SUD Support Newsletter

Authority & Quality Improvement Services

April 2022

WHAT'S NEW?

SUD Support Team

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UPDATES

Medication Assisted Treatment (MAT) Services

Effective January 1st, 2022, providers within the Drug Medi-Cal Organized Delivery System (DMC-ODS) network are required to:

1. Offer MAT directly, OR
2. Have referral mechanisms in place to facilitate access to MAT off-site

...continued on page 2

CONGRATULATIONS!

Azahar and her husband, Craig, welcomed twins earlier in the month. The twins arrived ahead of schedule, so Azahar was not able to share the news with everyone personally. Azahar and her husband have added a daughter, Morgan Graciela, and a son, Mateo Alexander, to their family. Azahar will be on leave for several months and she looks forward to returning toward the end of summer. She hopes everyone will have a fantastic summer! She is sure all will be fine with CalAIM and with the other exciting changes ahead and knows that everyone is in great hands with the wonderful and highly capable members of the SUD support team!

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!

If my title is "Case Manager," I should be billing all one-on-one sessions with my clients as Care Coordination (previously known as Case Management).

a. TRUE
b. FALSE

…UPDATES (continued)

…continued from page 1

Some important information regarding the provision of MAT Services:

1. Under the DMC-ODS, MAT services can only be provided by:
    a. LPHA Physician
    b. LPHA non-physician (Physician Assistant, Registered Nurse Practitioner, Registered Nurse)

2. All providers use the same billing codes – either the MAT billing code or MAT Care Coordination billing code (i.e., no difference between MD and RN)

3. MAT billing code includes the following*:
    a. Assessment
    b. Treatment Planning
    c. Ordering
    d. Prescribing
    e. Administering
    f. Monitoring

    **Since all providers use the same billing codes, what is billable will depend largely on scope of practice for the medical professional.*

★ Coming Soon… ★

MAT Documentation Guide

******Please note a correction to the MAT slide (#64) of the Annual Provider Training (APT)******

Item #2 on the slide should read as follows, "Administration of buprenorphine, naltrexone (oral and injectable), acamprosate, disulfiram and naloxone." (Instead of "Vivitrol.")

Documentation FAQ

1. Can the LPHA have a consultation with a provider who did not complete the assessment of the client (such as the supervising counselor for the non-LPHA who met with the client)?

No. The State's intention for the consultation with the LPHA was for the LPHA to obtain information from the provider who met with the client, since the LPHA is not required to meet with the client to establish medical necessity. Although a supervising counselor may be familiar with the client's case, he/she/they did not meet with the client directly. If there is an unexpected circumstance that necessitates the supervising counselor to complete the consultation in the non-LPHA's place, the reason should be clearly documented. Such scenarios should be the exception and not the norm. Please note that the State may consider this a disallowance. This is a substantial risk because if an assessment is determined to be invalid based on the consultation with an individual other than the provider who met with the client, it has the potential to affect a large number of services.

…continued on page 3

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 issues we have been seeing most recently that we all need to be careful of…

Missing any one of the psychosocial elements

The Initial Assessment not addressing all 10 of the required psychosocial elements continues to be a trend in the reviews. Missing just one element will result in a disallowance, which means that the entire assessment becomes invalid!

Care Coordination services claimed for non-billable activities

A common reason for recoupment of Care Coordination progress notes continues to be due to billing for activities that are not reimbursable. Administrative tasks such as leaving a message, emailing, rescheduling a client's appointment, providing transportation, waiting, and observing clients, and drug testing are not billable under DMC-ODS. If these activities are documented, be sure to indicate that the time spent doing so is not part of the total time claimed. Be careful of "Blended" notes that include some billable and non-billable activities or two different service types (such as Care Coordination and Individual Counseling).

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

Documentation FAQ (continued)

…continued from page 2

2. I just inherited a client from a provider who is no longer with the agency…what should I be looking for when I review the chart?

There are several items that need to be checked in order to determine if services are currently billable:

- Is there an Initial Assessment, Re-Assessment, or Continuing Services Justification that has addressed all 10 psychosocial elements required for each episode of care?
- Is there an Initial Assessment, Re-Assessment, or Continuing Services Justification that clearly documents how the client meets medical necessity?
- Is there an Initial Assessment, Re-Assessment, or Continuing Services Justification that has utilized the 6 ASAM Dimensions to determine the client's need for the level of care being received?
- For the Residential level of care, has there been a Re-Assessment completed every 30 calendar days?
- For the Outpatient levels of care, was the CSJ completed between the 5th and 6th month from the client's admission?
- Is there a valid treatment plan for the client? (Remember that treatment plans are only valid for up to 90 calendar days. If there is a current treatment plan, be sure to calculate when it will expire.)

3. A client in my group left early today, how should I document and bill for this?

In terms of billing for when a client leaves a group early, there will be no difference in the total service minutes and number of clients in attendance as for any other group billing. The State allows us to claim the entire duration of the group time with the total number of participants in attendance, including those who left the group early. However, a few key pieces of documentation are needed:

1. The group-sign in sheets need to indicate the start and end time of the client who left early. For example, the group start and end time might have been from 1:00pm – 2:30pm, but the client who left early may have only been present from 1:00pm – 2:06pm. So, next to the client's name on the group sign-in sheet, it should be written "1:00pm – 2:06pm."
2. The progress note for the client who left the group early should indicate in the body of the note the reason the client left the group early and the client's start and end time for the group. This way, the information between the progress note and the group sign-in sheet will be congruent.

Documentation Tip!

If you are a non-LPHA, waiting for the LPHA to complete the Case Formulation, it is OK for you to begin collaborating with the client on a draft of the treatment plan.* Once the LPHA completes and signs the Case Formulation, you can re-visit the treatment plan with the client to confirm what will be addressed and obtain signatures.

*It is NOT OK for the treatment plan to be finalized and signed before the LPHA has completed and signed the Case Formulation! (A treatment plan that is signed by the counselor and client before the LPHA has completed and signed the Case Formulation will result in the treatment plan being invalid. That means there can be NO billing until a valid treatment plan is in place!)

Reminders

Intake: Care Coordination or Individual Counseling?!

Intake sessions where the intake paperwork is reviewed with client and signatures are obtained should be coded as Intake Individual Counseling. Remember, aside from reviewing paperwork, the session involves obtaining the minimum necessary information to establish a preliminary diagnosis.

Have you completed the 2021-2022 Annual Provider Training (APT)? Don't forget this is a required training for all providers in the County's DMC-ODS network.

Access it here: https://www.ochealthinfo.com/about-hca/mental-health-and-recovery-services/providers/authority-quality-improvement-services-11

"Test Your DMC-ODS Knowledge"
Answer: False

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

CLINICAL/COUNSELOR SUPERVISION

- Supervision must be provided and documented for **ALL** registered/waivered employees, interns and volunteers. If supervision is not provided the individual is **prohibited** from providing and billing for services.
- BBS license-waivered providers are required to submit their Clinical Supervision Report Form (CSRF) only when they have a registration number.

- DMC-ODS AOD Registered Counselors must be in supervision until they become Certified Counselors. The MCST has created a **SUD Counselor Supervision Reporting Form** (SUD CSRF) form specifically for AOD Registered Counselors to track the providers and supervisors. The anticipated date to begin completing the new form for ALL Registered AOD Counselor will go into effect **4/1/22.** Deadline to submit the SUD CSRF will be by **5/1/22**.

ACCESS LOGS

- ALL **new** recipients requesting **initial access** to Specialty Mental Health Services (SMHS) for serious and persistent mental illness (SPMI) and/or Substance Use Disorder (SUD) Drug Medi-Cal Organized Delivery System (DMC-ODS) (via phone, walk-in, etc.) must complete an Access Log.
- Every **access point** should be entering an Access Log in IRIS for beneficiaries.
- If your clinic/program doesn't have an appointment available within the timeframe (e.g., emergent, urgent, routine), you can schedule an appointment with another clinic/program to meet the timely access requirement. For SUD, you may contact the Beneficiary Access Line (BAL) to schedule and locate an available appointment across the DMC-ODS network.
- Access Logs must be entered in IRIS **immediately** after the beneficiary has been screened for an initial appointment to access services.
- Service Chiefs/Program Directors are to run and review Access Log reports in IRIS **weekly** to fix timely access errors and ensure Access Log entries are entered **daily** by the staff (e.g. Intake Counselor, Screeners, etc.).

GRIEVANCES

- "Grievance" is defined to mean an expression of dissatisfaction to the MHP, DMC-ODS, or any provider about any matter having to do with the provision of Medi-Cal services.
- Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect Medi-Cal beneficiary rights regardless of whether remedial action is requested, and the beneficiary right to dispute an extension of time proposed by the Plan to make an authorization decision.
- County-contracted programs that have an internal grievance process **MUST** also file a County grievance form on the beneficiary's behalf when the client has expressed dissatisfaction to the provider. If the beneficiary has Medi-Cal or may have Medi-Cal a Grievance Tracking Form will be required to complete as well.
- Minors have the right to file a grievance and it cannot be waived by the person's parent, guardian, or conservator.

MANAGED CARE SUPPORT TEAM

REMINDERS (CONTINUED)

2ND OPINION/CHANGE OF PROVIDER (DMC-ODS ONLY)

DMC-ODS County and County Contracted programs will be required to complete the 2nd Opinion/Change of Provider log and submit it to the MCST each quarter starting July 1 – September 30, 2022. The quarterly log must be submitted to the MCST by **October 10, 2022** deadline. A training will be provided in May and/or June at the SUD QI Coordinators' Meeting to go over the form, requirements and expectation.

PROVIDER DIRECTORY

The Provider Directory is a DHCS requirement (DHCS IN#18-020) that entails an exhaustive list of providers and program information under the Health Plans to be made available for all beneficiaries to access mental health and substance use disorder services. The MCST heavily relies on the accuracy of the Service Chiefs/Head of Services submission to compile the Provider Directory for publishing. You must review the monthly spreadsheet to ensure the list of providers are current and accurate before submitting it to the MCST by the 15th of each month.

2022 DHCS ENHANCED MONITORING REQUIREMENTS FOR NOABDS & ACCESS LOGS

Per DHCS, MCST is now required to enhance the tracking and monitoring of all NOABD submissions and Access Log entries:

- ✓ A quarterly report tracking NOABD submissions and Access Log entries will be e-mailed to the Director, Division Manager and Program Managers to review and disseminate to all County and Contracted providers to assist and discuss with program the need to adhere to the DHCS requirements.
- ✓ The report will identify programs that have zero or a low numbers of submissions and entries.
- ✓ Programs that are determined to be non-compliant could be placed on a Corrective Action Plan (CAP).
- ✓ The MCST can offer NOABD and/or Access Log Training, if necessary.

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 Administrative Manager, Annette Tran at anntran@ochca.com.

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER

Leads: 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

Credentialing Lead: Elaine Estrada, LCSW
Cal Optima Credentialing Lead: Sam Fraga, Staff Specialist
Provider Directory Lead: Paula Bishop, LMFT

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MCST ADMINISTRATIVE MANAGER

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