SUD Support Newsletter

Authority & Quality Improvement Services

November/December 2022

WHAT'S NEW?

With 2022 coming to a close, the Substance Use Disorder (SUD) Support Team (SST) would like to take this opportunity to thank our providers for all of the hard work you do for our beneficiaries! You provide an invaluable service and it is without a doubt that your commitment to the quality of care for our beneficiaries is above and beyond.

On top of the meaningful work that you do, this year has brought on a tremendous amount of change that has required you to dramatically shift your practices and operations. We recognize that this is no small feat and we are very grateful for the patience and collaborative spirit you have demonstrated.

We look forward to an exciting and eventful 2023! A few items that will be coming shortly after the new year…

- Updated Documentation Manual
- Updated Documentation Training

Both will incorporate the CalAIM requirements!

Happy Holidays!

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

**Note: CalAIM Memo #001 and #004 only apply to MHP.*

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

SUD Support Team

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UPDATES

Disallowances and Recoupments under CalAIM

With the implementation of CalAIM, disallowances and recoupments will focus on services or billing considered as fraud, waste, and/or abuse. A few areas that can result in a disallowance and/or recoupment of services include, but are not limited to, the following:

- Services provided and claimed by a non-DMC certified provider (i.e., lapsed/expired

…continued on page 2

UPDATES (continued)

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license/registration/certification)

- Services provided and claimed outside of the provider's scope of practice
- Assessment services provided and claimed by a provider who has not completed the ASAM A and B training
- Medical Necessity and Access Criteria not established
- Justification for the level of care indicated not established
- No corresponding progress note to accompany the claim
- Claiming for non-billable activities
- Claiming for group services with more than twelve (12) clients
- Claiming for group services without a corresponding group list of participants
- Excessive and unsubstantiated service or documentation time claimed
- *For Residential programs only:* Claiming for treatment days when the client has not received the five (5) clinical hours required each week

Please be advised…

- ✓ The above list is not exhaustive
- ✓ Each occurrence of a potential disallowance and/or recoupment will be carefully reviewed for the appearance of fraud, waste, and/or abuse.
- ✓ It is important to be diligent in adhering to the timelines as best you can. Although a single instance of late documentation will not be disallowed or recouped, a pattern of timeliness issues across any one provider or agency/organization will be scrutinized for the potential for fraud, waste, and/or abuse.

Documentation FAQ

1. Would documentation that is "templated" or copied/pasted be considered fraud, waste, and/or abuse?

Yes. "Templating" is the use of the same information from one progress note to another, where it looks like a carbon copy or copy and paste of another progress note intended for a different day or different client. This type of documentation is considered fraudulent and will result in recoupment and/or compliance investigations. The exception would be for group service documentation where the same intervention will have been provided to all group attendees for that particular group. However, there should be some documentation specific to each client so that it is individualized.

2. How should I document if I have billable and non-billable activities?

You can use the billable code and document what was provided to the client. Be clear in the documentation that if a non-billable activity was provided, in addition to the billable activity, the time claimed does not include the time spent for the non-billable activity. For example, if you would like to document that you completed a referral form and faxed it, the documentation could look something like, "Treatment Authorization Request form completed and faxed to the County (time not billed)." The total number of minutes claimed for the service can only include the time spent for the billable activity. Depending on how your agency/entity has structured the progress note, there may be some variations. For example, if your agency/entity uses a progress note format that includes separate sections for billable and non-billable activities, there may be no need to be explicit in what was not billed.

3. My client wants to receive Recovery Services. How do I document adding this?

The client can receive Recovery Services as an additional service within his/her/their treatment episode at the current program.

…continued on page 3

Documentation FAQ (continued)

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Therefore, there is only one EOC (for treatment). The discussion with the client about his/her/their desire for enrollment in Recovery Services should be documented as well as how the client is clinically appropriate for this level of care in a progress note. The problem list should be updated accordingly.

Please note that a client receiving both SUD treatment and Recovery Services simultaneously is not a common scenario. The client must meet the access criteria and need for both levels of care. Clinical judgment should be used to determine the need for concurrent enrollment and the documentation must reflect this.

Before having a Recovery Services client attend individual/group sessions at the Residential facility, verify with the Department of Health Care Services' (DHCS) licensing and certification to ensure it would be permitted for non-residents (i.e., Alumni) to be onsite at the same time as current clients/residents.

SST CLINICAL CHART REVIEWS WILL BE STARTING IN JANUARY 2023!

The focus of the reviews will be on providing technical assistance and qualitative feedback.

If you have any questions, be sure to reach out to your assigned consultant or send an email to AQISSUDSUPPORT@ochca.com

Notice Of Adverse Benefit Determination (NOABD)

Additional clarification about the requirements for issuing NOABD terminations are coming in January 2023, as we continuously keep on learning. Thank you for your patience!

County DUI/Drug Court & Residential Treatment

Clients coming into the DUI/Drug Court programs at the County clinics, who are later referred and admitted into a residential level of care, may continue to receive care coordination services with the DUI/Drug Court programs. This helps to ensure that the client will transition smoothly from DUI/Drug Court to residential and then back to DUI/Drug Court upon the client's conclusion of residential services. While the residential program will provide the full array of services as they would with any other client, the DUI/Drug Court program will only be able to provide and bill for care coordination. Care coordination services are provided, at minimum, one (1) time every thirty (30) days to avoid the need to discharge the client. The DUI/Drug Court program and the residential program can bill care coordination services simultaneously during this time. Activities may include a conversation with the client at court by the court lead (who may or may not be the assigned provider). It may also be a check in with the client in regard to impending discharge from a residential program or a consultation between the DUI/Drug Court provider and a residential services provider.

Once the client leaves the residential program (either by planned or unplanned discharge) and returns to the DUI/Drug Court clinic, a re-assessment is needed to document how the client meets the access criteria and demonstrates a need for the ODF/IOT level of care. If the client had a planned discharge, such as a successful completion, from the residential program and a re-assessment was completed by the residential provider that demonstrates the need for ODF/IOT, the document may be used by the DUI/Drug Court outpatient provider.

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 DIRECTORY

REMINDERS

COUNTY CREDENTIALING

- All **new providers** must submit their County credentialing packet within 5-10 business days of being hired to the MCST. The newly hired provider must **NOT** deliver any Medi-Cal covered services under their license, waiver, registration and/or certification until they obtain a letter of approval confirming they have been credentialed by the MCST. The IRIS team will **NOT** activate a new provider in the IRIS system without proof of the credentialing approval letter. It is the responsibility of the direct supervisor to review and submit the new County employee credentialing packet to the MCST.
- **Existing County Employees** who are licensed, waivered, registered and/or certified providers that deliver Medi-Cal covered services are now undergoing the credentialing process in phases as of September 2022. A Credentialing Team member will reach out to the Service Chiefs 3-4 weeks prior to the credentialing timeframe to schedule a "Meet & Greet" in order to provide support when undergoing the process.

EXPIRED LICENSES, CERTIFICATION AND REGISTRATION

- Providers are required to maintain their credentials under their certifying board (i.e., BBS, BOP, CCAAP, etc.) and must renew it **on-time**. If the provider has let their credentials lapse, they must **NOT** deliver Medi-Cal covered services or claim Medi-Cal reimbursement in reliance of those services. This practice is viewed as fraudulent.
- When the provider's credential has expired, the MCST and IRIS immediately take action to deactivate the provider in the County system. The provider must petition for their credentialing suspension to be lifted and provide proof of their license, certification and/or registration renewal to the MCST and IRIS. The reinstatement is **NOT** automatic.
- Certifying Organizations (CO) may likely renew licenses, certifications, and registration back to the original expiration. The County cannot assume that the CO or licensing board will renew this retroactively, which places the provider at risk for non-compliance. Therefore, the provider is **NOT** to deliver any Medi-Cal covered services if the credentials have expired.

CHANGE OF PROVIDERS AND SECOND OPINIONS – NEW

- The MCST will begin e-mailing notifications to direct supervisors for those providers who have been identified as having multiple requests for a "Change of Provider" within a quarter. The frequency for a change of provider usually indicates concerns with the quality of care, including the lack of dignity and respect towards the beneficiaries receiving treatment services. This will assist the direct supervisor to improve the provider's quality of treatment services and reduce the number change of requests. If the provider continues to receive repeated requests for a change of provider, he/she/they may be subject to a corrective action plan.

MANAGED CARE SUPPORT TEAM

REMINDERS (CONTINUED)

PROVIDER DIRECTORY

- The Provider Directory spreadsheet has been streamlined and incorporates the NACT requirement fields. This will help reduce the reporting duplication and save time for you as a provider. A brief training on the new spreadsheet was offered at the QI Coordinators' Meetings in November. The newly revised Provider Directory spreadsheet will go into effect **January 1, 2023**. Below is a sneak peek:

NEW FORMAT COMING SOON EFFECTIVE 1/1/2023

PROGRAM TAB

Orange County Provider Directory
Program Details

Program Name	Program Specialty	Trained in Cultural Competency Yes/No	Cultural Capabilities	Street Number	Address	City	Zip Code	Website	Phone	Linguistic Capabilities (Non-English)	Business Type	Populations Served ex. Perinatal, Children, Youth, & Adult NACT Requirement	Provider Type	ADA Compliant Yes/No	Provider NPI	Hours of Operation	Provider Services/Modality (ASAM Level Of Care) *SUD Only

PROVIDER TAB

Launch Form View

Orange County Provider Directory
Provider Details

Provider Name Last Name, First Name	Provider Status	Provider Type & License # Ex. LMFT #####	License Expiration Date	Program	Provider Business Address	City	Website	Business Type	Postal Code	Trained in Cultural Competency Yes/No	Linguistic Capabilities (Non-English)	Phone (Program Main #)	ADA Compliant Yes/No	Provider NPI	Providers Specialty (e.g. Cognitive Behavioral Therapy) *no abbreviations
Example: Smith, John	New	LCSW 12345	12/31/2022		1234 Main Street	Santa Ana	www.ochca.com	SUD	92701	No	ASL	(714)123-4567	Yes	1234567890	Cognitive Behavioral Therapy

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

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MCST ADMINISTRATORS

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