SUD Support Newsletter

Authority & Quality Improvement Services

September 2022

SUD Support Team

Azahar Lopez, PsyD, CHC
Yvonne Brack, LCSW
Claudia Gonzalez de Griese, LMFT
Laura Parsley, LCSW
Emi Tanaka, LCSW
Faith Morrison, Staff Assistant
Oscar Camarena, Office Specialist
Marsi Hartwell, Secretary

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

UPDATE

There are **no changes with the Physical Exam requirement.** Please continue to find out, for all levels of care, whether a client has received a physical exam within the prior 12 months from the date of admission. If the client has not had a physical exam in that timeframe, we will need to coordinate care to help the client obtain one. The State is not explicit on how this needs to be accounted for. The client's need for a physical exam can best be addressed by

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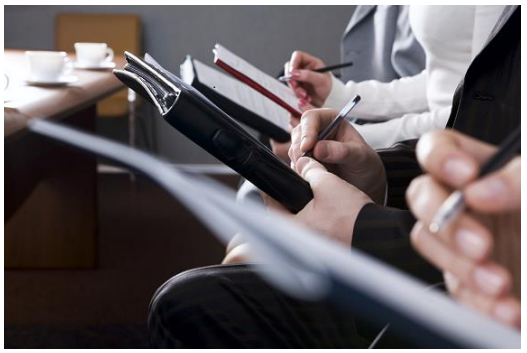
WHAT'S NEW?

You may be wondering about the Authority & Quality Improvement Services (AQIS) Substance Use Disorder Support Team (SST) Clinical Chart Reviews for fiscal year 2022-2023. As you know, your SST Consultants conduct reviews annually of each provider site to ensure compliance with Medi-Cal billing and documentation requirements. We are currently working on developing the review process. However, we know that with all the changes involved with the CalAIM initiative, the reviews will primarily be focused on providing qualitative feedback. We understand that many of your practices previously established are now requiring significant shifts, which have taken some time to put into practice. Therefore, feedback from the Clinical Chart Reviews will be geared towards technical assistance for the application of the new CalAIM changes.

As always, please feel free to reach out to your assigned consultant or to the general SST mailbox for any questions and concerns at AQISSUDSUPPORT@ochca.com.



CalAIM Memos

Thus far, the AQIS SST has distributed the following Memos specific to DMC-ODS:

- CalAIM Memo #002 – Code Selection During Assessment Period - Outpatient
- CalAIM Memo #003 – Documentation requirements to SMHS DMC-ODS Progress Notes
- Diagnostic Code Selection During Assessment Period (SUD Outpatient)

**Note: CalAIM Memo #004 is only applicable to MHP.*

NEW

- CalAIM Memo #005 – Assessment Period Access Criteria Medical Necessity
- CalAIM Memo #006 – DMC-ODS Level of Care Determination

If you need a copy of any of the Memos, please speak with your assigned consultant or email your request to AQISSUDSUPPORT@ochca.com

UPDATE

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placing it on the Problem List. Consider using the ICD-10 code of Z75.8 – "Other problems related to medical facilities and other health care."

What about youth clients under the age of 21 receiving Early Intervention Services?

Although not explicitly required by the State, best practice would be to address the need for a physical exam with our youth clients, even in Early Intervention.

What about the use of SNOMED codes?

There is no requirement to use the codes under the Systematized Nomenclature of Medicine (SNOMED) Clinical Terms. If your agency's electronic health record (EHR) allows for the use of SNOMED codes, this is permissible. Please bear in mind scope of practice implications when using the SNOMED codes.

DAILY NOTES (Residential)

The intention of the daily note requirement at the Residential levels of care is to demonstrate that a valid service was provided to justify the billing of the treatment day. Thus, the requirement can be fulfilled in one of the following ways:

1. A summary note of all services provided to the client for that day;
2. A progress note for an individual counseling or group counseling session for that day*; or
3. Documentation of client's participation in an eligible structured activity for that day.

**Note: Care Coordination DOES NOT count as it is billed separately*

How should a Daily Note be written?

If taking option #1 above, think of the daily note as a bird's eye view of the client's day. It should give the reader a good picture of all that was provided to the client on any given day. Consider…

- What clinical services were provided?
- What Care Coordination services were provided?
- What structured activities did the client participate in?
- Was programming missed due to an off-site appointment?

Important! Demonstrating medical necessity: Including information about how the client responded to the services (i.e., whether the client was engaged, interacted appropriately with peers, expressing ambivalence about being in treatment, etc.) that gives insight into how the treatment services are benefitting the client is helpful for tracking progress towards resolution of problems/needs.

Documentation FAQ

1. Do we still need to have Group Sign-In Sheets with client signatures?

No. Group Sign-In Sheets with the participants' signatures are no longer required. Instead, please be sure that each group that is provided has a corresponding participant list that includes the names of all attendees for the group. The group topic or name, date and time should continue to be noted so that it can be matched up with the respective progress note. The provider's signature is not required but recommended to demonstrate that the provider conducted the group session as documented. The provider's printed name, credentials, and date of signature should also accompany the signature.

2. Will services be disallowed if medical necessity is not met?

Yes. All DMC-ODS services provided must be based on medical necessity. Therefore, services claimed after the assessment phase (for outpatient, 30 days following the first visit or up to 60 days for youth and those experiencing homelessness) without demonstration of how the client meets the access criteria can be considered fraud, waste, and/or abuse.

3. Do we still need to document the start and end times on Progress Notes?

Yes. Until we have more specific information from the State, please be sure to continue documenting the start and end times for the service and documentation minutes on the Progress Notes. As has been in the past, it is important that the start and end times on the Progress Notes match up with the number of minutes claimed in the billing system. All time that is claimed should be appropriately justified by the documentation.

Did you know…someone is back!

Welcome Back, Azahar!

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

- GRIEVANCES & INVESTIGATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- PAVE ENROLLMENT FOR COUNTY DMC-ODS CLINICS & PROVIDERS
- PAVE ENROLLMENT FOR MHP PROVIDERS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP/DMC-ODS)
- COUNTY CREDENTIALING
- CAL-OPTIMA CREDENTIALING
- ACCESS LOGS
- CLINICAL/COUNSELOR SUPERVISION
- MHPS/DMC-ODS PROVIDER DIRECTORIES

REMINDERS

GRIEVANCES

- "Grievance" is defined to mean an expression of dissatisfaction to the 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's 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 beneficiary has expressed dissatisfaction to the provider.
- Minors have the right to file a grievance and it cannot be waived by the person's parent, guardian, or conservator.
- When a beneficiary is filing a grievance that is a complaint against a provider, it is important to identify the name of the provider on the grievance forms.

COUNTY CREDENTIALING

- If the **County Contracted Programs** have completed credentialing for all their providers during the initial credentialing timeline, then any new providers on-barding going forward must submit their credentialing packet within 5-10 business days of being hired.
- **County Employees** who are licensed, waivered, registered and/or certified providers will undergo the credentialing process starting in phases for existing providers beginning September 1, 2022. All new hires must submit their credentialing packet within 5-10 business days of being hired.
- **ALL newly hired providers** must not deliver Medi-Cal covered services under their license, registration and/or certification until their credentials are approved by the MCST. *IRIS will not activate the new provider in the system to bill for services without a credentialing letter of approval.*

UPDATE: NOABD LETTERS

The NOABD letters have been updated to reflect Ian Kemmer, LMFT, AQIS Director's name in the signature portion of the letters. The newly revised NOABD templates are available on the AQIS website to begin using, immediately. Discard all old NOABD templates.

Hyperlink Access: https://ochealthinfo.com/providers-partners/authority-quality-improvement-services-division-aqis/quality-assurance-quality-1

MANAGED CARE SUPPORT TEAM

REMINDERS (CONTINUED)

ACCESS LOGS REPORTS & CORRECTIONS

- Service Chiefs/Program Directors are to run and review Access Log reports **weekly** to fix timely access errors and ensure Access Log entries are entered **daily** by the staff (e.g., Intake Counselor).
- MCST runs an IRIS Access Log report monthly and quarterly for the DMC-ODS to monitor, reconcile and request errors to be corrected by the programs.
- Any errors found by the MCST must be corrected and re-submitted by the program within **3 business days**.
- The MCST Access Log Team is required to reach out to the program to correct the errors and then confirm with the program that the corrections have been completed.
- If the Access Log corrections are not resolved in a timely manner each month, the programs may be subject to a corrective action plan (CAP).

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.

Dolores Castaneda, LMFT
Service Chief II

Congratulations to Dolores on her promotion! The AQIS/MCST family is very excited to welcome you!

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

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

MCST ADMINISTRATORS
Annette Tran, LCSW, Administrative Manager
Dolores Castaneda, LMFT, Service Chief II