SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

September 2023

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UPDATES

The State has provided clarification that the **treatment plan is no longer required for programs under the Substance Abuse Block Grant (SABG), Alcohol and/or Other Drug (AOD) Program Certification Standards, Adolescent Substance Use Disorder (SUD) Best Practices Guide, and Perinatal Practice Guidelines**. The problem list may be used instead. Please note that treatment plans will continue to be required for the Residential Treatment

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WHAT'S NEW?

Counties that are part of the Drug Medi-Cal Organized Delivery System (DMC-ODS) are required to participate in an annual External Quality Review (EQR). These reviews must be completed by a third-party organization and the main focus is on access, timeliness, quality, and outcomes. For Orange County, the review for this year took place virtually from September 19 – 21. Various sessions were held to present information on our network's processes as well as focus groups where providers and beneficiaries had the opportunity to give feedback on their experiences. Now that the review has concluded, we will be waiting to receive the final report that will contain recommendations for where we can make improvements as well as the areas we are doing well. The results will be shared with providers when it becomes available.

Thank you to all who participated in providing valuable feedback and engaging in the focus groups!

SUD Documentation Training

The SUD Documentation Training that addresses the CalAIM changes is available online here:

http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods/providers

Be sure to retain a copy of the certificate of completion for your records!

SUD Documentation Manual

This is your "go-to" reference tool that includes all of the information discussed in the online Documentation Training. Access it here:

https://www.ochealthinfo.com/sites/healthcare/files/2023-02/DMC-ODS%20CalAIM%20Doc%20Manual.pdf

UPDATES (continued)

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levels of care. There are no changes to Treatment Plans being required for the Peer Support Programs and Narcotic Treatment Programs (NTPs).

Previously, the date of service counted as day one for the timeline of completing progress note documentation. However, the State has changed this to now have **the date of service count as day zero (0) in regards to progress notes being completed within three (3) business days**.

The most recent DHCS Billing Manual has made it explicit that reimbursable services need to be "direct patient care," which "does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a client visit" (DHCS Drug Medi-Cal ODS Billing Manual, June 2023). Therefore, there are a few **non-face-to-face activities that are no longer billable**:

- **Review of documents**
  - LPHA's independent review of non-LPHA's ASAM based assessment
  - Physician's review of the physical exam
  - Reviewing documents from outside entities (court, hospital, etc.)
  - Review of past progress notes to prepare for upcoming session
  - Review of assessments, treatment plans, and/or problem lists received from other providers/programs
- **Time spent completing the discharge summary** for a client with an unplanned discharge
- **Completion of sections of the ASAM** based assessment (i.e., Dimensions 1-6, risk ratings, rationales) *with the exception of the Case Formulation by the LPHA*

The **LPHA can bill for the non-face-to-face time spent on conceptualization of the Case Formulation** (or narrative write up) to justify the client's level of care placement using the SUD Treatment Plan Development and Modification (70899-125) code.

Non-face-to-face time spent creating/developing the treatment plan or problem list, by either the non-LPHA or LPHA, is also billable using the SUD Treatment Plan Development and Modification (70899-125) code.

DHCS DMC-ODS Billing Manual - https://www.dhcs.ca.gov/Documents/DMC-ODS-Billing-Manual-v-1-4.pdf

SST's DMC-ODS Payment Reform CPT Guide - https://www.ochealthinfo.com/sites/healthcare/files/2023-06/DMC-ODS%20Payment%20Reform%202023%20CPT%20Guide%206

Documentation FAQ

1. Can groups at Recovery Services have more than 12 participants?

No. The same group requirements apply at the Recovery Services level of care. The maximum number of participants is 12. Groups at Recovery Services should be claimed using the Psychosocial Rehabilitation, Group, per 15 Min (70899-123) code. Any groups that are conducted at Recovery Services that exceed 12 clients in attendance will need to be made non-billable.

2. How do I bill for crisis intervention at Residential?

A crisis intervention service is not a separate, billable service at the residential levels of care. It is considered part of the daily bundle of services. The time spent de-escalating a client and providing medically necessary interventions, if documented properly, can count towards the required five clinical hours in the week.

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Important!

Assignment of Benefits

An Assignment of Benefits (AOB) for the DMC-ODS is an agreement that transfers the Medi-Cal claims rights or benefits to a third party (or program/entity), which allows the program/entity to be reimbursed. An AOB document or form should be one of the items discussed in the intake process. Clients must provide their signature on an AOB in order for claims to be sent to the State for reimbursement. Client charts without this document or form will not be able to bill Medi-Cal. This means that in an audit or chart review, any charts without this on file will be considered to be out of compliance and will result in recoupment. It will also result in a compliance investigation due to the breach of protected health information.

Documentation FAQ (continued)

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3. How do I bill for a couples counseling session when both participants are clients in our program?

If the rendering provider is an LPHA, the Family Psychotherapy (w/ Pt Present), 26-50 Min (90847-1) code should be used. The non-LPHA can use the SUD Family Counseling (70899-116) code. How the service time is claimed will depend on the focus or content of the session. If the session/service addressed both clients' treatment needs, you would split the time and do two separate progress notes because the session/service is relevant to both clients. Each progress note needs to focus on the respective client's needs and how the couples' session centers on each client. This kind of documentation is very easy to "template," so make sure that the specific client's issues/needs are being highlighted as the focus of interventions for each progress note. Since the documentation needs to center around the client, if the content/focus of the session is more about one client than the other, it may make more sense to just document one progress note for that client and what was addressed to help them in their recovery/treatment.

Telehealth Consent and Documentation

We are still permitted to provide services by telehealth. In those cases where we do provide services by telehealth, it is important that we are familiar with and are adhering to the requirements. Below is an overview:

Consent for services by telehealth can be obtained either verbally or in writing. This consent needs to be documented in the client's chart. It is acceptable for this to be documented in the progress note for the session/service that is conducted by telehealth. The documentation should make it clear that the client gave verbal consent to the service via telehealth. The consent (verbal or written) needs to contain the following:

- The client's right to access services in person;
- The voluntary nature of the consent, which can be withdrawn at any time;
- That transportation can be made available for in-person services; and
- Any limits/risks compared to in-person services

Documentation in the progress note for each session/service provided by telehealth should include the following:

- How the client's confidentiality was ensured;
- Confirmation that client is present in California;
- Reason for the telehealth service (as opposed to in-person); and
- The clinical appropriateness of the client receiving a service by telehealth

REMINDERS

"Note to Chart" or administrative notes in a client's chart:

Please be sure that there is no clinical content in a "Note to Chart" or administrative note. Any clinically relevant information should be documented in a progress note. A "Note to Chart" or administrative note should be reserved for such activities as attempts to contact a client or appointment rescheduling/confirmations. Be aware that since "Note to Chart" and administrative notes are part of the record, it is released upon request to clients, client representatives, and to third parties. Hence, it is very important that such documentation be completed accurately and appropriately.

For assistance with the billing codes and IRIS, contact the Front Office Coordination team at bhsirisfrontofficesupport@ochca.com

For assistance on documentation and CPT codes, contact the aqissudsupport@ochca.com

CALOMS CLINICAL TRAINING:

Have you taken this important training? If you have yet to do so or could use a refresher, the training can be accessed here:

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

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

- EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- PAVE ENROLLMENT (MHP PROVIDERS ONLY)
- CHANGE OF PROVIDER/2ND OPINIONS (MHP/DMC-ODS)
- CAL-OPTIMA CREDENTIALING (AOA COUNTY CLINICS)
- GRIEVANCES & INVESTIGATIONS
- COUNTY CREDENTIALING
- ACCESS LOGS
- CLINICAL/COUNSELOR SUPERVISION
- MHP & DMC-ODS PROVIDER DIRECTORY

REMINDERS, ANNOUNCEMENTS & UPDATES

CLINICAL/COUNSELOR SUPERVISION

- The Clinical/Counselor Supervision Reporting Form (CSRF) has been revised to enhance the tracking and monitoring of all supervisees and clinical supervisors. In an effort, to maintain an accurate tracking record, we are requiring all clinical supervisors to also complete the 2nd page of the CSRF that list each of their supervisees and any time there is a change. The revised CSRF goes into effect **10/1/23**. Please discard all old versions of the CSRF as it will be invalid, and you will be required to resubmit the newly revised form.

- ✓ A supervisee must be in clinical/counselor supervision until they become licensed/certified.
- ✓ A CSRF is required for each supervisee being provided clinical supervision, whether it is individual, group, or both.
- ✓ If a supervisee has two or more licenses (e.g., AMFT and APCC) and is collecting clinical hours for both then two CSRFs for each discipline is required.
- ✓ If there is a status change with clinical/counselor supervision (e.g., change in supervisor, supervisee license, termination in supervision) then the CSRF is required to be submitted.
- ✓ If a CSRF is not on file and the supervisee has been providing services without clinical supervision a potential compliance investigation will be initiated and recoupment of services may occur.

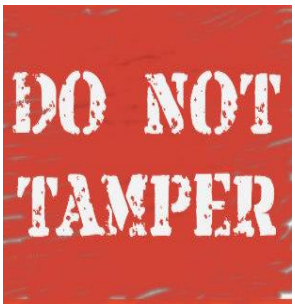
- **COUNTY EMPLOYEES ONLY** – As a result of the new differential pay, Administration has directed the MCST to provide Auditor Controller and Human Resources a bi-weekly report of clinical supervisors who are approved to utilize the CLS pay code on their timecard. If the MCST does NOT receive the missing and/or required documents upon request, the Clinical Supervisor will be removed from the eligible list for differential pay. Be sure to submit the Clinical Supervisor Agreement (CSA) as a one-time form to be completed by the Clinical Supervisor who must obtain a two-step approval from their direct supervisor and program manager along with the 2nd page of the CSRF.
- The P&P for Clinical Supervision Requirements has been updated as of **8/11/23** to reflect the various changes impacting the Clinical Supervisors who are County Employees. Clinical Supervisors are encouraged to review the P&P thoroughly. Hyperlink: Clinical Supervision Requirements (ochealthinfo.com)

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

COUNTY CREDENTIALING

New Applicant Request Form (NARF) – this form is required to be filled out by the Direct Supervisor or QA/QI Representative when initiating the credentialing process. Verge/RLDatix is reporting a trend of provider's utilizing personal e-mail addresses who do not respond and delays the credentialing process. The new provider's business e-mail address is recommended to be used on the NARF instead of their personal e-mail address to avoid any issues.

PROVIDER DIRECTORY



Over the last few months there have been spreadsheet submissions with invalid conditions and formulas creating inaccurate data collection. Tampering with the spreadsheet validations will require the program to resubmit their information using the correct spreadsheet version to the MCST and IRIS.

NOABDs

- The NOABD letters have been updated to reflect **Azahar Lopez, QMS Interim Assistant Deputy Director** in the signature portion of the letters. The newly revised NOABD templates is available on the QMS website to download. Please begin using the revised NOABD templates, immediately and discard all old versions.
- NOABDs must be e-mailed to the AQISGrievance@ochca.com and should not be faxed. The MCST moved towards paperless submissions over a year ago to enhance the processing of NOABDs and improving the security with patient information.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **NEW** MHP and DMC-ODS programs are required to schedule a full-day training to comply with the MCST oversight and DHCS requirements. It is recommended to have the Directors, Managers, Supervisors and Clinical Staff participate in the training to ensure those requirements are met and implemented. Please contact the MCST to schedule the training at least a month prior to delivering Medi-Cal covered services.
- If you and your staff would like a refresher on a specific topic or a full training about the MCST's oversight please e-mail the Health Services Administrator, Annette Tran at anntran@ochca.com and/or the Service Chief II, Dolores Castaneda at dcastaneda@ochca.com.

MANAGED CARE SUPPORT TEAM

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
Leads: Araceli Cueva, Staff Specialist Elizabeth "Liz" Fraga, 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

COMPLIANCE INVESTIGATIONS
Lead: Ashley Cortez, LCSW

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