SUD Support Newsletter

Authority & Quality Improvement Services

January 2023

WHAT'S NEW?

Happy New Year!

We would like to wish you all the best for 2023! We look forward to working alongside you as we continue to navigate the new terrain under CalAIM. As mentioned in the previous month's newsletter, we will begin offering the updated Documentation Training, which will address the CalAIM requirements. The training will be offered via video conferencing. The following is the training schedule for February:

- Tuesday, February 7th 9am – 3pm
- Tuesday, February 14th 9am – 3pm
- Tuesday, February 21st 9am – 3pm
- Tuesday, February 28th 9am – 3pm

Please sign up for a training by sending your request to aqissudsupport@ochca.com.

Be sure to indicate the name of the staff, credentials, and agency/organization along with the date of the training requested.

We look forward to seeing you there!

Coming soon... the updated Documentation Manual!

CalAIM Memos

The AQIS SST has distributed the following Memos specific to DMC-ODS to communicate the CalAIM requirements:

- 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

No More Continuing Services Justification (CSJ)?

With CalAIM, there is no longer a requirement for the outpatient levels of care to complete a CSJ every 5 to 6 months. A Re-Assessment is needed at the outpatient levels of care only when clinically indicated for a change in the client's condition, such as a change in the client's diagnosis or level of care. Use your best clinical judgement to decide when and if it is warranted.

Does a discharge constitute a

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UPDATES (continued)

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change in the client's condition?

It is best practice to complete a re-assessment of some kind to inform the client's readiness for discharge or transition out of the current level of care. In considering the six (6) ASAM Criteria dimensions, if the client's functioning has improved, this means that the client's condition has changed. Likewise, if the client's presentation has declined, a re-assessment across the six (6) ASAM Criteria dimensions may indicate a need for a higher level of care.

Re-Assessments are required at Residential levels of care!

Due to the statewide goal for the average length of stay for residential treatment services being thirty (30) days, we must ensure that clients are transitioned to another level of care when clinically appropriate based on treatment progress. Therefore, a Re-Assessment at the residential levels of care will be required every thirty (30) days. There is no re-authorization process or requirement, so it is up to each provider to ensure that it is completed in a timely manner and filed in the client's chart. For clients who are in need of the residential level of care beyond the first thirty (30) days, be sure the Re-Assessment is clearly indicating how the client, based on the six (6) ASAM Criteria dimensions, continues to need the residential level of care. It is important to consider the progress or lack of progress in treatment and the needs of the client that warrant the continued stay in residential treatment. Be clear in your documentation how the additional time in residential treatment is medically necessary to address the client's problems and needs.

SST Clinical Chart Reviews

The Clinical Chart Reviews for Fiscal Year 2022-2023 have begun! We know you are just as excited as we are. This year, the monitoring reviews will predominantly be qualitative in nature to help us all get in line with the changes brought on by CalAIM. As the SST conducts reviews, we will try to keep you abreast of trends and findings that we can all learn from.

Here are a few reminders…

- In order to utilize the Perinatal billing codes, there must be medical documentation on file

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Documentation FAQ

1. Can my client at the residential program, who is transitioning to outpatient, continue Recovery Services with us?

Yes. It would be acceptable to include the client's need for Recovery Services in the re-assessment completed at the residential program that documents the client's readiness for outpatient and no longer meeting medical necessity for the residential level of care. In the re-assessment, it can be explained how the client has achieved enough progress in residential treatment to transition to the outpatient level of care and that the client will be assisted with the linkage to the outpatient provider. Additionally, the documentation should be clear on the client's need to continue with Recovery Services at the current provider location. Remember that the concurrent enrollment of a client in treatment services and Recovery Services is allowed, but not typical. Therefore, the documentation in the re-assessment should describe the need for both levels of care.

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.

2. I am a non-LPHA. Can I complete the Diagnosis and Case Formulation section of the County's SUD Assessment?

No. A non-LPHA cannot diagnose and cannot establish the access criteria under the DMC-ODS. Therefore, completing the Diagnosis and Case Formulation section of the assessment is out of the scope of practice for the non-LPHA. The LPHA cannot simply co-sign these sections! The LPHA must be the one who is completing both sections in full. If your program utilizes an Electronic Health Record (EHR), be mindful of timestamps and the potential for a section to appear as though a non-LPHA has completed a section that he/she/they should not be completing. Please remember

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Documentation FAQ (continued)

...continued from page 2

that services or activities conducted out of the scope of practice will result in disallowance/recoupment and may lead to a compliance investigation.

3. What happens to the services that were provided and claimed by a provider with an expired license?

The period of time during which a provider's license is inactive, DMC-ODS services cannot be provided and claimed. If it is discovered that services have been claimed using the billable codes, it should be corrected to the non-compliant codes so that it is not billed to the State. Remember, it is not just the individual services that are impacted. If a provider with an expired license has completed an initial assessment, this means that the assessment document is not valid along with all of the services claimed based on that assessment. A new assessment will need to be completed to bring the chart into compliance.

SST Clinical Chart Reviews (continued)

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to evidence the client's pregnancy or post-partum status. In cases where medical documentation is unable to be obtained, please be sure the non-perinatal billing codes are utilized.

- Group counseling progress note documentation must have a corresponding group participant list. Please be sure information is consistent between the progress note and the group list!
- For referrals from legal entities (i.e., Courts, probation, Social Services, etc.), please remember that a referral alone is not enough to warrant the need for treatment. The client must meet the access criteria. It is important to be clear in the documentation how the information about the client's functioning across the six (6) ASAM Criteria dimensions supports the need for the treatment at the indicated level of care.
- Provider signatures (along with printed name, credentials, and date of signature) are required on the assessment. If both the non-LPHA and the LPHA are involved in the assessment, both provider signatures are required.

What's up with Evidence Based Practices (EBPs)?

As you know, all DMC-ODS providers must be trained in at least two (2) EBPs. The County is responsible for monitoring the use of EBPs across the network. The way this information is monitored is through review of the progress note documentation. Obviously, not every progress note will include information about an EBP because not every service is EBP-driven. Therefore, if and when an EBP is utilized in a session, the progress note documentation should clearly indicate this. When doing so, it is important to be more descriptive than just stating which EBP was used. Be sure to individualize how the particular EBP was used with the client. For example, what technique was used and how it is applicable to the client. Perhaps we have an ambivalent client demonstrating some resistance to treatment where, "Counselor used open-ended questions, affirmations, reflective listening, and summarizing (OARS of Motivational Interviewing) to obtain assessment information and help client feel more at ease and open to considering the benefits of enrollment."

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 by visiting the "Providers" tab of the DMC-ODS website, here: http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods/providers

Send us your questions, comments, and/or concerns at: aqissudsupport@ochca.com

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

- Any provider who is licensed, waivered, registered, and/or certified AND delivers Medi-Cal covered services must be credentialed by the County.
- DMC-ODS programs with multiple locations will have a credential approval letter that will cover their entity for that provider. However, if a provider works at two different entities, then **two** credential approval letters will be issued.

EXPIRED LICENSES, CERTIFICATION AND REGISTRATION

- Providers are required to maintain their credentials under their certifying board (i.e., BBS, CCAAP, etc.) and must renew it on-time. If the provider has let their credentials lapse, they must **NOT** deliver Medi-Cal covered services and claim Medi-Cal reimbursement in reliance of those services. This practice is viewed as fraudulent.
- Starting January 2023, the MCST will be issuing a formal Corrective Action Plan to programs that have 3 providers with expired credentials. There may be extenuating circumstances which can be addressed on an individual basis.

CLINICAL SUPERVISION

- BBS requires supervisors to complete and submit a Supervisor Self-Assessment Report to the board by January 1, 2023 attesting that the clinical supervisor has fulfilled the requirements.
- The MCST requires a copy of this form as proof to be kept on file. If the form is completed online using the Breeze portal, it must be submitted as proof to the MCST as well.

NOABDS

- The MCST has made some modifications to the Termination NOABD requirements per discussion with DHCS and EQRO.
- NOABD Terminations are no longer required for beneficiaries who have successfully completed the program, even if they are not moving onto a lower level of care.

REMINDERS (CONTINUED)

NOABDS (CONTINUED)

MHP/DMC-ODS Termination Timelines for Termination NOABDs

Termination Reason	Issue	Termination Timeline
No contact with beneficiary/no services provided for a period of time (30 days or longer for DMC-ODS or 60 days or longer for MHP).	Yes	10 Days
Beneficiary declines services verbally or no longer wishes to receive services but clinically would still benefit from ongoing services.	Yes	10 Days
Beneficiary declines services with a signed statement (wet signature/date) and no longer wishes to receive services but clinically would still benefit from ongoing services.	Yes	Same day
Beneficiary has completed treatment/services and AGREES with discharge.	No	N/A
Beneficiary has completed treatment/services and DISAGREES with discharge.	Yes	10 Days
Beneficiary transitioned to provider within MHP/DMC-ODS.	No	N/A
The beneficiary's whereabouts are unknown and the post office returns agency mail directed beneficiary indicating no forwarding address.	Yes	Same day
Beneficiary is in a long term care facility.	Yes	Same day
Beneficiary is incarcerated for a lengthy period of time.	Yes	Same day
Beneficiary is deceased.	Yes	Same day

"10 days" refers to providing the beneficiary with at least 10 days prior to the adverse action. The adverse action is the termination. The date of the NOABD counts as day 1, therefore, the termination date occurs on day 11. For example, if a NOABD is issued on 6/1/22, the earliest termination date provided is 6/11/22 if the circumstances fall in the 10 day timeline.

PROVIDER DIRECTORY

- The new Provider Directory spreadsheet (Version 12.31.22) is required to be used effective 1/1/23. Refer to the Provider Directory guideline for detailed instructions.
- Providers covering at the other sites must be identified and placed on the "Provider Tab" for each program location.

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 or Service Chief II, Dolores Castaneda at dcastaneda@ochca.com.

MANAGED CARE SUPPORT TEAM

ochealth CARE AGENCY

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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