SUD Support Newsletter

Authority & Quality Improvement Services

May 2021

WHAT'S NEW?

Please help us welcome Yvonne Brack, LCSW to the Substance Use Disorder (SUD) Support Team! Yvonne will be the new Service Chief II who will be leading the consultants in the multitude of quality improvement and compliance activities taking place. She may be a familiar face to you as she joins us from having worked in the Children & Youth Behavioral Health Division and has been involved with the early stages of the Drug Medi-Cal Organized Delivery System (DMC-ODS) implementation in our county. We are excited to have her join us!

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:
Orange County, California - For Providers (ochealthinfo.com)

SUD Support Team

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UPDATES

- It's that time again…**The Annual Provider Training (APT) 2020-2021 is now available!** It is a requirement for all DMC-ODS providers to complete the APT every year.

Access to the APT:
https://www.ochealthinfo.com/bhs/providers/trainings

Be sure to select *2020-2021 SUD Integrated Annual Provider Training*!

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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 on a quarterly basis.
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

…UPDATES (continued)

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- **Clients who transfer to a different provider, but within the same level of care.** There are two options for transfers.

Option 1: If a client transfers to another program (within the same level of care), the client's timelines would remain the same. For the purposes of the County's billing system (IRIS), we must close the client's Episode of Care (EOC) with the first provider and open a new EOC at the next provider. This will trigger a new admission or start date for the EOC; however, the existing timeline stays with the case since it is a transfer within the same level of care. ***Providers will need to pay attention to the timeline based off the admission or start date of the EOC for the first provider where the client was opened.*** The receiving provider should obtain new legal paperwork (i.e., Informed Consent, Receipt of Notice of Privacy Practices, etc.) to ensure that the client is fully informed of the specifics at the new provider. If an assessment and treatment plan were started or finished at the first provider, they may be used at the receiving program, if appropriate. Documentation by the new provider should clearly explain how information from the first provider is applicable.

Option 2: Client cases for transfers (across the same level of care, between different legal entities) can be completed by discharging the client from the first provider and admitting them as a brand new client at the next provider. Doing so will be in line with the process in IRIS (closing of one EOC at the first provider and the opening of a new EOC at the next provider). ***This will mean that all new intake paperwork is needed for the new provider.*** The assessment document can be used across providers, but it will be the responsibility of the receiving provider to ensure that all of the necessary information has been obtained and adequately demonstrates medical necessity for the

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Documentation FAQ

1. What are the services that qualify to count towards the required 5 clinical hours at the Residential level of care?

The services that fall under Individual and Group Counseling count towards the required clinical hours. Case Management is not a service that counts towards the 5 hours. Intake and assessment sessions with the client to gather information needed to complete the client's SUD Assessment, Treatment Planning sessions with the client, and Discharge Planning sessions with the client (specifically to discuss non-case management related issues pertinent to discharge, such as how the client will prepare to return to a home where the family member may have a tendency to enable the client) count as Individual Counseling. Keep in mind that only sessions with the client present will count towards the 5 clinical hours. As far as the types of groups that will count towards the 5 clinical hours, the content of the group must be clinical in nature and within the scope of practice for the facilitating provider. Groups such as House meetings, chore groups, and in-house 12 Step meetings are part the structured activities and cannot count towards the clinical hours.

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Treatment Plans Created by Non-LPHA

Treatment plans created by a non-LPHA require the additional signature by the LPHA.

As you know, the LPHA has 15 calendar days from the counselor's signature to sign the treatment plan. Please note that this "grace period" only applies to treatment plans that are created within the required timeframes (due within 10 days of admission at Residential and within 30 days of admission at Intensive Outpatient/Outpatient Drug Free).

When the non-LPHA is late in creating the treatment plan (beyond the 10 days at Residential and 30 days at Intensive Outpatient/Outpatient Drug Free), the treatment plan is out of compliance until all required signatures are obtained. This means that the LPHA does not have the additional 15 calendar days from the counselor's signature. When the non-LPHA has completed the treatment plan after the due date, it is not valid until the LPHA provides his/her signature. Therefore, the LPHA should sign any treatment plans created late by the non-LPHA as soon as possible.

In this case, if the LPHA is unable to sign on the same date as the non-LPHA, any services provided until the LPHA signature is obtained must be made non-compliant. This also applies to client signatures (if reason for missing signature is not explained).

Documentation FAQ (continued)

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2. Am I supposed to put the date I met with the client in the date and initial section on the bottom of each page of the SUD Assessment?

The initial and date at the bottom of each page of the SUD Assessment is intended for the date on which you work on that page. This date needs to match with the billing if you are claiming time spent working on the document. If this date is the same as the date of the session with the client, the dates would match. However, oftentimes, providers will meet with the client on one day and spend time working on the SUD Assessment at a later date. If you are billing for the time spent working on the document, be sure that the dates of completion indicated by the initial and date match with the date of service on the progress note. If there are multiple dates on which a particular page was worked on, be sure the documentation is clear. Remember, the intent of the initials and date on the SUD Assessment is to support the billing of time spent working on the Assessment. Any appearance of a discrepancy between what you are billing and what is evident in the documentation raises the potential for the appearance of fraudulent billing. If you are claiming time for having added to one of the sections of the SUD Assessment that had already been completed (initials and date already on the bottom of the page), be sure to initial and date whatever additional documentation has been included. Lastly, the provider's final signature at the end of the Placement Summary should be reserved for when all pages up through the Placement Summary has been completed.

3. Is the Episode of Care (EOC) End Date the last time I meet with client?

Not necessarily. The EOC End Date is the last date of charting for that client. The last date of charting may not be the same as the last session date with the client. For example, if you saw the client for his/her termination session last week and the client is no longer programming, but you are completing the discharge summary for him/her today, the EOC End Date would be today.

Intake Note

You may have noticed on your findings report from an SST Clinical Chart Review the guidance to **explicitly document that the Informed Consent has been reviewed and that the client's signature has been obtained.** In the past, it was sufficient to indicate that "all legal paperwork was reviewed and signed." However, aside from having the signed Informed Consent in the client's chart, we also want to demonstrate that the client has been appropriately educated on the risks and benefits of treatment and that enrollment is voluntary. By being explicit in the documentation, it is clear to the reviewer that this was done. It is adequate to indicate that, "All legal paperwork (including the Informed Consent) was reviewed and signatures were obtained."

…UPDATES (continued)

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current level of care. Best practice, as a new admission, would be for the receiving provider to complete the full initial assessment and treatment plan. This is especially important if some time has passed since the assessment was completed. At minimum, the receiving provider should document that the information has been reviewed and continues to be relevant.

Remember: As the receiving provider, your documentation is going to be key in explaining to a reviewer *what was done* with the information you obtained from the previous provider and *what the result was* (i.e., review of the documents and encounters with the client to confirm/update information that results in a change or no change in course of treatment).

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.

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

- GRIEVANCES & INVESTIGATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- CLINICAL SUPERVISION
- **PAVE ENROLLMENT FOR MHP (EFFECTIVE 6/1/21)** NEW
- CREDENTIALING
- ACCESS LOGS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP)
- MHP & SUD DMC-ODS PROVIDER DIRECTORIES

REMINDERS

PAVE ENROLLMENT FOR MHP PROVIDERS

- PAVE enrollment has officially transferred over to MCST as of 6/1/21.
- Programs must ensure ALL new and existing providers are enrolled in PAVE - Nurse Practitioner, LCSW, LMFT, LPCC, Psychologist, MD, DO, Physician Assistant, Pharmacist and Speech Therapist.
- Send all inquiries and information to process PAVE enrollments to AQISManagedCare@ochca.com with the Subject Line: PAVE Enrollment - _____.

PERSONNEL ACTION NOTIFICATION (PAN) FORM

- A newly revised PAN form is available and programs are now required to cc: AQISManagedCare@ochca.com for ALL new hires, terminations and change of status (i.e., newly licensed, program change, etc.).

CLINICAL SUPERVISION

- A Clinical Supervisor outside of the MHP and SUD DMC-ODS health plans must provide a signed and dated Written Oversight Agreement Letter (See BBS website for sample) on employer letterhead **PRIOR** to gaining hours of experience. The Direct Supervisor MUST ensure the CSRF, BBS and Written Oversight Agreement is submitted to MCST.

ACCESS LOGS

- Service Chiefs/Program Directors are to run and review Access Log reports weekly to fix timely access errors and ensure Access Log entries are entered daily by the clinic staff.
- Providers should speak with the beneficiary, legal guardian/conservator requesting access to services. If the beneficiary, legal guardian or conservator agrees with having a representative acting on their behalf, then an initial appointment can be made (i.e. hospital Social Worker). It should also be noted in the "referral comment" section of the Access Log that verbal consent from the beneficiary was given.
  - ✓ Referral Comment Example #1: *Provider obtained verbal consent from the beneficiary to allow the representative to schedule an appointment.*
  - ✓ Referral Comment Example #2: *Hospital SW indicated beneficiary was unavailable to speak and attested confirming the beneficiary's desire to access treatment services upon hospital discharge.*
- •The provider is to determine if a request for an appointment is deemed urgent, routine or emergent, NOT the beneficiary.
- •The provider must **always** "offer" an appointment within the required timeframe (i.e., Routine – 10 business days, Urgent – 24 hours, Emergent – 4 hours) and the beneficiary may decline and accept another appointment date (even if it is outside the timeframe). Remember, as long as the provider schedules an appointment within the timeframe or schedules an appointment with another clinic, an NOABD for Timely Access is not required.

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
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ACCESS LOGS AND CLINICAL SUPERVISION
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AQISManagedCare@ochca.com

Latest from DHCS…

End of certain facility flexibilities related to the public health emergency: Based on guidance from the California Department of Public Health, DHCS is ending certain flexibilities implemented during the public health emergency. The following flexibilities have been extended, to **expire on June 30, 2021**, and the following BHINs will be updated accordingly:

1. Flexibility related to criminal background checks for Alcohol and Other Drug (AOD) facilities. **BHIN 20-017 – Flexibility for AOD facilities during the COVID-19 Public Emergency**.

2. Flexibility related to criminal background checks for Narcotic Treatment Programs. **DHCS COVID-19 Frequently Asked Questions: Narcotic Treatment Programs (NTPs)**, attached.

If any facilities anticipate difficulty accommodating to this change, please contact your DHCS analyst or send any questions to LCDQuestions@dhcs.ca.gov or MHLC@dhcs.ca.gov.

MAT Expansion

- **BHIN 21-024 DMC-ODS-Expanding Access to Medications for Addiction Treatment (MAT, also known as medication-assisted treatment).** Provides policy updates and clarification on access to MAT during the waiver extension period, January – December 2021.

MAT Services: DMC-ODS Counties shall require that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have effective referral mechanisms to MAT to beneficiaries with SUD diagnoses that are treatable with Food and Drug administration (FDA)-approved medications and biological products.

Additionally, Narcotic Treatment Programs (NTPs) are now required to directly offer MAT to beneficiaries with SUD diagnoses that are treatable with FDA-approved medications and biological products, including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), naloxone, and disulfiram.

DHCS has just issued notice to counties about a planned Medi-Cal claims review by the Centers for Medicare and Medicaid (CMS).

CMS conducts the Payment Error Rate Measurement (PERM) review in all 50 states every three years. California's Medicaid Program, also known as Medi-Cal has been identified as a program at risk for significant erroneous payments.

As a result, the Orange County Behavioral Health Services Medi-Cal system is likely to be subject of review. It will be very important that we all work together to ensure all DMC-ODS claims are accurate and submitted properly.

Annual Provider Training

Thank you all who have completed the Behavioral Health Services, SUD Annual Provider Training (APT). As a reminder, the final date to complete the training is **06/19/2021.**

It is important that we reach 100% compliance with completion of the APT to ensure all our providers, administrators and those responsible for beneficiary care and Medi-Cal claims are well trained about the requirements of the DMC-ODS and Federal funding sources.

As a system, we must ensure that all providers and administrators complete training on the requirement of the DMC-ODS on an annual basis. We achieve this through the APT.

You can also find information and resources in the "For Providers" page of the Orange County DMC-ODS website.

Advance Health Care Directives (AHCD)

One item we would like to highlight that was covered in the APT is the requirement to provide information to beneficiaries about their right to establish Advance Health Care Directives (AHCD). It is the policy of BHS that all providers offer information to beneficiaries and clients about this. You can find the policy here: https://www.ochealthinfo.com/sites/hca/files/import/data/files/50198.pdf

While BHS does not require any specific format to be used for this purpose, providers can find sample information sheets and links to other resources by visiting the "For Providers" page of our website, here: https://ochealthinfo.com/about-hca/behavioral-health-services/bh-services/drug-medi-cal-organized-delivery-system-dmc-ods