health CARE AGENCY

SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

August 2024

WHAT'S NEW?

SUD Support TEAM

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UPDATE

Clinician Consultations: DHCS has updated in their recent FAQ that consultations with licensed individuals outside of one's agency is permitted, *given that the outside clinicians are also Drug Medi-Cal Organized Delivery System (DMC-ODS) providers*. This means that to bill using the Clinician Consultation code, all three (3) clinicians involved must be qualified to provide DMC-ODS services. It remains that the rendering

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Words Matter

The reality is that the stigma surrounding substance use and substance use disorders (SUDs) still exists. The Centers for Disease Control and Prevention (CDC) has indicated that the research shows that more than 75% of people do not consider SUDs to be a chronic illness (like diabetes, for example). In ongoing efforts to de-stigmatize SUDs, the language we use can make a difference. Some suggestions for more neutral, less stigmatizing language include:

- "Substance Use Disorder" instead of "drug abuse"
- "A person with a SUD" instead of "addict"
- "Having a positive drug test" instead of "testing dirty"
- "Return to use" instead of "relapse"

September is National Recovery Month and one of the ways that we can celebrate and support our recovery communities is to refine our vocabulary to promote dignity and respect for the people we serve.

Treatment Perception Surveys (TPS)

As part of the DMC-ODS waiver, each county is required to administer the TPS on an annual basis. UCLA coordinates the TPS data collection for the Department of Health Care Services (DHCS). The surveys serve some important purposes:

- Fulfill the External Quality Review

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Training & Resources Access

Updated DMC-ODS Payment Reform 2024 - CPT Guide (version 2):

DMC-ODS Payment Reform 2024 CPT Guide v2.pdf (ochealthinfo.com)

MAT Documentation Manual

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

Coming Soon…

Updated SUD Documentation Manual

NOTICE: Until there is an updated SUD Documentation Manual and Training, please refer to the most recent Documentation Manual, CPT Guide, 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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provider is the only provider who can bill for that consultation. The documentation should make clear all parties involved so there is no question that all clinicians are qualified DMC-ODS providers. Consultations with licensed, qualified health professionals who are not DMC-ODS providers (e.g., physicians, clinicians, pharmacists specializing in addiction outside of the network) should be billed using the Targeted Case Management code. In either case, the consultation must be medically necessary to bill for the service.

WHAT'S NEW? (continued)

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Organization (EQRO) requirement to conduct a client satisfaction survey;

- Fulfill data collection needs as part of the Centers for Medicare and Medicaid Services (CMS) requirement for evaluation of the DMC-ODS demonstration; and
- Support quality improvement efforts for the DMC-ODS.

This year the survey period will be from Monday, October 21, 2024, through Friday, October 25, 2024.

For additional support…

County Clinics: For questions on billing in IRIS, such as correcting charge entries, contact the IRIS Liaison Team at bhsirisliaisonteam@ochca.com

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

Documentation FAQ

1. Can clients who discharge from Residential Treatment Services, access the Recovery Services level of care?

Yes, if the client desires and needs Recovery Services, they may be enrolled. The residential episode of care would be closed, and a new episode of care would be opened at Recovery Services. If a re-assessment was completed at the residential program that documents how the client no longer qualifies for the residential level of care and is appropriate for Recovery Services, this re-assessment document can be used as the initial assessment for Recovery Services. The documentation should clearly indicate how Recovery Services will address the client's needs, particularly regarding recurrence of or continued use potential and risk.

2. Can the Clinical Opiate Withdrawal Scale (COWS) and Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-AR) be administered by an AOD Counselor?

No. The COWS and CIWA-AR should be administered by a medical professional. As a result, the Subjective Opiate Withdrawal Scale (SOWS) is an appropriate alternative for AOD Counselors as this is based on the client's self-report. The SOWS is one of the measures approved by the State to assess for withdrawals as part of the required evidence-based assessment to determine a client's need for a MAT referral. As a reminder, any evidence-based assessment(s) indicated in your program's MAT policy needs to address the following indications: (1) withdrawal, (2) cravings to use substances, and (3) substance use disorder severity.

3. A non-LPHA is going to be the new primary counselor for a client whose former counselor has left the agency. Can they bill for reviewing

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Documentation FAQ (continued)

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the client's ASAM assessment and problem list?

No. Review of documents is not billable for a non-LPHA. One way to account for this might be to incorporate the review of the ASAM assessment and problem list with the client in a session. This is a good way to build rapport and discuss what has changed or not changed with the client's information or presenting issues, confirm areas that the client desires to address, and ensure that the problem list is up to date.

3. How do I document when part of the service involved a non-billable activity?

When including documentation of having conducted activities that are not billable, it is advised that it is made clear to the reader that the time spent was not included in the total service time claimed. Remember that billing for time that is not billable can be interpreted as fraud, waste, and/or abuse. One way to be clear in the documentation is to include "time not billed for" to separate the non-billable activity from the overall billable service. For example, if there was time that was spent walking with the client to another unit or part of the facility and you would like to document that this was done, it can be written as "This counselor escorted client upstairs for further assessment by medical staff (time not billed for)."

Fiscal Year 2024-2025 SUD Support Team (SST) Clinical Chart Reviews

The Clinical Chart Reviews will be starting in September!

Why are SST Clinical Chart Reviews necessary?

The County is mandated by DHCS to conduct monitoring of providers to ensure compliance with Medi-Cal documentation and billing requirements for potential fraud, waste, and/or abuse.

What does the SST Clinical Chart Review consist of?

An on-site visit by some of the SST Consultants who will review a random sampling of services that have been claimed for a particular period in the fiscal year. Consultants will also be looking at the supporting chart documents to verify that the services claimed are appropriately justified. Upon conclusion of the review, the Consultants will provide an overview of the preliminary findings with the program. This provides an opportunity for the Consultants to offer one-on-one technical assistance to clarify requirements and address program-specific questions that providers may have. An itemized, formal findings report will be provided later once the SST returns to the office and analyzes the information against current regulations.

For more information or questions, please reach out to your respective SST Consultant or email aqissudsupport@ochca.com

Did you know…

The **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013** code can be used for additional reimbursement when it is necessary to utilize a sign language or oral interpreter for a client who is unable to speak or speak the same language as the provider. The provider conducting the service cannot be the interpreter. This is a supplemental code, which means that it may be used along with another primary service, such as individual counseling. It may be used by all provider disciplines (non-LPHA and LPHA) and with all services, except at the Withdrawal Management and Residential levels of care. For more specifics, refer to the Payment Reform 2024 - CPT Guide (link on page 1).

MCST OVERSIGHT

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

REMINDERS, ANNOUNCEMENTS & UPDATES

ACCESS TIMEFRAMES

MHP

10 BUSINESS DAYS - ROUTINE
Outpatient Services

24 48 HOURS – URGENT
CALENDAR DAY
Inpatient Hospital Discharge
Correctional Health Jail Discharge

4 HOURS - EMERGENT
CALENDAR DAY
Crisis Assessment/Evaluation

TIMELY ACCESS & ISSUING NOABDS (MHP ONLY)

- Federal Access Standards defines **Urgent** appointments to be offered within **48 hours** **NOT** 24 hours.
- **Emergent – 4 hours** is a County standard that does not require a Timely Access NOABDs to be issued to the beneficiary. This is not a Federal Access standard.
- If timely access is NOT met for "Routine" and "Urgent" access appointments, then the provider must issue a Timely Access NOABD to **new** clients initially requesting access to services for the first time. Existing clients currently receiving services within the MHP do **NOT** require a Timely Access NOABD for a follow-up appointment upon a hospital or jail discharge.
- The County and County-Contracted programs will continue to offer an appointment for hospital and jail discharges within 24 hours to provide a higher standard for quality of care. Programs do NOT need to issue timely access NOABDs to **new** clients unless it exceeds offering an appointment within 48 hours.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

PROVIDERS TYPES NEWLY ELIGIBLE TO CLAIM FOR SERVICES EFFECTIVE 7/1/23:

MHP	DMC-ODS
• Medical Assistant* • Nurse Practitioner/Clinical Nurse Specialist Clinical Trainee** • Psychologist Clinical Trainee** • Clinical Social Worker (LCSW) Clinical Trainee** • Marriage and Family Therapist (MFT) Clinical Trainee** • Professional Counselor (LPCC) Clinical Trainee** • Psychiatric Technician Clinical Trainee** • Registered Nurse Clinical Trainee** • Vocational Nurse Clinical Trainee** • Occupational Therapist Clinical Trainee** • Pharmacist Clinical Trainee** • Physician Assistant Clinical Trainee** • Medical Student in Clerkship (Physician Clinical Trainee)**	• Medical Assistant* • Occupational Therapist • Licensed Vocational Nurse • Licensed Psychiatric Technician • Nurse Practitioner Clinical Trainee** • Psychologist Clinical Trainee** • Clinical Social Worker (LCSW) Clinical Trainee** • Marriage and Family Therapist (MFT) Clinical Trainee** • Professional Counselor (LPCC) Clinical Trainee** • Psychiatric Technician Clinical Trainee** • Registered Nurse Clinical Trainee** • Vocational Nurse Clinical Trainee** • Occupational Therapist Clinical Trainee** • Pharmacist Clinical Trainee** • Physician Assistant Clinical Trainee** • Medical Student in Clerkship (Physician Clinical Trainee)**

SUPERVISION REPORTING FORMS

The State Plan Amendment (SPA) 23-0026 has added more rendering provider types (see above). Therefore, DHCS requires County to be responsible for ensuring all educational, experiences and supervisory requirements are met, tracked and monitored for all newly eligible and existing providers.

- MCST has revised and developed additional supervision reporting forms to include clinical trainees, medical professionals and other qualified provider types. There are four types of forms to choose from to complete and submit to MCST:
  1. Clinical Supervision Reporting Form
  2. Counselor Supervision Reporting Form
  3. Medical Supervision Reporting Form - NEW
  4. Qualified Provider Supervision Reporting Form – NEW & PENDING
- MCST will be providing more guidance and details with completing the new forms and sharing some of the revisions made to the Clinical and Counselor Supervision Reporting forms at the monthly QI Coordinators' Meeting for AOA, CYS and SUD.
- The implementation of these new forms will go into effect **9/1/24** for all applicable providers to submit to MCST. The three forms are currently posted and available on the QMS website.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MEDI-CAL CLAIMING DURING THE BBS 90-DAY RULE PRIOR TO BBS REGISTRATION NUMBER (OPTIONAL COUNTY CONTRACTED PROGRAMS ONLY)

- The State Department of Health Care Services (DHCS) will honor the 90-day Board of Behavioral Sciences (BBS) rule and allow practitioners to provide services as if they are registered while they wait for their registration number after the completion of their Live Scan. DHCS has confirmed that Associates are considered "registered" during this 90-day period and can claim Medi-Cal for assessments and therapy services.
- The provider must submit the Clinical Supervision Report Form (CSRF) to MCST and follow the 90-day BBS rule guidelines below prior to delivering any Medi-Cal covered services:

health CARE AGENCY

CLINICAL SUPERVISION

COUNTY-CONTRACTED PROGRAM REQUIREMENT

- ✓ Post degree hours may only be counted as of the date recorded at the bottom of the Request for Live Scan Service form.
- ✓ CSRF Form, BBS Responsibility Form, Written Agreement (if applicable) and a completed **Live Scan Fingerprint Form** from the employer must be submitted to MCST.
- ✓ IRIS will **NOT** enter the provider into the system to bill for services if they do not have an Associate #.
- ✓ Once BBS issues an Associate #, the provider must submit updated clinical supervision forms to IRIS and MCST, along with the PAN.
- ✓ Without a PAN, IRIS will **NOT** activate the provider to begin billing for Medi-Cal covered services.
- ✓ County Employees do **NOT** qualify for the BBS "90-day rule" clause in the law. Human Resources requires an Associate # in order to hire a Behavioral Health Clinician I.

https://www.bbs.ca.gov/pdf/90day_rule.pdf

90-DAY RULE FOR GRADUATES

- County-Contracted programs **MUST** hold the claims until the registration number comes through (if it is issued retroactively). The Live Scan date on the Live Scan form is the date the BBS will use as the registration date for the Associates. This means, as soon as the provider receives their registration number from BBS the program administrator must immediately:
  1. Submit an updated CSRF with the newly assigned registration #.
  2. County Credential the provider and include a copy of the **Request for Live Scan Service form** for the credentialing approval letter to incorporate the date the Live Scan form was completed to deliver Medi-Cal covered services.
  3. Submit an updated PAN along with supporting documents to IRIS to add the provider into the system to begin entering and billing for services, retroactively.

DISCLAIMER:
The program will take the risk of any billed services being disallowed, if the provider separates from their employer prior to receiving their BBS registration # or if the BBS registration # is not granted.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

PROVIDER DIRECTORY (MHP ONLY)

- All MHP programs are **NO** longer required to enter NACT data on the Provider Directory Spreadsheet. The newly revised Provider Directory spreadsheet will have the NACT fields removed, the newly eligible providers included, etc.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **NEW** MHP and DMC-ODS programs are required to schedule a full 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 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.

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 MHP or DMC-ODS and a MCST representative will send you an e-mail invitation to attend the training via Microsoft Teams.

2nd Tuesdays of the Month @ 1 p.m. MCST Training (MHP)
4th Tuesdays of the Month @ 1 p.m. MCST Training (DMC-ODS)

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, 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 Leads: Elaine Estrada, LCSW   Sam Fraga, Staff Specialist

COMPLIANCE INVESTIGATIONS

Lead: Catherine Shreenan, LMFT

CONTACT INFORMATION

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E-MAIL ADDRESSES

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MCST ADMINISTRATORS

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Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II