to co-sign the Re-Assessment (if completed by a non-LPHA), if there is no change in diagnosis or level of care. The LPHA's co-signature is of utmost importance. Since the LPHA is the only one who can establish medical necessity, a Re-Assessment without the LPHA co-signature is not valid. Essentially, it means that medical necessity has not been properly established to justify the continuation of services at the current level of care.

Therefore, in an SST Clinical Chart Review, a missing Re-Assessment will result in recoupment.

Re-Assessments without the LPHA co-signature will also result in recoupment.

If the LPHA co-signature is late, the Re-Assessment is not valid until the date of the co-signature (even if the non-LPHA has completed their portion of the Re-Assessment within the required timeframe). Unfortunately, there is no additional "grace period" for the LPHA to co-sign the Re-Assessment.

An example of what the deficiency would look like is:

If the non-LPHA completes the Re-Assessment by day 30 from the client's date of admission, but the LPHA does not co-sign until day 45, this means that services provided from days 31 to 44 must be made non-compliant.

Please ensure that if it is known that a Re-Assessment has not been completed and/or the LPHA has not co-signed, services are made non-compliant until there is a valid Re-Assessment on file.

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Was the Treatment Plan created AFTER the session with the client? If so, this would lead to questions about whether the finalized Treatment Plan was properly reviewed with the client.

In an SST Clinical Chart Review, Treatment Plans with a date of signature different than the date of service of the session where the Treatment Plan was reviewed with the client for obtaining verbal consent will result in recoupment.

No statement on the Treatment Plan about verbal consent being obtained (i.e., client signature line left blank) AND no documentation of a session where the Treatment Plan was reviewed with the client and consent was obtained, will result in an invalid Treatment Plan. Services claimed based on that Treatment Plan must be made non-compliant.

The client's physical signature should be obtained if, during his or her course of treatment, the client is able to present to an on-site service, on the first opportunity.

This newsletter was established to help communicate any changes or updates as well as to reinforce our current understanding of requirements related to the provision of services under the DMC-ODS. You can access additional resources and previous issues of this newsletter (SUDsies) by visiting the "Providers" tab of the DMC-ODS website, here: http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods/providers

Do you have suggestions for questions or information you would like to see addressed in a SUD Newsletter? E-mail us your thoughts at AQISSUDSUPPORT@ochca.com