SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

November 2023

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UPDATES

We have received clarification from the State regarding what is allowable for billing when it comes to activities that may not involve direct client care. **Time spent consolidating and synthesizing clinical information that is part of the assessment would count as service time.** This means that a non-LPHA or LPHA's time outside of an encounter with the client (non-face-to-face) to work on the ASAM based assessment is billable. Assessment activities include

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WHAT'S NEW?

Happy Thanksgiving!

The Substance Use Disorder (SUD) Support Team (SST) would like to take this opportunity to express our gratitude to all our providers!

It goes without saying that it has not been easy navigating all the changes with CalAIM and Payment Reform. We appreciate how hard you work to ensure that our Drug Medi-Cal Organized Delivery System (DMC-ODS) beneficiaries continually receive the highest level of quality substance use disorder treatment services possible. Thank you for your support and collaboration in making the necessary adjustments as efficiently as possible.

As always, should you have any questions or concerns, please do not hesitate to reach out to your designated SST consultant or email us at aqissudsupport@ochca.com

Training & Resources Access

NEW **UPDATED DMC-ODS Payment Reform 2023 - CPT Guide:**

https://www.ochealthinfo.com/sites/healthcare/files/2023-11/DMC-ODS%20Payment%20Reform%202023-1115.pdf

What's been updated…

- What is no longer billable regarding services outside of direct client care (including review of documents)
- Guidance on the use of the Psychiatric Evaluation of Hospital Records (90885-1) code
- Clarification on use of the SUD Screening (70899-105) code & billing intake/assessment
- Addition of non-billable codes according to activity type

…and more!

UPDATES (continued)

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developing dimensions 1 – 6 of the ASAM Criteria, determining the risk ratings, formulating the rationales for the risk ratings, making recommendations for treatment, and determining the diagnosis and level of care placement. The SUD Structured Assessment (70899-102/70899-100/70899-101) codes may be used to account for the non-face-to-face time. This is not applicable to the Residential and Withdrawal Management levels of care as assessment is part of the daily rate and there is no separate billing permitted.

If you have not already been doing so, for the **LPHA's time spent conceptualizing the Case Formulation or narrative write-up**, the Psychiatric Diagnostic Evaluation (90791-1) should be used moving forward. This is not applicable to the Residential and Withdrawal Management levels of care as assessment is part of the daily rate and there is no separate billing permitted.

Review of documents, even if for the purpose of informing the assessment, is no longer billable. The exception to this is for the LPHA when the focus and intent is on establishing, confirming, or updating the client's diagnosis. The LPHA may use the Psychiatric Evaluation of Hospital Record (90885-1) code to claim the time for this purpose. The maximum number of minutes that can be claimed is 15 minutes for this code. This can be used for the LPHA's review of the non-LPHA's completed portions of the ASAM based assessment as well as for reviewing assessment documents received from other providers. Be sure to clearly document in the progress note the purpose of the review to either establish, confirm, or update the client's diagnosis. Review of documents by the non-LPHA is not billable.

What else is no longer billable?

- The review of the physical exam by the physician
- Completion of the discharge summary for unplanned discharges

Documentation FAQ

1. Can the SUD Screening (70899-105) code be used for a client who presents to a residential program for an assessment, but does not stay?

Yes, if the treatment day is not claimed. On rare occasions, a residential program may encounter a situation where a client arrives with the intention of admitting but ends up deciding to leave. Since the client leaves after only receiving an assessment service, the SUD Screening (70899-105) code may be used to bill for the time spent conducting the intake/assessment instead of billing for the treatment day. A progress note must be completed with the appropriate documentation to substantiate the amount of time claimed.

2. Do we have to do a daily note at Withdrawal Management?

No. Please be sure that observation checks continue to be documented to evidence that the appropriate monitoring of clients are being conducted. To claim the time spent providing

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Additional Resources

Be sure to check out these resources that are available to all DMC-ODS providers!

***UPDATED* MAT Documentation Manual**

- https://www.ochealthinfo.com/sites/healthcare/files/2023-11/CalAIM_MAT_Documentation_Manual_v2_11.8.23_FINAL.pdf

The SUD Documentation Training:

- 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:

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

Documentation FAQ (continued)

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any relevant care coordination activities, there must be documentation in a progress note. Aside from care coordination, if there are any situations requiring a one-on-one clinical intervention (i.e., re-assessment, individual or family counseling, crisis intervention, etc.), it is advised that this be documented. There is no separate billing allowed as these services are considered part of the daily rate. However, if clinically relevant to the client's case, best practice would dictate that it should be properly documented in the client's chart.

3. How should we use the SUD Treatment Plan Development and Modification (70899-125) code now?

The SUD Treatment Plan Development and Modification code can be used by non-LPHA and LPHA. Due to the State's emphasis on direct client care, the time claimed must be time spent with the client to address the treatment plan or problem list. This can be in relation to creating the initial treatment plan or problem list or updating it throughout the course of the client's episode of care. Time spent without the client (non-face-to-face) to develop or modify the treatment plan or problem list is no longer billable. If you are conducting a pertinent consultation with a team member regarding any changes needed to the treatment plan or problem list, the service time claimed for the consultation can be billed using the Targeted Case Management (70899-120) code.

4. How do I bill for writing a progress letter if it contains relevant clinical information?

With the most recent update to the DHCS Billing Manual, there are now greater restrictions on time that is not considered direct client care. Therefore, time spent formulating progress letters on their own as non-face-to-face time is not billable. If there are clinical activities associated with the letter writing that is pertinent to the client's SUD treatment, it is recommended that these activities be incorporated into an encounter with the client so that the letter can be documented in collaboration with the client. This could be considered service time within an individual counseling or care coordination service (depending on focus of the service).

Same Day Billing: Transitions between Residential and Outpatient

In the past, we needed to pay careful attention to duplicate billing issues when it came to transitioning clients between the Residential and Outpatient levels of care. However, with the updated DHCS Billing Manual, there has been a change. Lockouts between outpatient and inpatient/24-hour services do not apply for the date of admission or discharge. This means that there are no longer concerns about same-day billing for those clients transitioning between the two levels of care for the date of admission or discharge. For example, when a client is leaving a residential program to enter an outpatient program, the residential program may claim the treatment day (if applicable) even when the outpatient program claims the intake/assessment service/session. It is important to remember that the residential program can only claim the treatment day when all requirements are met for claiming a treatment day and the documentation supports this.

REMINDERS

Outings at Residential Programs

Outings at the residential levels of care can be an important way to reinforce healthy ways to engage in a sober lifestyle as well as teaching independent living skills. At the residential levels of care, outings may count towards the structured activities. They cannot count towards the required clinical hours. If there are clinical interventions that are necessary for a particular client during the outing, this can be considered an individual counseling service (part of the daily bundle and not separately billable) that can count towards the clinical hours for the week if documented properly. The time that can be accounted for is only the time spent providing the direct intervention, not the entirety of the duration of the outing.

MAT policy

As indicated in the previous month's newsletter and QIC meeting, each SUD program will be required to implement and maintain a MAT policy approved by DHCS (see Behavioral Health Information Notice (BHIN) 23-054). Each program must submit their proposed MAT policy to their assigned DHCS licensing analyst within 90 days of the publication of the BHIN, which is **January 4, 2024**. All required components must also be implemented by this date to avoid any disciplinary action.

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

EXPIRED LICENSES, WAIVERS, CERTIFICATION AND REGISTRATIONS

When a provider's license has expired, the MCST sends an e-mail notification suspending the provider from delivering any Medi-Cal covered services. The e-mail requires an immediate response by the provider and/or administrator by the end of the business day to explain the reason for the lapse with the provider's credential. This is important information for the MCST to track and monitor. Be sure to respond promptly upon receiving the e-mail notification.

COUNTY RE-CREDENTIALING

Providers are required to be re-credentialed every 3 years. The Credentialing Verification Organization, Verge/RLDatix sends e-mail notifications to providers 90 days in advance and then every week until the provider attest and provides the required documents needed to initiate the re-credentialing process.

There is a trend of providers who have failed to complete the re-credentialing process upon the expiration and were suspended from delivering any Medi-Cal covered services until a re-credentialing approval letter is issued. Be sure to re-credential your providers on-time by promptly responding to the e-mail notifications!

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

CREDENTIALING CERTIFIED PEER SUPPORT SPECIALIST

The MCST began credentialing **Certified Peer Support Specialists** who are registered with the certifying organization, CalMHSA starting back in April/May 2023. If you have a provider with this certification you must submit their credential packet to the MCST in order to continue to deliver Medi-Cal covered services.

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.

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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