SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

July 2024

SUD Support TEAM

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Update

Same day billing: The Department of Health Care Services (DHCS) has recently clarified that NTP services, including methadone dosing, individual counseling, and group counseling services are reimbursable on the same day as any other DMC-ODS service. Providers recently experienced denials of NTP claims on the same day as residential services. However, the State is in the process of reversing lockouts

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WHAT'S NEW?

Clinician Consultation & Physician Consultation:

The State has made it clear that we still need to follow the requirements specific to the Healthcare Common Procedure Coding System (HCPCS) produced by the Centers for Medicare and Medicaid Services and the Current Procedural Terminology (CPT) codes produced by the American Medical Association. This means that we need to be in compliance with both, in addition to the requirements set forth by DHCS. One significant impact of this is the Clinician Consultation and Physician Consultation services.

The State has designated the **Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99368-1)** billing code for Clinician Consultations. The service involves DMC-ODS Licensed Practitioners of the Healing Arts (LPHAs) consulting with other LPHA to seek expert advice on complex cases to address such issues as medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. This code can only be used by non-MD LPHA (except Licensed Vocational Nurses, Vocational Nurse Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees). The State has designated the **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation of Physician, Patient and/or Family not Present, 30 Min+ (99367-1)** billing code for Physician Consultations. This code may only be used by a Licensed Physician or Medical Student in Clerkship.

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Training & Resources Access

NEW! 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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and updating the billing system, which is expected to be completed by October 2024 and be retroactive to October 2023.

WHAT'S NEW? (continued)

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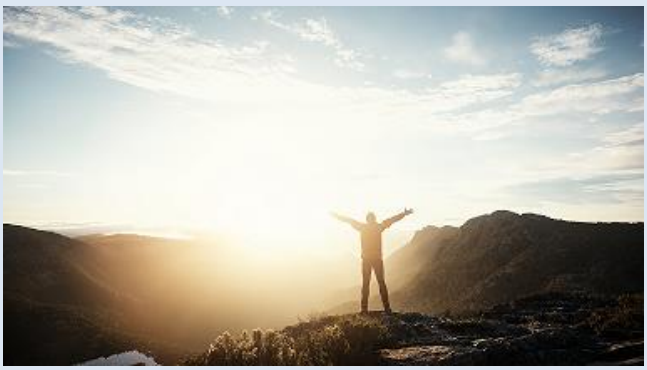
The CPT Manual provides further restrictions on the use of these codes as it needs to include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient) where the participants are actively involved in the development, revision, coordination, and implementation of health care services. The rendering provider needs to have had a face-to-face encounter (evaluation or treatment) with the client, independent of any team conference, within the previous 60 days.

What this means is that in order to bill for this service, it must be clear in the progress note documentation that the service was conducted face-to-face, and the 3 (at minimum) health care professionals involved in the consultation are identified. It must also be evident, based on information in the chart, that the rendering provider has provided a face-to-face service with the client within the 60 days prior to the date of service of the consultation. Be sure to include a description of what prompted the need for the consult (how it is relevant to the client's treatment) and the result or outcome.



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. Are the SUD Structured Assessment, 5-14/15-30/30+ Min (70899-100/70899-102/70899-101) G2011/G0396/G0397 codes still used for the ASAM Assessment?

No. The State no longer designates these codes for use on the ASAM Assessment effective July 1, 2024. At this time, these codes should be used for administering a brief screening, such as the required evidence-based assessment for MAT (i.e., COWS, CIWA-AR, DAST, AUDIT, etc.), according to each program's MAT Policies and Procedures. In general, the service billing code that is now most appropriate for the ASAM-based assessments is the SUD Assessment (70899-103) H0001 code. For LPHA conducting the ASAM-based assessments, the Psychiatric Diagnostic Evaluation, 60 Min (90791-1) should be used for services between 31 minutes and 67 minutes. Service durations of 30 minutes or less or 68 minutes or more need to be coded as SUD Assessment (70899-103) H0001 at this time. In the future, once ready in IRIS, assessment services by the LPHA that are 68 minutes or more will be coded using the Assessment Substitute T2024 code.

2. Is the Physical Exam still required?

Yes. The State's expectation remains that we are inquiring as to whether a client has received a physical exam in the prior 12 months from the client's admission to your program and providing any care coordination necessary to help the client access this. You may document this finding in the intake progress note, the ASAM-based assessment, etc. There is no requirement for it to be documented as a problem on the client's problem list, however, it is recommended since you will likely be addressing this issue by providing clients with some care coordination. The ICD-10 code of Z75.8 – "Other problems related to medical facilities and other health care" can be used for this purpose. Providing linkages, referrals, and warm hand-offs are billable activities that can be

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Documentation FAQ (continued)

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claimed using the Targeted Case Management (70899-120) T1017 code. The State understands the challenges in getting your clients to follow through with or be willing to complete a physical exam and that it may not always be possible to achieve this. Just be sure that you are documenting your efforts (i.e., use of motivational interviewing and education to encourage clients to be proactive in taking care of their physical/health care needs).

3. My client has completed a physical exam, and a copy has been obtained. What else is required?

Once a copy of the client's physical exam is obtained, the State requires that the Medical Director review the physical exam. Be sure that you are following your program's protocol for alerting the Medical Director of a physical exam in need of review so that this is able to be completed. The Medical Director's time spent reviewing the physical exam is not billable. However, in order to demonstrate compliance with this requirement, the Medical Director will need to complete some type of documentation that evidences that this review of the physical exam was completed. A few examples of this may be a non-billable care coordination progress note, a brief note on the copy of the physical exam that it was reviewed (include the physician's printed name, signature, date of signature), or if a consultation with other members of the client's treatment team is needed as a result of the review, mention the completion of the review of the physical exam in the corresponding progress note.

4. Can I bill for completing a referral form for my client to receive Enhanced Care Management (ECM)?

No. Completing a referral form for your client to receive ECM is not a billable activity as the form does not require any clinical expertise to complete. It is advised that documentation to serve as record of this linkage be completed on a note-to-chart or other administrative note.

Medication Services: Evaluation & Management

For Licensed Physicians, Medical Students in Clerkship, Physician Assistants, Physician Assistant Clinical Trainees, Nurse Practitioners, and Nurse Practitioner Clinical Trainees, there are now prolonged codes permissible for use when the maximum number of minutes allowed for an evaluation and management service code has been reached. The following grids help you to clearly see when these codes can be utilized for office or other outpatient visits of new or established patients:

Prolonged Clinical Staff Service, First Hour (99415 – CDM TBD) and Prolonged Clinical Staff Service, Each Additional 30 Mins. (99416 – CDM TBD)

Office or Other Outpatient Visit of a New Patient					
99202-1	**99203-1**	**99204-1**	**99205-1**	**99415*** (add on to 99205-1)	**99416*** (add on to 99205-1 and 99415)
15-29 minutes	30-44 minutes	45-59 minutes	60-103 minutes	104-148 minutes	149 minutes or more

Office or Other Outpatient Visit of an Established Patient					
99212-1	**99213-1**	**99214-1**	**99215-1**	**99415*** (add on to 99215-1)	**99416*** (add on to 99215-4 and 99415)
10-19 minutes	20-29 minutes	30-39 minutes	40-54 minutes	84-128 minutes	129 minutes or more

Until these codes are built in IRIS, the **Office Outpatient Visit of New Patient, 60-74 Min (99205-1) or the **Office Outpatient Visit of an Established Patient, 40-54 Min (99215-1)** code should be used. The actual number of service minutes should be noted in the progress note.*

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

MCST would like to welcome Joanne, one of our newest members of the team. She graduated with a Bachelor's degree in Human Development and has an eclectic background in administrative and clerical experiences. She has always been inspired and passionate about doing good work in hopes to make a positive impact to those around her. Please welcome her as our new Office Specialist!

COUNTY CREDENTIALING & RE-CREDENTIALING

- Department of Health Care Services (DHCS) recently indicated when a provider is hired for a provider type that does not require credentialing (e.g., Mental Health Rehabilitation Specialist (MHRS) or Other Qualified Providers (OQP), then there is no requirement to follow the credentialing process as stated in the BHIN 18-019, established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214. This mean, even if the provider also happens to have a license, certification or registration in a discipline that is not what they were hired for then they no longer need to be credentialed by the County.
- AOD Counselors are **NOT** permitted providers in the Mental Health Plan (MHP). They do **NOT** need to be credentialed and will **NOT** be able to accrue hours towards their certification. If the provider meets the qualification for either a MHRS or OQP, then they may work within the MHP program under that limited scope. To determine if the provider meets either of those qualifications, please consult with your division QMS Support Team.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MEDI-CAL CLAIMING DURING THE BBS 90-DAY RULE PRIOR TO BBS REGISTRATION NUMBER

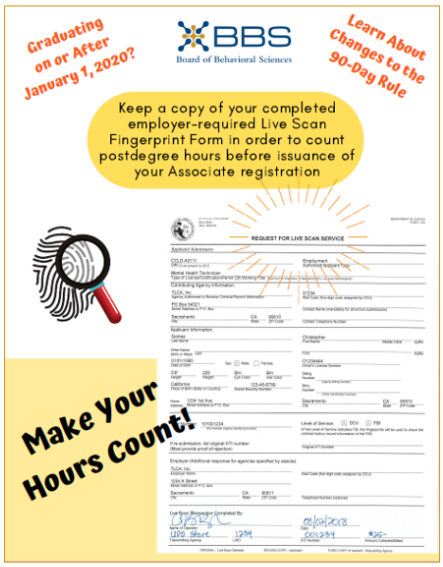
(COUNTY CONTRACTED PROGRAMS ONLY)

- 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:

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.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

FAQ - SCREENING & TRANSITION OF CARE TOOLS (MHP ONLY)

NOABD QUESTION: Is the Mental Health Plan (MHP) required to issue a Notice of Adverse Benefit Determination (NOABD) if an individual is referred to the other Medi-Cal mental health delivery system based on their screening score?

***NO**. The Screening Tools do not determine benefit or service eligibility, but instead determine the appropriate mental health delivery system referral for an initial assessment for Medi-Cal members who are not currently receiving mental health services when they contact the Managed Care Plan (MCP)/MHP seeking mental health services. MCPs/MHPs should not issue an NOABD if an individual is referred to the other Medi-Cal mental health delivery system for assessment based on their screening score. For additional information on NOABD requirements, MCPs and MHPs may refer to APL 21-011 and MHSUDS IN 18-010E, respectively.*

ACCESS LOG QUESTION: When the screening tool score results in the MHP routing to the MCP, does the MHP need to do an Access Log?

***NO**. The screening process is not considered an access request. There is no need to enter screenings into the Access Log, as no request for access in our system is being made if the member screens for the MCP. Similarly, there is no need to issue an NOABD at that point. All the Screening Tool does is help route the member to the appropriate system of care to help them. The Screening Tool is not considered an "assessment".*

CLINICAL/COUNSELOR SUPERVISION REPORTING FORM

The State Plan Amendment (SPA) 23-0026 has added more rendering provider types (see below). Therefore, DHCS expects the County to account for tracking, logging and determining the type of supervision required for these newly eligible providers claiming for services. This requires MCST to revise the supervision reporting forms to include clinical trainees, medical professionals and other qualified provider types. MCST is working to revise the supervision forms and make it available, as soon as possible.

EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS

- When the provider's license, certification or registration expires MCST immediately sends a notification e-mail suspending the provider from delivering any Medi-Cal covered services. If the provider still has not renewed their license within 3 months a follow-up e-mail will be sent to inquire on the status and if the expired credentials continues beyond 6 month the provider's County Credential will become deactivated. This will require the provider to undergo the credentialing process all over again upon receiving their renewed or newly issued credentials from their certifying organization.

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)**

* **Medical Assistants** must be under the supervision of a licensed physician or surgeon, or to the extent authorized under state law, a nurse practitioner or physician assistant that has been delegated supervisory authority by a physician and surgeon. The licensed physician or surgeon, nurse practitioner, or physician assistant **MUST** be physically present in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant, per the State Plan Amendment (SPA) 23-0026. If, the Medical Assistant does **NOT** have the required supervision on-site they will **NOT** be able to deliver any Medi-Cal covered services within that scope of practice.

** **Clinical Trainee** is an unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Practitioner of the Healing Arts; is participating in a practicum or internship approved by the individual's school/program; and meets all relevant requirements of the school/program and/or the applicable licensing board to participate in the practicum or internship and provides rehabilitative mental health services or substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements.

QUESTION: Our program has a **Medical Assistant (MA)** who provides some of the specific duties such as assisting with pharmacy calls to refill medication and obtain vitals (height, weight, BMI, blood pressure, temperature, pulse). Would this person fall under the same regulations requiring the supervising physician to be physically present to oversee them if they are not performing medical procedures despite their credentials as a MA?

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

ANSWER: ***YES****, since the individual is being hired with the title of a MA, they would be held to the same standard regardless of the type of services that they are providing. If the program is interested in hiring staff who can assist with assisting with pharmacy calls to refill medication, vitals, but don't want to be subject to the supervision requirement of an MA, then consider a different provider type, such as "Other Qualified Provider" (OQP) or even a Mental Health Rehabilitation Specialist (MHRS). However, the OQP would not be eligible to perform any of the MA related duties (i.e. vitals, pharmacy calls to refill, etc.). Please work with your assigned division QMS Support Team to determine which provider type would best fit your program's need.*

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

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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