SUD Support Newsletter

Authority & Quality Improvement Services

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SUD Support Team

Azahar Lopez, PsyD, CHC
Angela Lee, LMFT
Beatriz Garcia, LMFT
Dominic Ong, LMFT
Emi Tanaka, LCSW
Michelle Hour, LCSW
Faith Morrison, Staff Assistant
Marsi Hartwell, Secretary

CONTACT
aqissudsupport@ochca.com
(714) 834-8805

UPDATES

We have received clarification from the State regarding how we can handle **clients who transfer to a different location under the same legal entity and same LOC.** There are two options for transfers. **Option 1:** If a client transfers between your locations (within the same level of care), the State allows for the client's case to remain open, but the timelines must remain the same. As you know, for the purposes of the County's billing system (IRIS),

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WHAT'S NEW?

Happy New Year! We all have high hopes for 2021 based on the challenges experienced in the previous year. A new beginning and fresh start is what we have all been waiting for. The Substance Use Disorder (SUD) Support Team is looking forward to an exciting year as our network grows and expands.

On January 13, 2021, a virtual ribbon cutting ceremony was held for the new Be Well Orange Campus. This facility will be providing a multitude of needed services for our communities through a public-private partnership with Telecare. It will feature the first Sobering/Recovery Station in the county, which is set to open January 25, 2021. Other services that are set to launch in the coming months include Crisis Stabilization Units, Crisis Residential Program, Co-Occurring Disorders Residential, Withdrawal Management Program, and a Substance Use Treatment Services Program.

For more information, take a look here: https://bewelloc.org/overview/

Upcoming Documentation Training

- February 25th*

**Prerequisites: ASAM A and ASAM B*

Until further notice, all SST Documentation Trainings will be provided via online to ensure the health and safety of all.

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

Coming soon...

We are working on posting the SST Documentation Training online for easier access!

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we must close the client's Episode of Care (EOC) with the first location and open a new EOC at the next location. 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 provider and level of care. ***Providers will need to pay attention to the timeline based off of the admission or start date of the EOC for the first location where the client was opened.*** The legal paperwork (i.e., Informed Consent, Receipt of Notice of Privacy Practices, etc.) obtained at the first location can carry over to the new location. One issue to be mindful of is that if the client has already been opened for 30 days at the first location for the Outpatient level of care at the point at which they transfer to another location, their services at the next location must be made non-compliant until there is a valid assessment and treatment plan. If an assessment and treatment plan were started or finished at the first location, the documents can be used at the second location, if appropriate. If the assigned primary counselor or provider is changing from one location to the next, there should be documentation by the new provider on how information from the first location is applicable. **Option 2:** Client cases for transfers (across the same level of care, under the same legal entity) can be completed by discharging the client from the first location and re-admitting them as a brand new client at the next location. Doing so will be in line with the process in IRIS (closing of one EOC at the first location and the opening of a new EOC at the next location). ***However, this will mean that all new intake paperwork is needed for the new location.*** The assessment document can be used across locations, 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 level of care. The receiving provider should document that the information has been reviewed and continues to be relevant.

Documentation FAQ

1. Why do we need to include information about how the client meets the DSM-5 diagnostic criteria in the case formulation for the Continuing Services Justification (CSJ) if it is going to be the same as what was indicated in the Initial Assessment?

The CSJ is a stand-alone document that needs to include all of the information to support how the client meets medical necessity for ongoing services. Since medical necessity includes a primary substance use disorder related diagnosis, we are at risk of auditors saying that we did not properly establish medical necessity if we do not include the diagnostic criteria. If the client now qualifies for an "in remission" diagnosis, you can indicate what criteria were met for the substance use disorder at the time of the Initial Assessment and how the client has now been abstinent from use for X amount of time. Remember that this change in diagnosis may also mean a new LOC.

2. I work in a Residential program. Do we have to include the documentation start and end time

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Managed Care Support Team (MCST) Updates

CONTACT INFORMATION

200 W. Santa Ana Blvd., Suite #100A (Bldg 51-I)
Santa Ana, CA 92701
(714) 834-5601 FAX: (714) 480-0775

E-MAIL ADDRESSES

AQISGrievance@ochca.com (NOABDs/Grievance Only)
AQISManagedCare@ochca.com

*New Fax Number

*All E-mails must have a subject line indicating what type of subject matter they are referring to (e.g. credentialing, grievance, NOABD, etc.)

Documentation FAQ (continued)

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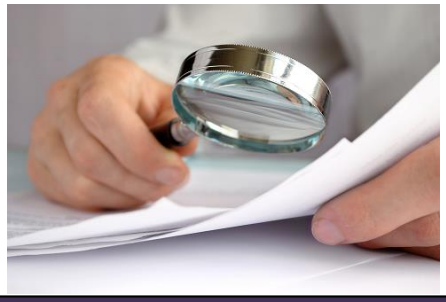
for individual and group counseling session notes, since they are part of the bundled services for the day?

We do not have explicit guidance from the State on this specific to Residential programs. The State has required this for all progress notes. Therefore, it is SST's recommendation that you indicate the documentation start and end times for individual and group counseling sessions at the Residential programs. Moreover, the main reason why the State instituted the requirement for documentation start and end times was to account for the provider's whereabouts at the times indicated to ensure that he or she was not providing multiple services at the same time. It would be in the best interest of all providers to make sure they are covering themselves by including documentation start and end times for all progress notes.

3. My agency still uses paper charts. After the client's intake, I am responsible for putting together the client's chart. Can I bill for this time?

No. Time spent organizing a paper chart or filing papers that are required to be in the client's chart is not a clinical activity. This falls under an administrative activity and is always considered a non-billable activity, according to the State. If you would like to document that you have completed this task, you may include a statement in your progress note about it, but be sure that it is made explicit that you did not bill for that time. An example might be, "Counselor filed all of client's signed legal paperwork into client's chart after intake session (time not billed)."



Important reminders...

Required assessment elements

An important requirement for the Initial Assessment is for the inclusion of the following information: drug/alcohol use history, medical history, family history, psychiatric/psychological history, social/recreational history, financial status/history, educational history, employment history, criminal history, legal status, and previous SUD treatment history. ***Any assessments reviewed by SST that are found to be missing any one of the components will result in recoupment.*** This means that all services provided based on that assessment will need to be recouped.

Types of services & frequency

All treatment plans need to identify the specific types of services that will be provided

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Providers with Multiple Credentials

As you know, if a provider is not considered a Licensed Practitioner of the Healing Arts (LPHA), the minimum qualifications required to provide billable services under the Drug Medi-Cal Organized Delivery System (DMC-ODS) is to be registered or certified as an Alcohol and Other Drug (AOD) Counselor. However, this does not mean that the staff at your site with credentials that are not recognized by the State can provide services for those credentials just because he or she has become a registered or certified AOD Counselor. A rendering provider must always provide services only within his or her scope of practice.

For example, a Licensed Vocational Nurse (LVN) is not one of the allowed provider types in the DMC-ODS. The LVN at your site cannot bill services as an LVN just because he or she has an AOD counselor certification on top of the LVN credential. When billing in the ODS as an AOD Counselor, the services provided must be within the scope of practice of an AOD Counselor, not the scope of practice of the other credentials that he or she may have. To do otherwise would be considered fraudulent.

Additionally, it is important to note what position or role the provider has been hired for in your program. Please obtain guidance from your agency's Human Resources department about individuals providing services and billing as an AOD Counselor when he or she has not been hired for an AOD Counselor position.

BEFORE YOU SIGN THAT PROGRESS NOTE…

Did you include a statement about the client's overall progress in treatment? One of the State's requirements for progress notes includes documentation about the client's progress towards treatment plan goals.

Here are some ways to do this for the services you provide –

For individual counseling sessions: Speak to the goals on the client's treatment plan that were addressed in that service/session and the client's progress towards achieving that goal. Consider what took place in the service/session (i.e., client's verbalizations, response to interventions, etc.) that indicate to you that he or she has or has not made progress toward that goal. If a new issue was addressed, consider how it ties into what the client has already been working on. Sometimes new issues can mean that the client has built up enough skills to move on to addressing these new areas.

For group counseling sessions: Since you may not be the primary counselor for all of the clients in attendance to your group, it may not be feasible to know what each of your attendees' treatment plan goals are. In such a case, it is advised that you address, at minimum, the client's progress in your group setting. If you have been facilitating the group week to week, you should be able to speak to how the client has been doing in your group based on his or her level of participation, interaction with peers, understanding of concepts, etc. You can mention how this may or may not be beneficial for the client's overall ability to maintain sobriety.

For case management sessions: If what you addressed in the service/session is part of the client's treatment plan goals, such as for obtaining the physical exam or following up on medical issues identified in the assessment, you will be able to speak to how the client is doing towards achieving that goal. Similar to an individual counseling session, use what took place in that service/session to demonstrate whether the client is or is not making progress towards that goal. If it is a new issue that just needs to be addressed one time and is not part of the client's current treatment plan, there may be no progress to document because the issue is being resolved. But if it is potentially an ongoing issue, you may want to indicate in the plan that this will be added to the treatment plan at the next update and subsequent services can document progress towards that new goal.

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

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to the client (i.e., case management, individual counseling, group counseling). ***If the treatment plan does not clearly indicate what types of services are going to be provided, those services cannot be claimed.*** For example, if the treatment plan does not authorize group counseling as a type of service that is going to be provided, there can be no groups billed for that client. In addition to the type of service, there needs to be a frequency (i.e., how often that type of service will be provided). Treatment plans reviewed by SST that do not properly authorize the types of services billed will result in recoupment of those services.

Non-LPHA & LPHA Consult

If a non-LPHA completes part of the assessment and the LPHA is involved to document how the diagnosis and medical necessity for services was established (also known as the Case Formulation), the State requires a face to face consultation. ***This consultation must be documented.*** Assessments reviewed by SST that are completed by both a non-LPHA and LPHA, but do not have corresponding documentation to evidence that a consultation took place will result in recoupment. This means that all services claimed based on that assessment would be non-compliant. If a subsequent Re-Assessment or Continuing Services Justification (depending on the level of care) does not bring the chart into compliance with a documented consultation, this could potentially be an entire treatment episode that must be repaid.

*Note: a Re-Assessment/CSJ does not require a consultation between non-LPHA & LPHA. The above scenario applies when the consultation is missing from the Initial Assessment.