SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

May 2024

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Update

In the latest version of the DMC-ODS Billing Manual, there was an update regarding the Covered Diagnoses at the Residential levels of care (Residential and WM 3.2) that requires at least one DMC covered substance use disorder diagnosis code. **The State removed all of the "unspecified" diagnoses, except for FXX.99 "____ use, unspecified with unspecified ____-induced disorder"** for each substance

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WHAT'S NEW?

Welcome to our new DMC-ODS providers:

- Recovery Beach
- Sober Solutions

Both providers will be offering Residential Treatment Services and Withdrawal Management for adults in the next fiscal year. We are excited for you to join our network!

Extended deadlines for IRIS billing entries:

With Payment Reform and the extended IRIS build, the deadline to enter all services for fiscal year 2023-2024 has been extended to **August 1st**. The exception is for providers that are still pending an org build who will have until **August 16th**. Programs that do not complete entering their services by these dates will still be allowed to enter services. However, please note that those services entered past the above dates will not count in the totals for the fiscal year.

County EHR-users ONLY:

For multiple care coordination services provided on the same day, by the same provider, for the same client, until updates can be made to add more rows for the start/end times, please total your minutes and adjust your start/end times in the rows you have so the total minutes account for all the services you provided. Include the following statement in the progress note narrative or add a comment to the start/end time field – *"Pending updates to the EHR: start and end times used only to calculate total service duration for combining duplicate services into one claim."* It is not required, but if you would like to, it is acceptable to include a breakdown of the minutes in the narrative.

Training & Resources Access

Updated DMC-ODS Payment Reform 2023 - CPT Guide:

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

Updated MAT Documentation Manual

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

NOTICE: Until there is an updated SUD Documentation Manual and Training, please refer to the most recent version of the Documentation Manual and the monthly newsletters for the most recent changes! If you are unsure about the current guidance, please reach out to aqissudsupport@ochca.com

Update (continued)

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classification. In general, the use of an "unspecified" diagnosis is for those cases where there is insufficient information to establish that the individual meets the full criteria for any other diagnosis. The "uncomplicated" diagnoses are for those cases where there are no other diagnosed complicating factors.

Residential levels of care:

To qualify for this level of care, a client's symptomatology and functioning should be severe enough that it is evident that the client meets the full criteria for a substance use disorder. On the rare occasion that it is determined that there is insufficient information to establish a substance use disorder diagnosis, the FXX.99 "____ use, unspecified with unspecified ____-induced disorder" diagnosis may be used. However, the documentation should clearly explain the reason for the use of this code and the plan for acquiring the necessary information to make a more definitive diagnosis. This diagnosis should be updated as soon as sufficient information is gathered.

Withdrawal Management levels of care:

In most cases, the intoxication or withdrawal diagnoses are most applicable for Withdrawal Management. However, due to challenges with assessment while a client may be experiencing intoxication or withdrawal, it is possible that there may not be enough information to make an intoxication, withdrawal, or use diagnosis. In such cases, the FXX.99 "____ use, unspecified with unspecified ____-induced disorder" diagnosis may be used. However, there should be an explanation in the documentation as to what led to the use of this code. Once there is sufficient information that is obtained, the diagnosis should be updated accordingly.

Documentation FAQ

1. How do I bill for the time spent assessing a client for Recovery Services?

Only those billing codes that have been designated for Recovery Services can be used to claim for services at the Recovery Services level of care. Using any of the other outpatient codes will result in claims being denied. Therefore, the Psychosocial Rehabilitation, Individual, per 15 Min (70899-122) code should be used to claim for assessment sessions/services, such as for conducting the ASAM-based assessment to determine the client's need for Recovery Services. This code may be used by non-LPHA and LPHA. There is no maximum number of minutes that can be claimed, however, the minimum number of minutes needed to use the billable code is 8 minutes.

2. I need to help my client complete paperwork to obtain an ID. Is this a billable care coordination activity?

In general, assisting the client to complete paperwork that does not require the clinical expertise of the provider is not billable in the DMC-ODS. Additionally, we need to keep in mind the medical necessity for the service. A task that the client can perform on their own, would not be billable. If there are circumstances related to the client's SUD that prevents or significantly impacts the client's ability to complete the task on their own and your clinical skills are necessary, this may be a billable activity. This would need to be clearly documented in the progress note. An example of a situation where you may need to be involved is if the client is unable to complete the task on their own due to difficulty in managing frustration, where irritability and frustration is a trigger for the client. In such a case, part of the clinical intervention consists of a direct exposure to a stressor (completing the form) so that the client can practice the skills learned for coping in real time. This, in conjunction with other

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Documentation FAQ (continued)

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care coordination activities (such as discussing next steps for obtaining an ID, other needed resources), could make this a billable care coordination service.

3. Do all the problems from the assessment need to be on the problem list?

There is nothing in the regulations for the DMC-ODS that indicates that all problems from the assessment need to be on the problem list. Although the client may have numerous issues that are evident from our thorough assessment of the client, it may not be realistic to expect that all can be adequately addressed. There are clinically appropriate considerations, such as with situations where clients may present with more critical needs that take precedence before other issues can be worked on. The problem list should consist of those issues that are going to be addressed currently and added upon as needs arise and items are resolved. Best practice is to document the reason(s) for any problems that have been identified, but not addressed (i.e., deferred for a later time, is contraindicated, client does not see it as a need or want to address, etc.).

4. How do I demonstrate medical necessity in group progress note documentation?

The State requires a brief description of the client's response for group progress note documentation. One way to help tailor the client's response towards demonstrating medical necessity would be to utilize the topic or group content and its purpose. For example, if the topic was anger management, we want to consider how the client learning to better manage anger is necessary for their recovery. This allows us to tie the topic (anger management) to SUD treatment (how the topic is going to benefit the client in their SUD treatment or recovery in general). Then, we can ask ourselves how the client responded and individualize the documentation and make it specific to the client and the session. Did the client understand how anger and healthy ways to manage it can impact their recovery? What did the client do or say in the group that illustrated this? Were they able to reflect on ways that their anger or expression of anger was tied to past use or presents potential barriers to staying sober? Were they able to give feedback to peers that signaled that the client demonstrated an awareness of this?

Tips & Reminders

- ***Credentials with signature:*** Don't forget that it is best practice to include credentials with your signature on chart documents!
- ***Group Progress Note and Group List:*** A corresponding participant list is required for each group progress note. It's important that the correct participant list can be produced to corroborate the information in the progress note. Therefore, it is advised that information about the group topic/name, date of service, and start/end time of the group match between the participant list and the group progress note.
- ***Unable to meet the 5 required clinical hours at Residential:*** When there is a particular circumstance (e.g., illness, off-site appointments, etc.) that prevents the client from achieving the 5 required clinical hours for the week and the client is unable to make-up for the missed time, it is advised to document the reason.
- ***Delay in completing the assessment:*** Although there are no longer explicit timelines for the completion of the assessment at the outpatient levels of care, it is best practice to document the reason(s) for a delay in being able to complete it within generally accepted standards of practice whenever possible.

Are there questions or topics that you'd like to see addressed in the monthly SUD Newsletter? Feel free to reach out to your assigned consultant or let us know at aqissudsupport@ochca.com.

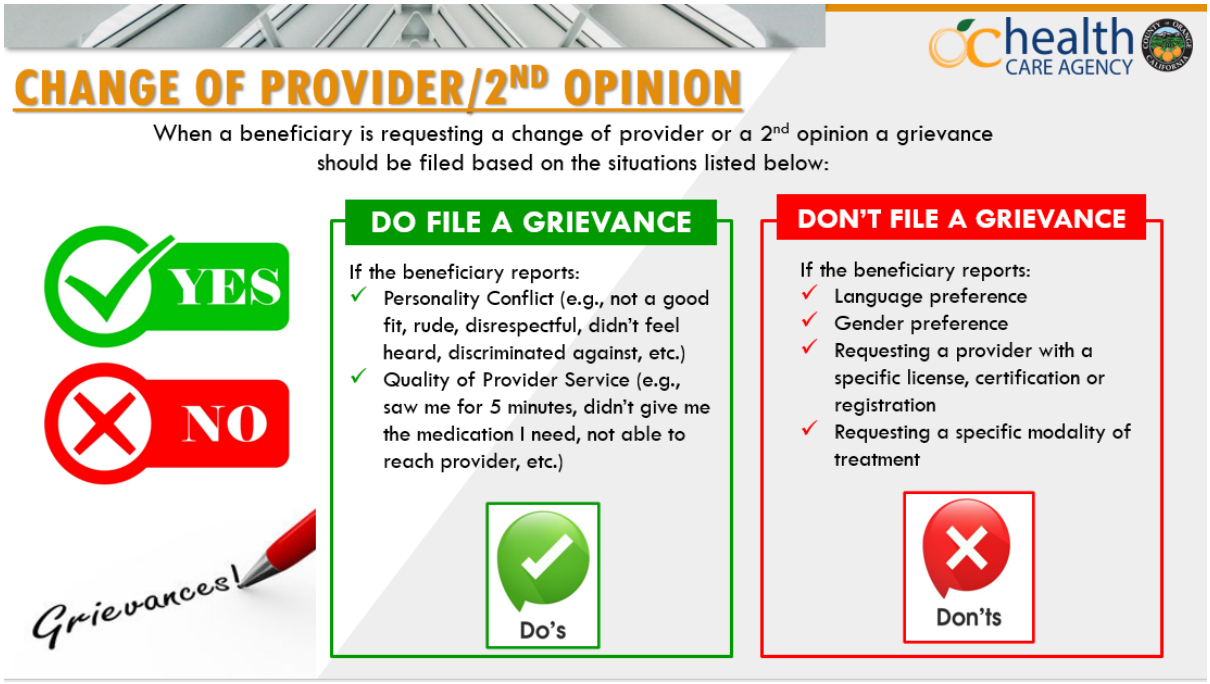
For questions about entering billing into IRIS or correcting charge entries, contact the Front Office Coordination Team at bhsirisfrontofficesupport@ochca.com.

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

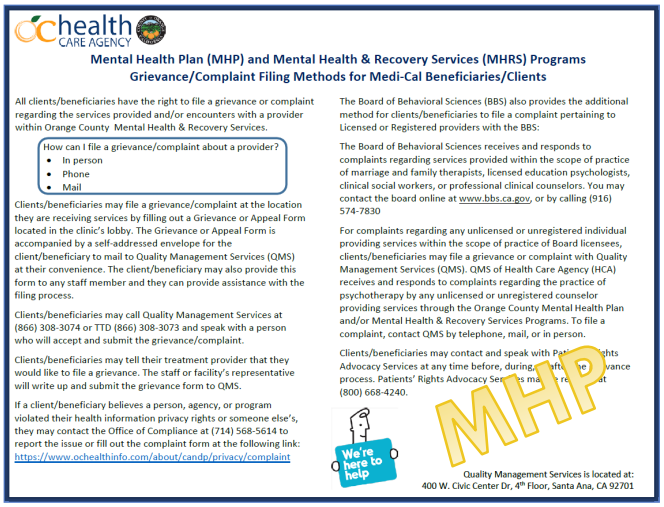


COUNTY CREDENTIALING & RE-CREDENTIALING

- 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. This means the new hire must **NOT** provide direct treatment or supportive services to a beneficiary on their own nor document any services. 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 hire credentialing packet to the MCST.
- Employees who are transferring from a non-Medi-Cal site to a Medi-Cal site as a new staff member who is a licensed, waivered, registered or a certified provider need to be credentialed, immediately. It is recommended for the program administrator to verify the status of the employee's county credentialing prior to delivering any Medi-Cal covered services.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

GRIEVANCES & APPEALS MATERIALS



Mental Health Plan (MHP) and Mental Health & Recovery Services (MHRS) Programs
Grievance/Complaint Filing Methods for Medi-Cal Beneficiaries/Clients

All clients/beneficiaries have the right to file a grievance or complaint regarding the services provided and/or encounters with a provider within Orange County Mental Health & Recovery Services.

How can I file a grievance/complaint about a provider?
- In person
- Phone
- Mail

Clients/beneficiaries may file a grievance/complaint at the location they are receiving services by filling out a Grievance or Appeal Form located in the clinic's lobby. The Grievance or Appeal Form is accompanied by a self-addressed envelope for the client/beneficiary to mail to Quality Management Services (QMS) at their convenience. The client/beneficiary may also provide this form to any staff member and they can provide assistance with the filing process.

Clients/beneficiaries may call Quality Management Services at (866) 308-3074 or TTD (866) 308-3073 and speak with a person who will accept and submit the grievance/complaint.

Clients/beneficiaries may tell their treatment provider that they would like to file a grievance. The staff or facility's representative will write up and submit the grievance form to QMS.

If a client/beneficiary believes a person, agency, or program violated their health information privacy rights or someone else's, they may contact the Office of Compliance at (714) 568-5614 to report the issue or fill out the complaint form at the following link: https://www.ochealthinfo.com/about/candp/privacy/complaint

The Board of Behavioral Sciences (BBS) also provides the additional method for clients/beneficiaries to file a complaint pertaining to Licensed or Registered providers with the BBS:

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists, licensed education psychologists, clinical social workers, or professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830

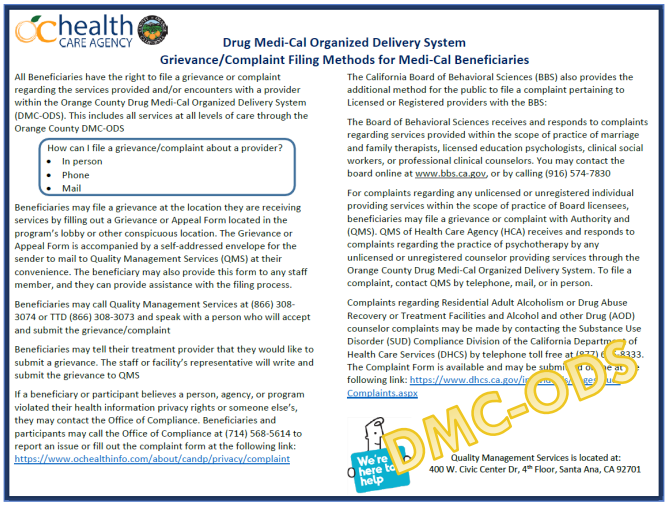
For complaints regarding any unlicensed or unregistered individual providing services within the scope of practice of Board licensees, clients/beneficiaries may file a grievance or complaint with Quality Management Services (QMS). QMS of Health Care Agency (HCA) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services through the Orange County Mental Health Plan and/or Mental Health & Recovery Services Programs. To file a complaint, contact QMS by telephone, mail, or in person.

Clients/beneficiaries may contact and speak with Patients' Rights Advocacy Services at any time before, during, after the grievance process. Patients' Rights Advocacy Services may be reached at (800) 668-4240.

We're here to help

Quality Management Services is located at:
400 W. Civic Center Dr, 4th Floor, Santa Ana, CA 92701

MHP



Drug Medi-Cal Organized Delivery System
Grievance/Complaint Filing Methods for Medi-Cal Beneficiaries

All Beneficiaries have the right to file a grievance or complaint regarding the services provided and/or encounters with a provider within the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS). This includes all services at all levels of care through the Orange County DMC-ODS

How can I file a grievance/complaint about a provider?
- In person
- Phone
- Mail

Beneficiaries may file a grievance at the location they are receiving services by filling out a Grievance or Appeal Form located in the program's lobby or other conspicuous location. The Grievance or Appeal Form is accompanied by a self-addressed envelope for the sender to mail to Quality Management Services (QMS) at their convenience. The beneficiary may also provide this form to any staff member, and they can provide assistance with the filing process.

Beneficiaries may call Quality Management Services at (866) 308-3074 or TTD (866) 308-3073 and speak with a person who will accept and submit the grievance/complaint

Beneficiaries may tell their treatment provider that they would like to submit a grievance. The staff or facility's representative will write and submit the grievance to QMS

If a beneficiary or participant believes a person, agency, or program violated their health information privacy rights or someone else's, they may contact the Office of Compliance. Beneficiaries and participants may call the Office of Compliance at (714) 568-5614 to report an issue or fill out the complaint form at the following link: https://www.ochealthinfo.com/about/candp/privacy/complaint

The California Board of Behavioral Sciences (BBS) also provides the additional method for the public to file a complaint pertaining to Licensed or Registered providers with the BBS:

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists, licensed education psychologists, clinical social workers, or professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830

For complaints regarding any unlicensed or unregistered individual providing services within the scope of practice of Board licensees, beneficiaries may file a grievance or complaint with Authority and (QMS). QMS of Health Care Agency (HCA) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services through the Orange County Drug Medi-Cal Organized Delivery System. To file a complaint, contact QMS by telephone, mail, or in person.

Complaints regarding Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities and Alcohol and other Drug (AOD) counselor complaints may be made by contacting the Substance Use Disorder (SUD) Compliance Division of the California Department of Health Care Services (DHCS) by telephone toll free at (877) [illegible]8333. The Complaint Form is available and may be submitted at the following link: https://www.dhcs.ca.gov/[illegible]Complaints.aspx

We're here to help

Quality Management Services is located at:
400 W. Civic Center Dr, 4th Floor, Santa Ana, CA 92701

DMC-ODS

- The Grievance/Complaint Filing Methods for Medi-Cal Beneficiaries is to be given upon intake. Be sure to check your program's process and ensure this is being provided to the beneficiary upon their initial entry into services and when they are inquiring about the various filing methods to complete a grievance.

NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)

Department of Health Care Services (DHCS) requires a Termination NOABD to be mailed to the last known address of the deceased beneficiary within two (2) business days.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **NEW** 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 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 the Service Chief II, Catherine Shreenan at cshreenan@ochca.com.

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MONTHLY MCST TRAININGS – NOW AVAILABLE

MCST is offering open training sessions effective **1/1/24** for new and existing providers. The 2-hour training will be on NOABDs, Grievances, Appeals, 2nd Opinion/Change of Provider and Access Logs.

Please e-mail AQISGrievance@ochca.com with Subject Line: MCST Training for DMC-ODS and a MCST representative will send you an e-mail invitation to attend the training via Microsoft Teams.

4th Tuesdays of the Month @ 1 p.m. MCST Training (DMC-ODS)

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
Leads: Esmi Carroll, LCSW Jennifer Fernandez, LCSW

CLINICAL SUPERVISION
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, LCSW

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: Ashley Cortez, LCSW

COMPLIANCE INVESTIGATIONS
Lead: Ashley Cortez, LCSW

CONTACT INFORMATION

400 W. Civic Center Drive., 4th floor
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
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II