SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

OC health CARE AGENCY

November/December 2024

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Updates

Evidence-Based MAT Assessment

Previously it was advised that the Clinical Opiate Withdrawal Scale (COWS) and Clinical Institute Withdrawal Assessment for Alcohol-Reviewed (CIWA-AR) be administered by a medical professional. This remains the recommendation for all programs except the Withdrawal Management levels of care. It is permissible

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WHAT'S NEW?

Standardized ASAM Assessments

The State recently tentatively announced that the anticipated effective date (January 1, 2025), for implementing the use of one of the two specified ASAM assessments noted in the Behavioral Health Information Notice (BHIN) 23-068 will be postponed until further notice. Therefore, at this time, no changes are necessary. Please continue with your current practices. We will provide any updates as soon as we receive any further information.

Many Thanks…

We would like to take this opportunity to express our appreciation for all your hard work to provide quality substance use disorder treatment services. We know it has not been easy – this year we saw unprecedented changes with Payment Reform that challenged all of us. We look forward to continued collaboration with you in the new year to serve our members in the community!

Happy Holidays!

Training & Resources Access

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

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

Updated SUD Documentation Manual

https://ochealthinfo.com/sites/healthcare/files/2024-09/FINAL_DMC-ODS_CalAIM_Doc_Manual_9.3.24.pdf

Updated MAT Documentation Manual

FINAL_CalAIM_MAT_Documentation_Manual_v3_11.6.24.pdf

NOTICE: In lieu of a standalone SUD Documentation 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

Updates (continued)

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for staff who are not licensed/credentialed to administer these scales at the Withdrawal Management levels of care because of the specific training in detoxification services that is required for these staff.

Timeliness of Documentation

Although services may be claimed when the documentation of the progress note is completed outside of the 3-day timeline, it is important that we maintain compliance with the requirement as much as possible. Aside from the importance of timely documentation for clinical integrity, please be aware that timeliness of documentation of services provided is essential for responding appropriately to records requests. For example, under the Privacy Rule, entities that must abide by HIPAA, should ensure that individuals have a right to access their health information within thirty (30) calendar days of the request. Another example is that, according to the Health & Safety Code, physicians must provide patients with the requested records within fifteen (15) days of receipt of the request. Please continue to complete required documentation in the client's chart as soon as possible!

For additional billing system 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 start and end times for documentation time required for progress notes at Residential?

No. Due to licensing and certification requirements, the start and end times for the ***service*** is required for all progress notes documented at the residential levels of care, not ***documentation*** time. For the care coordination services that are separately billable and entered in IRIS: Since the documentation time will continue to be entered into IRIS for the care coordination services, it is recommended that the documentation start and end time is captured on the progress note to corroborate with what is entered into IRIS. As always, please ensure that the total service and documentation time entered in IRIS is congruent with the duration indicated by the start and end times on the progress notes. For individual and group counseling services, only the start and end time for the service is required.

2. What billing code should be used for administering injections at a MAT program?

There is no specific code available for injections. The Oral Medication Administration, Direct Observation, 15 Minute (70899-109) H0033 code should be used for all medications, including injections. This code is applicable for the outpatient MAT programs as well as MAT in Residential and Withdrawal Management.

3. If a client presents to treatment already receiving MAT services in another program, do we still need to conduct the evidence-based MAT assessment?

No. The evidence-based MAT assessment requirement is for determining whether a client is in need of a referral to MAT services. Therefore, if a client is already receiving MAT services, there is no need to complete the evidence-based MAT

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Documentation FAQ (continued)

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assessment. In such cases, it will be important to clearly document that the client is already engaged in MAT services. Examples of places where you might document this include the intake progress note, the ASAM assessment, the LPHA's narrative to establish the appropriate level of care placement, etc. Additionally, it will be important to document how coordination will be provided with the client's MAT provider to ensure collaboration on client's treatment.

4. Is the use of an Evidence-Based Practice (EBP) required in every progress note?

No. The use of an EBP is dependent on the needs of the client and the service being provided. Not all individual counseling or therapy services may necessitate the use of a particular EBP, and this is OK. Since all professional staff are required to be trained in at least two (2) EBPs, the expectation is that when it is clinically appropriate, it is used and documented. The documentation should briefly describe how the EBP was incorporated into the interventions provided.

5. What is Patient Education?

According to the State, it means "providing research-based education on addiction, treatment, recovery and associated health risks." It is important to emphasize the "research-based" part, which means that the information presented should come from credible sources that can be referenced, if needed. This is different than psychoeducation. Additionally, Patient Education services should be an adjunct service that helps to support the other core clinical services that more directly addresses a client's specific SUD and treatment needs. For example, a Patient Education group teaching clients about the physical health risks of intravenous drug use and HIV education helps to further the client's knowledge of the negative impact of substance use that may aid in the client's behavior change.

Reminders...

- There are only two medication service codes available for MAT services at the Withdrawal Management and Residential treatment services levels of care - Medication Training and Support, Individual per 15 Min (70899-110) H0034 and Oral Medication Administration, Direct Observation, 15 Minute (70899-109) H0033.

- For care coordination, please remember that making or confirming an appointment is not billable (remember, it does not require any clinical expertise to do this!). If making an appointment for the client (such as for a doctor's appointment) requires clinical intervention, this must be made clear in the documentation to substantiate the billing for the activity. **see the June 2024 SUD Newsletter for more info.**

- Some service codes that do not have a specific time range are claimed in 15-minute increments (e.g., Targeted Case Management). For these services, remember that the midpoint must be reached to bill for the service. Services less than 8 minutes should be coded using the non-billable code.

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.

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 FOR NOVEMBER 2024

RUSSIAN THRESHOLD LANGUAGE

- The Department of Health Care Services (DHCS) has identified Orange County as meeting the population threshold language for Russian.
- Quality Management Services (QMS) is working on having all the member materials translated in Russian.

PROVIDER DIRECTORY

When entering the Provider Status on the Provider Directory spreadsheet monthly submission be sure to provide the correct status. Below are the definitions of the options to be used from the drop-down menu:

Active: Provider is a current/active provider of the program and is **not** a newly hired provider.
Separated: Provider has separated/no longer employed by the program.
New: New provider who has been hired by your program, and if they are required to be credentialed they are added when they have received their credentialing approval letter and not before, non-credentialed can be added during the next Provider Directory submission after being hired.
Credential Update: Provider's credential has been updated (i.e., from AMFT to LMFT etc.) **not** if the renewal date has changed for their license due to it expiring and being renewed.
Name Change: Provider's legal name has been changed.
LOA Start: Provider begins a leave of absence (please put effective date).
LOA End: Provider ends a leave of absence (please put effective date which is the date they return to your program).
Interagency Transfer: Provider who transfers within the same entity (i.e., WYS East to WYS North and please indicate this information in the “New or Inter-Agency Transfer Comments” section in the Provider Directory).

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

SUPERVISION REPORTING FORMS

The new and revised supervision reporting forms for Clinicians, Counselors and Medical Professionals is in effect, as of 10/1/24. MCST has provided reminders, announcements and trainings at the QIC Meetings from August – September 2024. Any provider who requires supervision per the certifying organizations, licensing boards and DHCS requirements must have a supervision reporting form submitted to MCST. If MCST does not have the supervision form on file, the provider must **NOT** delivery any Medi-Cal covered services until it is received.

SEEK ADVISEMENT WITH YOUR CERTIFYING ORGANIZATION/LICENSING BOARD

MCST encourages all supervisees and clinical supervisors to seek consultation directly with their certifying organizations and/or licensing boards for questions related to clinical supervision requirements and regulations. MCST is only required to track, log and monitor providers' supervision reporting forms to ensure the types of providers maintain the necessary supervision needed to deliver Medi-Cal covered services.

INTERIM NURSE PERMITEES & VOCATIONAL NURSE INTERIM PERMITEES (COUNTY-CONTRACTED ONLY)

HCA County Classifications does not allow for hiring an "Interim Nurse Permitees" and "Vocational Nurse Interim Permitees". These are providers who have completed their educational requirements for licensure in nursing, are no longer under the liability of the school and have not taken their licensing exam. If you are a County-Contracted program that allows for the employment of a "Nurse Permitee" and "Vocational Nurse Interim Permitee" it is the responsibility of the County-Contracted program to ensure the provider is under proper supervision, fulfills the requirements governed by the licensing board and consults with their agency risk management for any labor and liability concerns. Reference: [Interim Permitee (ca.gov)]

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

We apologize for the delay as MCST is experiencing a high work volume. All new hire initial credentialing packets will be processed within 5 business days instead of 24-72 hours upon receipt. The credentialing process can take up to 30 days to approve once the provider has completed their online attestation. We hope to approve the provider before the 30 days as the average time has been between 3-18 days.

CREDENTIALING NOTIFICATION (COUNTY ONLY)

- MCST will no longer provide a courtesy e-mail notification to credential new hires to the Service Chiefs, effective 10/4/24.
- All new hires who work in a job classification that requires a license, registration, certification or waiver must be credentialed prior to delivering any Medi-Cal covered services.

PROVIDERS REQUIRED TO BE CREDENTIALED:

NOTE: Any provider who works in a job classification that requires a license, waiver, certification and/or registration and delivers Medi-Cal covered services must be credentialed by the County. This list is not exhaustive, please inquire with the MCST for further guidance.

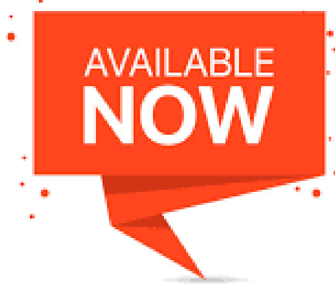
- ✓ Licensed Vocational Nurse
- ✓ Licensed Psychiatric Technician
- ✓ Certified Nurse Assistant
- ✓ Certified Medical Assistant
- ✓ Certified/Registered AOD Counselor
- ✓ BBS Licensed (LMFT, LPCC, LCSW)
- ✓ BBS Associate (AMFT, APCC, ACSW)
- ✓ BOP Registered/DHCS Waivered
- ✓ Physician Assistant
- ✓ Psychiatrist
- ✓ Physician
- ✓ Nurse Practitioner
- ✓ Registered Nurse
- ✓ Occupational Therapist
- ✓ Psychologist
- ✓ Pharmacist
- ✓ Certified Peer Support Specialist

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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, State Fair Hearings, 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)

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 & Annette Tran, LCSW

CONTACT INFORMATION
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(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

MCST OVERSIGHT

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- SUPERVISION REPORTING FORMS & REQUIREMENTS
- GRIEVANCES & INVESTIGATIONS
- COUNTY CREDENTIALING
- ACCESS LOGS
- MHP & DMC-ODS PROVIDER DIRECTORY
- PAVE ENROLLMENT (MHP PROVIDERS ONLY)

REMINDERS, ANNOUNCEMENTS & UPDATES FOR DECEMBER 2024

NOTIFICATION OF EXPIRED LICENSE, REGISTRATION, CERTIFICATION AND WAIVER

- Programs are strongly encouraged to have their providers renew their credentials with the certifying organization or licensing board at least 2-3 months prior to the expiration. It is not appropriate for a provider to continue delivering Medi-Cal covered services while a registration or certification has lapsed on the assumption that the certifying organization will renew the credential retroactively, as this may not always be the case and can potentially lead to a disallowance.
- When the provider's credential has expired, the MCST and IRIS takes action to deactivate the provider in the County system. The MCST e-mails a notification of the expired credential and requires the provider and direct supervisor to provide a response by the end of the business day.
- The provider's reinstatement is **NOT** automatic. The provider must petition for their credentialing suspension to be lifted and e-mail proof of the license, certification and/or registration renewal to the MCST and IRIS to reinstate their privileges to begin delivering Medi-Cal covered services.

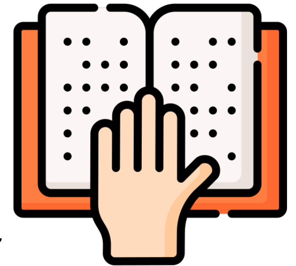
RUSSIAN THRESHOLD LANGUAGE

- The Department of Health Care Services (DHCS) has identified Orange County as meeting the population threshold language for Russian.
- Quality Management Services (QMS) is working on having all the member materials translated in Russian.
- The 8 threshold languages are English, Vietnamese, Spanish, Korean, Chinese (Simplified), Arabic, Farsi and Russian.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

BRAILLE REQUIREMENT

The Department of Health Care Services (DHCS) has required Orange County to provide member materials in Braille in the 8 threshold languages. The MCST has already requested the "Grievance & Appeals Poster" and "Grievance Form" that are under our oversight to be translated by a vendor through Behavioral Health Training Services (BHTS). **County Providers,** will need to reach out to BHTS to assist with ordering copies of the braille materials that MCST recently translated. For **Contract Providers**, please reach out to your contract monitor and/or County administrator for guidance with obtaining the required Braille materials to have available at your site. QMS is working diligently to have other member materials to be translated. Stay tuned.



PROVIDERS OPTING OUT OF MEDICARE

As part of the credentialing process, the MCST is notified by VERGE/RLDatix on a monthly basis if a provider "opts out" of being a Medicare provider. This sometimes happens when the provider has a private practice, and it means a beneficiary pays the provider out-of-pocket and no one is reimbursed by Medicare. As a provider under our Behavioral Health Plan the County requirement is to serve our Medi-Cal and Medi-Care patients and be reimbursed for those services.

When the MCST is notified by VERGE/RLDatix that a provider has opted out of Medicare, they will provide an e-mail notification to the provider, direct supervisor, program manager, contract monitor, IRIS, MBU and the QMS Support Teams about the implications of opting out. For **Contract providers,** discuss this item with your contract monitor and administrator to determine how this will impact your program as Medicare must be billed first when members are dual eligible Medi-Medi. For **County Providers,** if you are a licensed Medicare eligible provider, you are **NOT** eligible to opt out of Medicare.

Below are the resources detailing what to do with your Medicare opt-out status, consult with your supervisor on this matter and seek advisement about opting out/in procedures directly from the Centers for Medicaid and Medicare (CMS) for further guidance.

RESOURCES:

Opt Out of Medicare - JE Part B – Noridian

Medicare and Children: How Do I Get Medicare for My Child? | HelpAdvisor.com

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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SEEK ADVISEMENT WITH YOUR CERTIFYING ORGANIZATION/LICENSING BOARD

The MCST encourages all supervisees and clinical supervisors to seek consultation directly with their certifying organizations and/or licensing boards for questions related to clinical supervision requirements (e.g., collecting hours, face-to-face hours, etc.) and regulations. The MCST is only required to track, log and monitor providers supervision reporting forms to ensure the types of providers maintain the necessary supervision needed to deliver Medi-Cal covered services.

SUPERVISION REPORTING FORMS

We are still missing supervision reporting forms from the medical professionals! The new and revised supervision reporting forms for Clinician, Counselor and Medical Professional went into effect, 10/1/24. The MCST has provided reminders, announcements and trainings at the QIC Meetings from August – September 2024. Any provider who requires supervision per the certifying organizations, licensing boards and DHCS requirements mut have a supervision reporting form submitted to MCST. If, the MCST does not have the supervision form on file the provider must **NOT** delivery any Medi-Cal covered services until it is received.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

GENERAL REMINDERS ABOUT CLINICAL SUPERVISION REQUIREMENTS

- Any status change for clinicians, counselors and medical professionals requires an updated Supervision Reporting Form to be submitted to MCST (e.g., separation, change of Clinical Supervisor, etc.).
- BBS and BOP registered, waivered and trainees must be assigned to a clinical supervisor and remain in clinical supervision until they become licensed.
- BBS and BOP registered, waivered and trainees are required to have clinical supervision **weekly** until licensed.
- Medical Professionals and Registered Counselors must have "regular" supervision to meet the minimum requirements by their licensing board or certifying organization.
- Providers under required supervision by their licensing board or certifying organization (e.g., Nurse Practitioner, Registered AOD Counselor, AMFT, APCC, Certified Peer Support Specialist, Medical Assistant, etc.) are prohibited from delivering Medi-Cal covered services if they have **NOT** submitted their Supervision Reporting Form. Be sure to always secure supervision for the supervisee to prevent any supervision gaps and potential deficiency for disallowances or recoupments.

30 DAY RESOLUTION FOR GRIEVANCES

- DHCS is requiring grievances to be resolved within 30 calendar days instead of 90 calendar days to be aligned with the Federal requirements for the Managed Care Plan. This is slated to go into effect sometime in January 2025.
- DHCS will be issuing a revised BHIN 18-010E sometime soon.
- The MCST requires program's assistance to quickly respond to our Investigation Representative when requesting supporting evidence (e.g., chart, lab results, medication listing, etc.) and discussing the case to help conclude the grievance. Your cooperation is appreciated to help expedite information needed to resolve the member's grievance, timely.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

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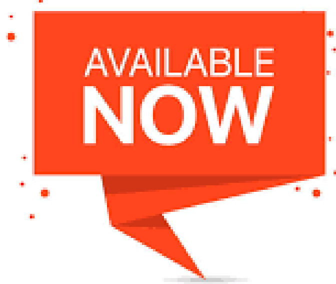

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