SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

October 2024

SUD Support

Chiyo Matsubayashi, LMFT
Yvonne Brack, LCSW
Claudia Gonzalez de Griese, LMFT
Ashlee Al Hawasli, LCSW
Caroline Roberts, LMFT
Crystal Swart, LMFT
Ashlee Weisz, LMFT
Emi Tanaka, LCSW
Susie Choi, MPH
Faith Morrison, Staff Assistant
Oscar Camarena, Office Specialist

CONTACT
aqissudsupport@ochca.com
(714) 834-8805

Updates

To provide some clarification regarding the use of the **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013** code, it is permissible for the outside interpreter to be another staff member of your program. It does not need to be a certified interpreter. The rendering provider of the service cannot be the individual doing the interpretation. Please keep in mind that this is a

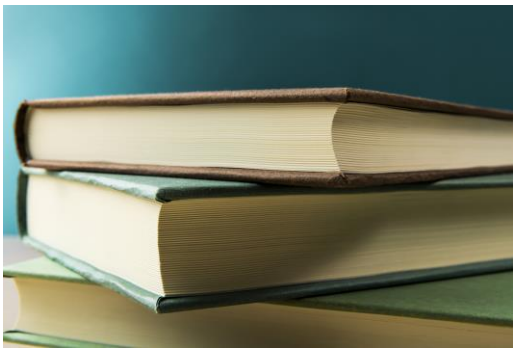
continued on page 2…

WHAT'S NEW?

Medicare

As you know, effective January 1, 2024, Marriage and Family Therapists (MFTs) and Licensed Professional Clinical Counselors (LPCCs) became eligible to bill Medicare. As a reminder, the Centers for Medicare and Medicaid Services (CMS) has established more stringent requirements than California. MFTs and LPCCs must have acquired all required hours or two years of clinically supervised experience *after* obtaining the applicable doctor's or master's degree. In other words, if part of the MFT's 3,000 hours or two years of clinically supervised experience were accrued *before* the individual obtained their degree, they are not eligible to bill Medicare. In such cases, the MFT/LPCC should claim Medi-Cal directly and use the HL modifier. Providers in this situation should coordinate with IRIS to ensure that their profile is built with the HL modifier.

County Providers ONLY: If you are eligible to bill Medicare (i.e., achieved all clinically supervised hours after graduation), you must "opt-in" to become a Medicare provider if you have not yet elected to opt-in or opt-out. This is because Medi-Cal is the payer of last resort. For questions or concerns, please speak with your Service Chief.



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

Coming Soon…

Updated MAT Documentation Manual

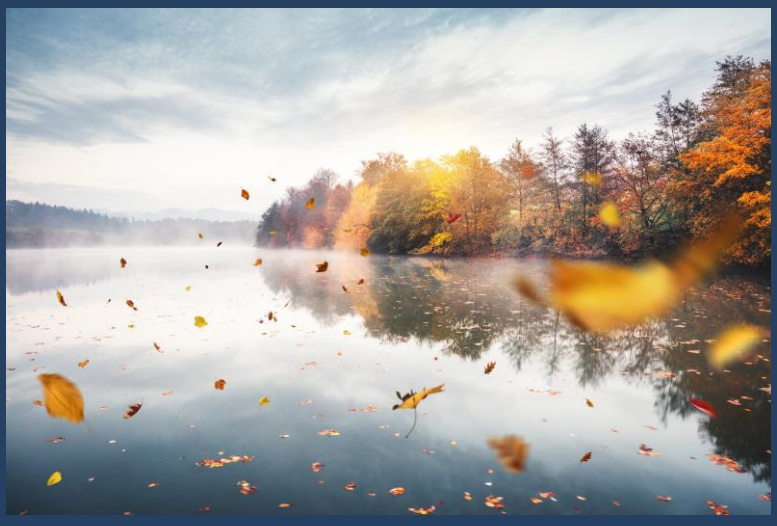
NOTICE: Until there is an updated SUD Documentation Training, please refer to the most recent Documentation Manual, CPT Guide, and the monthly newsletters for the most recent changes! If you are unsure about the current guidance, please reach out to aqissudsupport@ochca.com

Updates (continued)

…continued from page 1

supplemental code, so it must be attached to the primary service. This means that the staff member who is conducting the interpretation cannot bill for the time as a standalone service. If, for example, the individual counseling service was 30 minutes, the Sign Language or Oral Interpretation Services code would be claimed with that counseling service for 30 minutes. In the billing system, the two codes would go on the same Financial Identification Number (FIN). The amount of time claimed for the supplemental code must not exceed the amount of the service time for the primary service.

For clients who may **arrive late to or leave early from a group and only attend for part of a group at the outpatient levels of care**, it is permissible to continue to bill for that client's attendance in the group. Clients should be participating in the group for most of the service time. For ensuring that the billing for a client who only partially attends a group is not perceived as fraud, waste, and/or abuse, it is advised that the group is billed only for those cases where the client is in attendance for more than 50% of the total group time. It remains that there is no way to distinguish in the billing system that the client attended for less than the total group time. Therefore, we continue to recommend that situations where clients are unable to attend the entirety of the group, be documented in the group progress note for the client that this applies to. For example, "Client arrived 10 minutes late to the group due to coming from court, per client report."



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.

Documentation FAQ

1. Is having the treatment planning activities in my session progress note sufficient?

The State does not make explicit where the treatment planning activities must be documented. Therefore, documentation in a session progress note is sufficient to fulfill the requirement. However, it is important to point out that one of the requirements for treatment planning activities is that the information be readily available to be produced and communicated to others (i.e., the client, other providers, etc.) for the purpose of supporting care coordination. We should keep in mind that if the treatment planning activities are embedded in with other content from an encounter with the client, this may mean sharing more information than what is necessary. Given this consideration, a suggested place for documenting the treatment planning activities would be on or attached to the client's problem list.

2. Is an evidence-based MAT assessment required at the Withdrawal Management level of care?

Yes. Withdrawal Management programs will need to adhere to the requirement of assessing clients to determine whether a referral to MAT is warranted, as outlined in each program's policies and procedures. As a reminder, the evidence-based MAT assessment must be administered within 24 hours of the client's admission and linkage (including transportation) must be provided to ensure the client accesses the MAT provider if MAT is not offered on-site. Please be sure that there is documentation to show that the evidence-based MAT assessment was conducted along with what the outcome was.

3. If our program's physician sees all clients admitted for a physical evaluation, do we still need the evidence-based MAT assessment?

The evidence-based MAT assessment requirement is to determine

Continued on page 3…

Documentation FAQ (continued)

…continued from page 2

a client's appropriateness for a referral to MAT. Therefore, a physical evaluation by your program's physician that includes an evaluation for MAT would supersede this. A separate evidence-based MAT assessment is not necessary. It is important to note, however, that the physician's physical evaluation needs to make clear that the client was also evaluated for MAT and what the outcome was to fulfill the requirement.

4. What billing code should be used by an RN doing vitals in a MAT program?

The Medication Training and Support, Individual per 15 Min (70899-110) H0034 code should be used. If the service is less than 8 minutes in duration, it must be coded using the non-billable code. If the taking of vitals happens in conjunction with the administration of medication, the Oral Medication Administration, Direct Observation, 15 Min (70899-109) H0033 code should be used. These codes can also be used at MAT within a Residential or Withdrawal Management program.

5. How is billing impacted if I pull my client out of the group early for an individual session?

Remember that duplicate billing (billing for the client's presence in two services at the same time) falls under fraud, waste, and/or abuse. Therefore, it is important that the documentation makes clear that the overlap between the two services is minimal if both services are being claimed. If there is a specific reason why this must be done, it is recommended that this be documented to explain the need for removing the client from a group. Such circumstances should be rare. This is where the inclusion of the start and end times of the service on the progress notes can be helpful in clearly demonstrating that there was no duplicate billing involved.

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

Reminders…

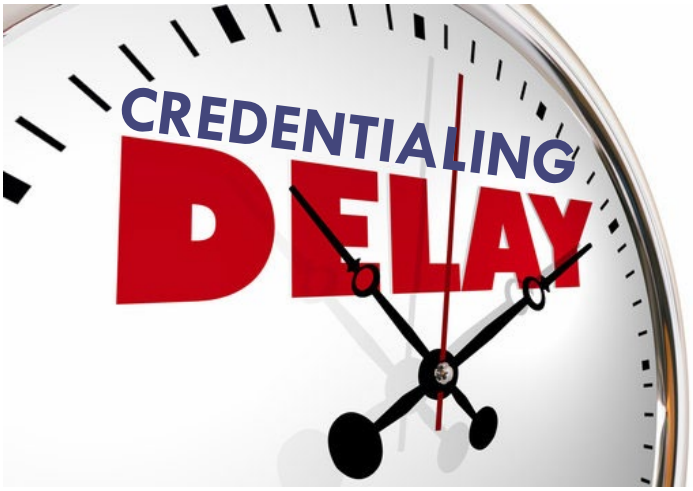
- Provider names and signatures should match with the name that is used for certification/credentialing. Please do not sign with your nickname if that is not the name that you are registered/certified/licensed/credentialed as.
- For the AOB/ATD, be sure that "Medi-Cal" is indicated for the name of the insurance, the Client Index Number (CIN) is used for the policy number, and the client signs the form!
- Please be mindful to consider the appropriateness of an "intoxication" or "withdrawal" diagnosis at the time of a client's discharge from withdrawal management. It may be necessary to have the LPHA update the client's diagnosis on the problem list in conjunction with their determination that the client is no longer demonstrating the need for the withdrawal management level of care.
- Service time should be actual total minutes, not an estimated number of minutes. For example, even if your group schedule consists of all 90-minute groups, not every group is going to be facilitated as exactly 90 minutes.

MANAGED CARE SUPPORT TEAM

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



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)

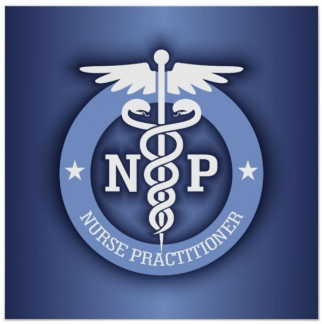
IMPORTANT SUPERVISION REQUIREMENTS

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

Nurse Practitioners are required to submit a Medical Supervision Reporting Form to confirm they are under the general direction of a physician.



NURSE PRACTITIONER (NP)

- NPs are not an independent practitioner.
- NPs may supervise LVNs, as they are required to have an active RN license.
- Every NP must be supervised by a licensed physician and at minimum, be available by telephone or other electronic communication method at the time the NP examines the patients.
- Assemble Bill 890 is a new regulation that will allow nurse practitioners to practice without physician supervision upon the licensing board approval.
  1. The initial phase currently allows the NPs (103) to apply to become an independent practitioners by being in good standing for at least 3 years under the general supervision of a physician starting January 2023.
  2. In the final phase the licensing board will review the applicant's progress and determine certifying the NPs (104) to begin practicing independently, effective January 2026.
  3. HCA has not approved this practice for County NPs, yet.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

TIMELY ACCESS & ISSUING NOABDS (MHP ONLY)

- Federal Access Standards defines **Urgent** appointments to be offered within **48 hours**, **NOT** 24 hours.
- The standard for an **Urgent** appointment must be "offered" within **48 hours of the request**. The provider is to determine if a request is urgent, not the beneficiary. If the provider determines that the request is urgent, they must "offer" the appointment within 48 hours, this is calendar days. This means that Saturday and Sunday cannot be skipped.
- For example, a beneficiary requesting to access services Friday morning, and the provider determines it is urgent then the beneficiary should be seen the same day as the 48 hours falls on a Sunday when most clinics are closed. If we do not see the beneficiary the same day, we are not meeting access standards and a timely access NOABD must be issued.

MHP

10 BUSINESS DAYS - ROUTINE
Outpatient Services

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

4 HOURS - EMERGENT
CALENDAR DAY
Crisis Assessment/Evaluation

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.

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, 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

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