SUD Support Newsletter

Authority & Quality Improvement Services

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SUD Support Team

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UPDATES

We have received some clarifying information from the State in regards to same day billing. When two programs provide services on the same day (such as for a client enrolled in Residential and being transitioned to Intensive Outpatient [IOT] at another program), **only one provider may claim a treatment service on any given day.** For Residential to Outpatient transitions, it is considered *duplicate billing*

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WHAT'S NEW?

In the near future, it will be a requirement for AOD Counselors (certified or registered) to submit Clinical Supervision Reporting Forms to the Managed Care Support Team (MCST). So far, we have only needed these for the Licensed Practitioner of the Healing Arts (LPHA). However, the Drug Medi-Cal Organized Delivery System (DMC-ODS) is moving in the direction of requiring this for the non-LPHA as well. In order to prepare for this transition, please begin taking a look at how you are tracking and documenting the clinical supervision of AOD Counselors.

This is also important for monitoring the expiration dates of credentials. We have recently come across an increase in the number of providers whose credentials have lapsed. *As a reminder, if a provider's credentials expire, he or she cannot provide nor bill any DMC-ODS services, until the date credentials are renewed.*

Please take some time to check and keep tabs on any upcoming expirations to ensure compliance!

Upcoming Documentation Training

- March 24th*

**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!

...UPDATES

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for the Residential program to claim a treatment day on the same day that an Outpatient program claims a service for assessing and admitting the client. This means that the provider at the Residential program who is looking to transition the client to Outpatient will need to coordinate with the provider at the Outpatient program so there is no overlap in billing.

Another clarification is that **Residential programs CANNOT claim the treatment day rates during the period of transition.** Although we are allowed a short transition period (no more than seven calendar days) from the time the client leaves the current level of care, for the purposes of continuity of care, to provide and bill for case management, treatment days cannot be claimed. The period of transition must also happen *within* the 90 days.

The last clarification is that, **residential programs CANNOT claim the treatment day rates after the client no longer meets medical necessity for Residential level of care.** Clients are able to stay for forty-eight (48) hours after no longer meeting medical necessity for that level of care, as long as it is for the purpose of transitioning the person to the next level of care, but this is room and board only, not treatment days.

Documentation FAQ

1. I had a telehealth session with a client, but halfway through the session, we lost connection and had to continue the session by telephone...how do I bill and document this session?

As far as coding for billing, the session should be marked as a "telehealth" session, even though only part of the time was spent using the telehealth platform. Differentiate the number of Face-to-Face (in this case, telehealth using a video chat format) vs. non-Face-to-Face (telephone) minutes and clearly document what occurred in the progress note. Clearly state what happened and what portion of the service was conducted "face-to-face" and what portion was not. If the technical issue was only on the client's end, remember to note that the telehealth service was available to the beneficiary for the entire session time, but the client was unable to access it.

2. I'm using the County's Discharge Summary form and am getting confused between "time spent on completing the discharge process" and the

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Provider Directory

The Health Plans must make available to beneficiaries specified information about its network of providers, in paper form upon request and in electronic form; this includes county-owned and operated providers and contracted organizational providers, provider groups and individual practitioners.

General requirements for the Provider Directory:

- All Medi-cal certified sites must submit a list of the providers to the Managed Care Support Team **every month by the 15th**. A Medi-Cal certified site that does not bill for Medi-cal covered services is still required to submit a list of the providers for the directory.
- A provider assigned to multiple locations must be listed at each Medi-Cal certified site.
- The list of providers are made up of licensed, waivered, registered mental health providers and certified, registered, licensed substance use disorder service providers (e.g. Registered Nurses, Psychiatrist, LCSW, ACSW, AOD Counselor, etc.)
- Programs that do not submit their monthly updates for 2 consecutive months will be subject to a Corrective Action Plan in order to be in compliance with the state and federal regulations.

For questions and monthly submissions, please e-mail MCST at AOISManagedCare@ochca.com with the subject line "Provider Directory".

Documentation FAQ (continued)

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"documentation time." What is the difference?

If using the County Discharge Summary form, please remember that the "Number of Minutes to Complete the Discharge Process" is equivalent to Service Minutes. This is the time it takes to research the client's chart for information to complete the treatment summary narrative and complete any other aspects of closing a client's case. Just as we need to justify the amount of time claimed for any progress note with Service Minutes, we must also include a brief explanation as to how the time was spent for "Number of Minutes to complete the Discharge Process." This can be included as part of the narrative section with the client's treatment summary. The "Documentation Minutes" will be the amount of time it takes to complete the discharge summary (since the progress note is embedded into the form). The "Documentation Date" and the "Facility and EOC Discharge Date" should be the same since the chart will be closed as of the last date of charting.

3. What should I put in the Goal section of the GIRP Progress Note?

The easiest way to remember what the Goal section of a GIRP Progress Note should entail is to think of it as the headline for a newspaper article. Try to avoid overly broad goals like "to address client's substance use" as this can apply to any service and client. If you spent time with the client to discuss housing options for post-discharge, it may be something like, "To assist client with the steps to securing housing upon discharge." Another way to take care of the Goal section is to directly pull in the goal(s) from the client's treatment plan that was addressed in the session or service. For example, one of your client's goals might be, "To identify and practice using relapse prevention skills 3x/week to reduce relapse risk." Your interventions for this particular session may have addressed the "identification" part of that goal by helping the client to understand the value of using sober social supports as part of developing a relapse prevention plan, examining how relationships have contributed to use in the past, and challenging the client to consider how some current relationships may or may not be conducive to the client's sobriety at this time. Thus, the Goal section of your Progress Note stating, "To address client's goal to identify and practice using relapse preventions skills 3x/week to reduce relapse risk," would be appropriate.

Residential Requirements Review

- **Authorizations for Residential programs are for "up to" 90 days**, which means that clients may not need the full 90 days. Length of stay will depend on the client's medical necessity for that level of care. This is why the Re-Assessment every 30 days from the date of admission to a Residential program is so important. It is necessary to demonstrate how severe the client's functioning is to warrant the need to continue at this level of care or that he or she has made enough progress to transition to a lower level of care.
- **Clients cannot stay beyond the 90 days without an authorized extension by the County (except in the case of Perinatal clients).**

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MISSING SIGNATURES

If you have forgotten to sign a document that you completed (i.e., progress note, assessment, treatment plan, etc.), you may sign it as of the date you discover the issue. Please be sure you are NOT backdating. The date of signature needs to be the date that you sign, not when you "should have" signed. For example –

Don't forget your credentials!

Rodger Rabbit, AMFT	*Rodger Rabbit, AMFT*	*2/18/21 Late Entry*
Counselor's Printed Name	Counselor's Signature	Date of Signature

What happens if signatures are missing in an SST clinical chart review?

If there is evidence of the timely completion of the document, SST will allow for the provider's signature to be added as described above, at this time. Because timely signatures are a requirement, in order to evidence the qualifications of the professional who completed each document and the date when it was done, **SST will evolve its practices to make recoupments mandatory for missing signatures in the future.**

MINIMIZING RECOUPMENT…

Timeline deficiencies continue to be the #1 source of recoupment in an SST Clinical Chart Review! This is due to the fact that missing or late assessments and treatment plans typically results in more than one failed service. There may be multiple days, weeks, and even months that are non-compliant. This adds up.

One way that we can all be proactive in reducing the chances of recoupment is to track your client's timelines-

Tracking your client's timelines can help you to know when you can bill for services and when you need to be using the non-compliant code. If the due dates for the assessment and treatment plan have passed, services must be made non-compliant until there is a valid assessment and treatment plan in place.

Here is an example of one way to clearly lay out the due dates for a client who admitted to a Residential program on 2/1/21:

Residential **(Admit date: 2/1/21)**			
Initial Assessment by day 3	Initial Treatment Plan by day 10	Re-Assessment by day 30	Re-Assessment by day 60
(2/3/21)	**(2/10/21)**	**(3/2/21)**	**(4/1/21)**

Coming Soon!

Authorization for Residential Treatment (ART)

Another exciting venture is starting! A new program called the Authorization for Residential Treatment (ART) will begin operating out of the County's Santa Ana Substance Use Disorder (SUD) Clinic. The ART team will be handling all assessments and authorizations for residential treatment in our network. This means that in most cases the initial assessments for residential will no longer take place at the individual provider sites or at any of the outpatient clinics. The intent is for us to streamline the authorization process as well as to help improve the coordination of getting our beneficiaries connected with the Residential level of care. More information about the ART team is coming soon.

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/agis/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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The County may grant a one-time 30 day extension for those clients who demonstrate medical necessity for Residential treatment beyond the 90 days. Without the proper authorization, clients who stay past the 90 days cannot have their services paid for by Medi-Cal.

- **An updated treatment plan is required every 90 days from the date of admission.** This means that for those clients who are permitted the 30 day extension, services cannot be billed if there is no updated treatment plan at 90 days.
- **Residential program may not bill for the days when the client is medically hospitalized.** For Interruptions in a Residential stay, the number of days away do not count towards the 90 days. However, the treatment plan is still only effective 90 days from the date of admit. An updated treatment plan is necessary to authorize services for the client's entire length of stay.
- **There is a difference between a treatment day rate and a bed day rate** - Treatment day rate entails billing Medi-Cal for treatment services (individual and group counseling) while a bed day rate is solely room and board (not billed to Medi-Cal).