SUD Support Newsletter

Authority & Quality Improvement Services

May 2019

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Documentation UPDATES…

The first consult between the non-LPHA and the LPHA to take place within the first 3 days from the date of admission or before the next service, whichever comes first.

In the last QI Coordinators' meeting, it was announced that the non-LPHA and the LPHA would need to consult on the same day as the first service (intake/assessment) in order to establish a working

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WHAT'S NEW?

For the Drug Medi-Cal Organized Delivery System (DMC-ODS), the State sets the minimum requirements that must be followed. Please remember, that the County can set more stringent standards. At times we will receive direction from the State that requires us to make changes to current workflows or practices. Although it may be confusing, we are all learning and adapting together. As you know, 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 by visiting the "Providers" tab of the DMC-ODS website, here: http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods/providers

Upcoming Documentation Trainings

- May 22nd (1 day)*
- June 3rd & 5th (fulfills ASAM B)
- June 26th (1 day)*
- July 1st & 3rd (fulfills ASAM B)
- July 24th (1 day)*
- August 5th & 7th (fulfills ASAM B)

**prerequisites: ASAM A and ASAM B*

For county staff: sign up through Training Partner. For contract staff: e-mail us at AQISSUDSupport@ochca.com.

…More UPDATES:

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diagnosis to bill for that service. The recommendation is to continue in this practice as there is always the risk of recoupment for those services being claimed with a diagnosis that is determined at a later date. However, in those cases when it is not feasible to do so, please be sure that this informal consultation (face-to-face not required) is completed within 3 calendar days or prior to the next service, whichever comes first.

Treatment plan updates are required every 90 days from the date of the client's admission to treatment. Although the State's requirement does allow for treatment plan updates to be completed every 90 days from the date of signature, the county's requirement is every 90 days from the date of admission. Since there are several timelines that need to be kept in mind, such as the Continuing Services Justification being required between the 5th and 6th month and the 15 days that the LPHA has to sign off on a treatment plan from the counselor's signature, there is less room for error to keep the due dates consistent from the date of the client's admission.

Coming Soon…

Credentialing

The Centers for Medicare and Medicaid Services (CMS) has published the Managed Care Final Rule, requiring the County (the managed care organization) to ensure that all providers in the network are in good standing. This means that a uniform credentialing and re-credentialing process will be starting in the near future. Once it begins, each site's Q/I Coordinator will have a role in ensuring all providers in their respective programs undergo the credentialing process. Providers who are not properly credentialed will not be eligible to provide services under DMC-ODS. Be on the lookout for more information as the process begins!

Documentation FAQ's

1. I am an LPHA and will complete the entire SUD Assessment…do I need to complete the "counselor's recommendation" if I am also doing the case formulation?

No, it is sufficient for the LPHA who is completing the whole assessment to indicate "N/A" in the counselor's recommendation section since he or she will be completing the case formulation. It is advised that the LPHA sign the page that includes the counselor's recommendation since it will make it clear to an auditor who completed dimensions 1-6 and the placement summary.

2. How do I bill for completing the discharge summary?

DMC allows for the time spent completing the discharge summary, if the discharge is unplanned. The time can be captured on a case management note as service time and can include time spent on any other activities required to close the case, such as reviewing the client's

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What do I need to begin providing DMC services?

Contract-

I. PAN (Personnel Action Notification)
II. Copy of the APT/NPT certificate (Annual/New Provider Training)
III. Copy of NPI (https://npiregistry.cms.hhs.gov/registry/)
IV. Copy of Official Professional License, Certificate or Registration
V. Module I or ASAM A certificate
VI. Module II or ASAM B certificate (for all staff providing assessments)
VII. Copy of PAVE Supplemental Changes Application (aka 6209) due within 30 days of hire or separation
VIII. Copy of PAVE SUDTP Application *Licensed Staff ONLY* (aka 6010) due within 30 days of hire or separation

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chart in order to gather information needed for the treatment summary narrative. For county staff, please remember that the county's discharge summary includes the progress note.

3. I am a non-LPHA who has completed the assessment and is waiting for the LPHA to complete the case formulation. I have already created the client's treatment plan. Can the LPHA sign off on the treatment plan first and complete the case formulation later?

No. The LPHA needs to review the assessment and complete the case formulation prior to signing off on the treatment plan. In order for an LPHA to properly determine the validity of the treatment plan, he or she would need to know what the client's problems are as identified in the assessment. It would be acceptable to have the LPHA review all documents together on the same day. By doing so, there is also a greater chance that there will be a stronger congruency between the assessment and the treatment plan. Reviewing the assessment and completing the case formulation, followed by reviewing the treatment plan, will help to ensure that all issues identified in the assessment are reflected on the treatment plan appropriately.

4. The LPHA did not sign the treatment plan within 15 calendar days of the counselor's signature, but it is still within the first 30 days at ODF.

The non-LPHA completing the treatment plan early does not allow the LPHA extra time to sign off on it. This is because the State's requirement is explicit that the LPHA must sign the treatment plan within 15 calendar days of the counselor's signature. So a treatment plan completed by a non-LPHA on day 5 would need to be signed by the LPHA no later than day 20. If in the same situation, the LPHA does not sign the treatment plan until day 25, those services between day 20 and 25 could be recouped by the State.

Reminder

- Residential programs: Please be mindful that the timeframe for 7 calendar days to complete a progress note is still applicable at the residential levels of care. Even if your program is completing a weekly summary note, this note needs to be completed within 7 calendar days of the last day of service to be captured in the weekly note. If your program is completing per service notes, it will be crucial to keep up with the timeframes as any progress notes completed outside of the 7 calendar days are non-compliant AND has the potential for impacting the total number of required clinical hours of service each week.

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County-

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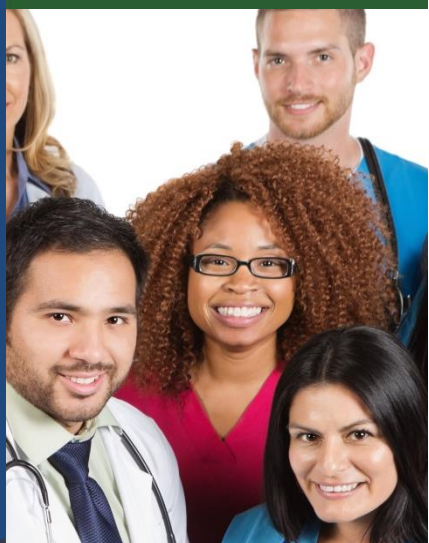
VII. Copy of PAVE Supplemental Changes Application (aka 6209) due within 30 days of hire or separation
VIII. Copy of PAVE SUDTP Application *Licensed Staff ONLY* (aka 6010) due within 30 days of hire or separation
IX. Schedule (County only)
X. NAR (Network Access Request) (County only)



Continuity of Care and Referrals in SUD Programs

Did you know the County has a Policy and Procedure (P&P) to ensure beneficiaries receive the most appropriate level of care and additional resources they need during treatment? You are probably familiar with the various levels of care in the DMC-ODS and you have already been helping beneficiaries transition between levels of care as needed. But, did you realize that continuity of care also includes making sure that resources and services outside the DMC-ODS are also provided?

As a minimum, providers must maintain and make available to beneficiaries a current list of resources within the community that offer services that are not provided within the program. The list of resources includes:
a) Medical
b) Dental
c) Mental Health
d) Social Services
e) Public Health
f) Where to apply for the determination of eligibility for State, Federal and County entitlement program.

Some of the reasons why referrals and coordination of care for your clients may be needed include:
A. Unstable Housing/homelessness.
B. Identified or possible untreated medical condition.
C. Identified or possible untreated mental health condition.
D. Identified or possible untreated dental health condition.
E. Financial instability that may result in eligibility for Social Services programs, such as, general relief, CalFresh, etc.
F. Vocational/Educational needs.

You have an important and active role in ensuring that all beneficiaries are linked and receive services to support their recovery. Here are the steps that treating providers are expected to take when making referrals and linkages.
A. Contact the identified resource program and consult with appropriate personnel regarding the admission criteria and requirements for such program.
B. Acquire and complete all available and appropriate forms applicable to such program.
C. Provide clear instructions regarding admission criteria to the beneficiary for access to the program.
D. Provide directions to the program or resource for the beneficiary and assist with transportation, if appropriate and available. (i.e. bus passes or printing directions).
E. Assist the beneficiary in completing an ATD and any other documents that will ensure two way consultation/communication between the treating provider and identified resource program (if appropriate).
F. Document the referral in the Encounter Document as a case management progress note.
G. Follow up with the beneficiary in 7-14 days to ensure that the beneficiary has successfully accessed the referral/resource. Document the results in the beneficiary Electronic Health Record or chart.
H. If linkage was not successful, the treating provider may follow up with the beneficiary and address any barriers to linkage, as appropriate.
And as always, remember to include all necessary referrals and linkages on your treatment plan and to document your work as case management. You can see the entire Continuity of Care and Referrals in SUD programs P&P here. If you have questions about how this is done at your program, talk to your Q/I coordinator. He or she can help.

How to respond to a DHCS Monitoring review

The Department of Health Care Services (DHCS) and the County of Orange have an agreement in place for the provision of Drug Medi-Cal, Organized Delivery System (DMC-ODS) services for Medi-Cal beneficiaries in the County, known as “the Intergovernmental Agreement” (IA).
The IA requires the county to pass down all contractual requirements under this agreement to any sub-contractor the County may utilize. DHCS has the authority to monitor and review the County and any sub-contractor to ensure compliance with the IA and all State and Federal Regulations. The IA also places the County as an agent of DCHS.
When a provider enters into a contract with the County, the provider agrees to follow all State, Federal and County regulations and requirements. Being a network provider means that all oversight, monitoring and implementation of corrective actions by a provider is done under the authority of the County. This may be confusing for some providers who were direct service providers with the State prior to the start of the DMC-ODS. So let’s look into what this means under the current system.
When DHCS visits a contracted provider for a review, they are also reviewing the County by extension. The provider reviews are a way for DHCS to monitor if the County is fulfilling its obligation to monitor providers and to require corrective action when requirements are not met.
In the past, a direct service provider would have interacted with DHCS directly. However, since the start of the DMC-ODS, all network providers must always go through the County to get their questions answered and to respond to the State. This means that as DHCS makes the rounds, reviewing providers, providers will be working with the County only to prepare Corrective Action Plans (CAP) for submission to the State, to implement their CAP and finally to confirm that all necessary actions have been completed.