SUD Support Newsletter

Authority & Quality Improvement Services

November 2021

WHAT'S NEW?

SUD Support Team

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UPDATES

Since the State has removed restrictions for the length of stay in Residential Treatment, **please pay particularly close attention to the documentation of medical necessity for the Residential level of care.** The SUD Re-Assessments that are required every 30-calendar days at the Residential level of care must clearly demonstrate how the client continues to need the Residential level of care. What this means is that the composite picture of the client's impairments and needs

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Looking to make a referral to the peer mentoring program?

The peer mentor linkage form can be e-mailed securely to:
OCAdmissions@PhoenixHouseCA.org

As we draw closer to the end of the year, we would like to take time to express our gratitude and appreciation for all that you do for our beneficiaries!

In addition to all your hard work with the beneficiaries, we know that keeping up with the standards to stay in compliance with all the State requirements for billing and documentation can be overwhelming. Thank you very much for working so diligently with us to maintain compliance. We are grateful for your commitment and collaboration in these efforts.

Please know that we are here to support you as much as we can and welcome all your feedback and suggestions for improvement. As always, if you should have any questions or concerns, please feel free to reach out to us at AQISSUDSupport@ochca.com

Documentation Training

SST SUD Documentation Training (online):
https://www1.ochca.com/ochealthinfo.com/training/bhs/aqis/SUDDocumentationTraining/story.html

The SUD Case Management Training:
https://www.ochealthinfo.com/about-hca/behavioral-health-services/bh-services/drug-medi-cal-organized-delivery-system-dmc-ods

Test Your DMC-ODS Knowledge!

What needs to happen after a copy of the client's Physical Exam is obtained?

a. Medical Director needs to review it
b. Give client a cookie
c. File the Physical Exam in the client's chart
d. a. and c.

…UPDATES (continued)

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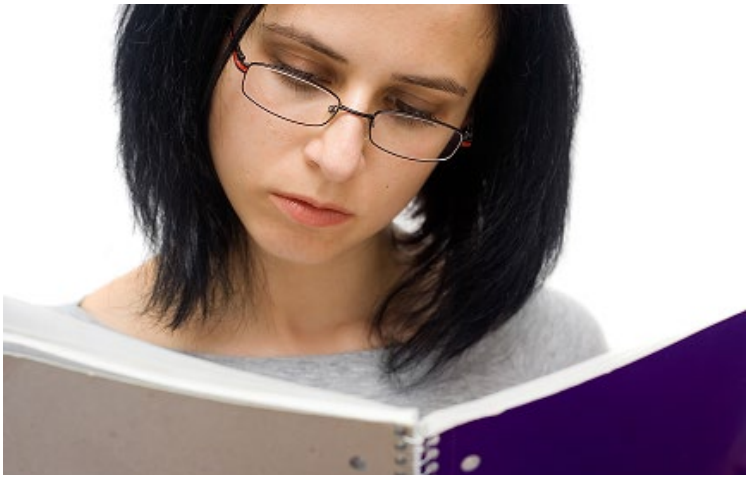
based on the severity of the client's risk in each of the six dimensions of the ASAM Criteria, must warrant the Residential level of care.

Please be mindful when stepping clients down from 3.5 to 3.1 when clinically appropriate. For this change in level of care, be sure the LPHA is documenting how the client meets medical necessity for the lower level of care. If you are using the County's SUD Re-Assessment form, the LPHA should be completing the Case Formulation for any changes in diagnosis and/or level of care. During SST's Clinical Chart Reviews, any Re-Assessments reviewed that do not meet medical necessity for the Residential level of care provided will result in recoupment.

Also, don't forget about the 10 psychosocial elements – double check that all 10 elements have been addressed in the Initial Assessment, particularly if your program received an Assessment from another provider.

Residential Bed Days (Room & Board)

It appears that there have been some cases where the client has been occupying a Residential bed without a Treatment Authorization Request (TAR). If you are a Residential provider awaiting to receive a client's Initial Assessment (to justify appropriateness for the Residential level of care) and the TAR from the Authorization for Residential Treatment (ART) team, please be sure there are no treatment days being claimed to Drug Medi-Cal. Billing can only begin when there is evidence that the client meets medical necessity and is approved for the Residential level of care. For questions on whether the bed days (or Room & Board) can be subsidized for this period, please follow up with your program's Contract Monitor.



Documentation FAQ

1. I am an LPHA and completed my consultation with the non-LPHA today. I am working on the Case Formulation now. Can I do one progress note for both activities to bill for my time?

No. These activities fall under two different types of services. The consultation between the LPHA and non-LPHA to discuss the initial assessment findings is billable as a Case Management Service. The time it takes the LPHA to work on the Case Formulation to establish medical necessity for the client is an Individual Counseling Service. To bill for both activities, there must be a separate progress note for each.

If you choose to only bill for one, here are some options:

1) Complete a Case Management Service progress note to bill for the consultation time and document within the progress note that the time spent creating the Case Formulation was not billed for in the progress note. In this case, the service time will only include the consultation time.

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SST Clinical Chart Review Findings & Trends

As the SST QI Consultants continue to conduct Clinical Chart Reviews for fiscal year 2021-2022, here are a few of the recoupment issues we have been seeing most recently that we all need to be careful about…

- Not addressing the 10 psychosocial elements in the Initial Assessment
    - For Residential programs, please take a careful look at the Assessments provided to you by the ART (Authorization for Residential Treatment) team. If you discover that any of the elements are not properly addressed, there should either be a new Assessment or addendum to rectify it. Unfortunately, failure to bring the Assessment into compliance will result in a period of non-compliance!
- Missing or Late Re-Assessments or Continuing Services Justification (CSJ)
- Missing or Late Treatment Plans

If you have questions or need clarification, please be sure to ask your designated AQIS SUD SST Consultant!

Documentation FAQ (continued)

…continued from page 2

2) Complete an Individual Counseling Service progress note to bill for the time spent synthesizing the Case Formulation and document within the note that time spent in consultation with the non-LPHA was not billed for. In this case, the service time will only include the time spent devising the Case Formulation.

2. I will be facilitating groups. What needs to be on the group sign-in sheets?

- LPHA or non-LPHA's printed name, which must be legible
- LPHA/non-LPHA's signature, adjacent to the printed name, and date (same day of the session)
- Date of the group session
- Topic of the group session
- Start/end time of the group session
- Printed name for each participant, which must be legible
- Each participant's signature

There must be a corresponding group sign-in sheet for every group. Without a corresponding group sign-in sheet, that group cannot be billed (if IOT or ODF) or counted towards the required five clinical hours/week (if Residential). Additionally, when there is a mismatch between the group sign-in sheet information and the actual progress note, the State may disallow that service, so it is very important that all the information is on the group sign-in sheet and is consistent with the progress note.

3. I must issue an NOABD for a client that I have been unable to contact. Can I bill Case Management for the time I spend reviewing the client's chart to complete the NOABD letter?

No. This is not a billable activity. If you need to document this action, please do so in a manner that is not tied to any billing, such as a Note-to-Chart or an Administrative Note.

Does the Treatment Plan Reflect the Assessment???

THE REQUIREMENT: The Treatment Plan needs to address ALL problems identified in the Assessment. *Remember this does not mean that there must be a GOAL for all problems, but the State wants to see that we are taking into consideration whether each of the client's problems need to be worked on.*

If you identify a problem, consider whether it needs to be a goal or simply noted on the Treatment Plan.

How this might look…

In exploring issues related to Dimension 2, the client shares that he can't see as well as he used to, especially at night. It turns out that the client has never been to an optometrist or seen a doctor about his eyes. When asked if he would be interested in receiving assistance to connect him with services that could better assess his needs, the client states, "No…I think I can still see well enough for now."

On the client's Treatment Plan, you note that the client reports a problem with his vision; however, the client declines any help with this at this time and no goal will be created, but the issue can be explored again at the time of re-assessment.

REMINDERS

Did you include your credentials?

Be sure to check that your printed name and signature on your client's chart documents include your credentials. Your name and credentials should be written as it appears on your certification as a Drug Medi-Cal provider with the State.

Client signature inconsistencies

As much as possible, please have clients sign his/her/their name in a consistent manner across various documents. This means that signatures on the group sign-in sheets should be the same as the legal intake documents. We understand that sometimes clients like to sign differently. But please stress the importance of this issue in helping to reduce disallowances due to the possible appearance of fraud. How might this appear fraudulent? If signatures look completely different across documents, there is a danger that it may be perceived as forged signatures.

"Test Your DMC-ODS Knowledge" Answer: d

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 COUNTY SUD DMC-ODS CLINICS & PROVIDERS
- PAVE ENROLLMENT FOR MHP PROVIDERS
- COUNTY CREDENTIALING
- CAL-OPTIMA CREDENTIALING
- ACCESS LOGS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP)
- MHP/SUD DMC-ODS PROVIDER DIRECTORIES

REMINDERS

CREDENTIALING

- As the MCST rolls out credentialing with the County's health plan network, all program administrators who have completed credentialing their staff must ensure existing/new providers are credentialed. The uniform credentialing and re-credentialing requirements apply to all licensed, waivered, or registered mental health providers and licensed substance use disorder services providers employed by or contracting with the health plan to deliver Medi-Cal covered services.

Expired Certificates of Insurance (COI)

- The provider and/or program administrators receive courtesy e-mail notifications from VERGE (the County's contracted Credential Verification Organization) 30/14/1 day(s) prior to the expiration of the individual or agency COI. To avoid receiving a notification, the provider and/or program administrators must provide the required document to VERGE 30 days prior to the expiration.

Expired Licenses, Certification and Registration

- The MCST has the ability to track and monitor expired credentials for providers who have successfully completed the County credentialing process. **Over the last several months there has been a significant rise of providers who have not renewed their expired credentials on time.** This will result in suspension and disallowances. Avoid letting your credentials lapse.
- VERGE e-mails notifications to providers 90/60/30 days in advance about expiring licenses, certifications and registrations. After VERGE's multiple attempts to obtain an updated credential MCST and IRIS intervenes to suspend and deactivate the provider. The provider is then no longer permitted to deliver services requiring licensure for the Orange County Health Care Agency.
- When this occurs the provider must immediately petition for their credentialing suspension to be lifted and provide proof of the license, certification and/or registration renewal to MCST and IRIS. The reinstatement is **NOT** automatic.

7-Day Online Attestation for Credentialing

- When the provider begins credentialing, he/she will receive an e-mail from VERGE requesting to complete the online attestation within 7 calendar days to officially start the process.
- If the existing provider does **NOT** complete the attestation within the allotted timeframe MCST and IRIS will intervene to suspend and deactivate the provider. The provider will no longer be permitted to deliver Medi-Cal covered services for the Orange County Health Care Agency until they have completed the credentialing process and show proof of the credential approval letter to IRIS before they can be re-activated to bill for services.

MANAGED CARE SUPPORT TEAM

REMINDERS (CONTINUED)

CREDENTIALING (CONTINUED)

Separation of Credentialed Providers

- Program administrators must notify the MCST within 72 hours when a provider has separated. The MCST will deactivate the provider in order to prevent the County from being charged each month to maintain the separated provider's credential profile.

PAVE ENROLLMENT FOR MHP & COUNTY SUD CLINICS ONLY

PAVE PORTAL

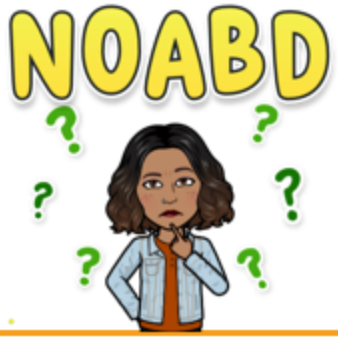
- PAVE enrollment and affiliation for County SUD Staff and MHP County Clinics/Contracted Programs was officially transferred over to MCST as of 7/1/21.
- Programs are required to have providers enrolled in PAVE before they can provide any Medi-Cal covered services.
- The providers required to enroll in PAVE are: Nurse Practitioner, LCSW, LMFT, LPCC, Psychologist, MD, DO, Physician Assistant, Pharmacist, Speech Therapist, AOD Counselors and SUD DMC-ODS County Clinics.
- MHP and County SUD Staff/Clinics may send all questions and information to process PAVE enrollment/affiliation to AQISManagedCare@ochca.com with the Subject Line: PAVE Enrollment - _____.
- Any county PAVE enrollment documents and/or forms disseminated prior to 7/1/21 should be discarded since the process has been streamlined and updated. In order to obtain the most current PAVE enrollment information, please e-mail MCST.

PROVIDER DIRECTORY

- All Medi-Cal certified sites are required to provide an updated provider list to the MCST **every month by the 15th**. We ask that you also cc: IRIS (BHSIRISLiaisonTeam@ochca.com) on the monthly submission that went into effect 11/1/21.

NOABD - BENEFICIARY REQUESTING AN APPEAL

- Under federal regulations, an NOABD "Appeal" is a review by the Plan of an Adverse Benefit Determination.
- Federal regulations require beneficiaries to file an appeal within 60 calendar days from the date of when the NOABD was issued.
- When the beneficiary files an NOABD "Appeal" the MCST is required to open an investigation and resolve it within 30 calendar days.
- The program is also required to assist the beneficiary with the continuation of benefits during an appeal of the adverse benefit determination in accordance with federal regulations. This means, the program must keep the case open and continue to provide services until the investigation has been upheld or overturned.
- **If the appeal has been overturned, the beneficiary continues treatment services with the program.**



MANAGED CARE SUPPORT TEAM

REMINDERS (CONTINUED)

NOABD - BENEFICIARY REQUESTING AN APPEAL

- Refer to DHCS MHSUDS Information Notice #18-010E: https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf
- Refer to OC HCA Policy and Procedures: https://www.ochealthinfo.com/sites/hca/files/import/data/files/68158.pdf.

CLINICAL SUPERVISION (EFFECTIVE 1/1/22)

- The Board of Behavioral Sciences (BBS) has approved changes to the supervision related regulations that will go into effect January 1, 2022. If you have specific questions related to the changes, please contact BBS for further guidance.
- Refer to the link to view the summary of the BBS Supervision-Related Regulations: https://bbs.ca.gov/pdf/law_changes_2022/supervision_reg_changes.pdf
- The MCST will soon establish a more detailed protocol with a revised Clinical Supervision Reporting Form (CSRF) and requiring additional supervision documents from all new clinical supervisors/supervisees such as the Supervision Agreement (which replaces the Supervisor Responsibility Statement and Supervisory Plan), Written Oversight Agreement and the Supervisor Self-Assessment Report. At this time, we have not received further guidance and await the BBS to post more information about the new forms and instructions prior to 1/1/22.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- If you and your staff would like a specific or a full training about the MCST's oversight and updates on the State and Federal regulations governing Managed Care please e-mail the Program Manager, Annette Tran at anntran@ochca.com.

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
Lead(s): Esmi Carroll, LCSW Jennifer Fernandez, MSW

CLINICAL SUPERVISION
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, MSW

PAVE ENROLLMENT FOR MHP & SUD
Leads: Araceli Cueva, Staff Specialist Elizabeth "Liz" Martinez, Staff Specialist

CREDENTIALING AND PROVIDER DIRECTORY
Lead: Elaine Estrada, LCSW (County Credentialing & Provider Directory)
Lead: Sam Fraga, Staff Specialist (Cal-Optima Credentialing)

CONTACT INFORMATION
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