SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

May 2025

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Update

Observations in Withdrawal Management CORRECTION

We would like to make a correction to guidance on a question posed in the most recent Documentation Clinical Super User Meeting about the requirement for observation checks at the withdrawal management level of care. Although the updated AOD Certification Standards do not indicate that changes cannot be made to the frequency of

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WHAT'S NEW?

Updated AOD Certification Standards

In February, the Department of Health Care Services (DHCS) released Behavioral Health Information Notice (BHIN) 25-003 that made explicit the mandatory certification of all outpatient Substance Use Disorder (SUD) programs. The requirements that programs must abide by under the certification have also been updated. All outpatient SUD programs and residential or withdrawal management programs that are certified should review the updated version to ensure continued compliance. The following are a few of the highlights as it pertains to documentation:

- Documentation of referral to MAT services, if applicable;
- Progress notes of services conducted via telehealth must include the address of the location where the client received the service;
- Documentation that evidences that the client received an individualized, outcome-driven treatment plan or progress note; and
- Development of a discharge summary within seven (7) days of the client's discharge

What does an "individualized, outcome-driven treatment plan or progress note" mean?

This does not mean that a standalone treatment

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Training & Resources Access

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

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

SUD Documentation Manual

DMC-ODS_CalAIM_Doc_Manual.pdf

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 BHPSUDSupport@ochca.com

Update (continued)

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the physical and vitals checks within the first twenty-four (24) hours, the requirements under licensing and certification do:

"Physical checks and monitoring of vital signs may be discontinued or reduced after 24 hours following admission based upon a determination by personnel trained in providing detoxification services" (BHIN 21-001).

There must be documentation on file that explains the reason for the modification. The regulations do not require that an LPHA make the determination and document. It is advised that a medical professional make this determination as it necessitates the consideration of the client's physical functioning or health status, however, personnel who have received the appropriate training to provide detoxification services are permitted to do so.

WHAT'S NEW? (continued)

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plan is required. If your program chooses to utilize a treatment plan document, this is acceptable. The AOD Certification Standards have aligned with the DMC-ODS documentation requirements in terms of care planning. The State is expecting that treatment planning (i.e., a collaborative discussion with the client and other relevant parties) that guides a client's course of treatment, taking into consideration the specific needs of the client and how the services available can meet those needs, is provided. This can be documented anywhere, including in a progress note, as long as it is documented and can be readily available to be produced and communicated to others (see September & October 2024 SUD Newsletters for more information on treatment planning activities).

Note about the discharge summary: Different requirements for outpatient and residential programs

Outpatient –

1. Summary of services provided;
2. Date of discharge;
3. Reason for discharge; and
4. Referrals (if applicable)

Residential & Withdrawal Management –

1. Description of treatment episode;
2. Description of recovery services completed (if applicable);
3. Current alcohol and/or other drug usage;
4. Vocational and educational achievements; and
5. Client's comments

For more information, see the BHIN here: Behavioral Health Information Notice No: 25-003 - Certification of Alcohol and Other Drug Programs

Documentation FAQ

1. Our Electronic Health Record (EHR) only allows for entering time by the hour or half-hour (e.g., 10:00AM, 10:30AM, etc.) or in set increments (e.g., 60 minutes, 90 minutes, etc.). How do we show exact minutes (e.g., 10:17AM or 72 minutes) on the progress note?

The requirement is for the service time or duration to be in actual minutes and not rounded up or down. But if your EHR does not allow you to enter the exact number of minutes or the exact start/end time to auto-calculate the total number of minutes on the progress note, it is sufficient to include this information in the narrative portion of the progress note. For example, you can document "Actual service minutes = 37 minutes" or "Service duration was 22 minutes." This is similar to if your EHR does not have a place to enter an exact start and end time. You could note in the body of the progress note that "Start time: 9:03am; End time: 10:29am" even though the scheduled time may have been "9:00am – 10:30am," for example. As a reminder, exact minutes documented will need to match the exact minutes entered into IRIS.

2. A client came for an intake appointment but declined services and requested referrals. Can we bill for providing the referrals?

If the individual is not admitting into the program, but we want to bill for what was provided in an encounter with them, we would first need to make sure the minimum, necessary legal documents have been completed. These would be the Informed Consent, Notice of Privacy Practices, Limits of Confidentiality, and AOB/ATD. Without these documents, we cannot bill. The next consideration, in this case about the referrals, is whether a billable activity was performed. If by "providing" referrals, it is meant that a list of resources was handed to the client, it is not billable. Conducting an exploration of what the individual needs

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Documentation FAQ (continued)

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or is looking for, providing an explanation to educate on the possible options that may be available in the community, contacting the organization with the individual to further determine appropriateness or eligibility, and/or helping to link them directly to the service, would be billable care coordination activities. Proper documentation of the service would be necessary to justify the billing.

3. I discussed the client's treatment plan with their Probation Officer (with the proper release of information). Is this billable using the Treatment Plan Development/Modification code?

The conversation with the client's Probation Officer would be considered a consultation for the purpose of coordinating the client's care. This can be billed using the Targeted Case Management, Each 15 Min (70899-120) T1017 code. Although the client's treatment plan is discussed, the purpose of doing so is to collaborate with the legal system involved in the client's care to achieve the most beneficial treatment outcome. The SUD Treatment Plan Development/Modification (70899-125) T1007 code is more appropriate for the discussion and collaboration with the client on their treatment (i.e., establishing areas of need, what services will be needed, the types of intervention modalities that will likely be the most effective to address clinical needs, etc.).

4. My client is stepping down from withdrawal management to residential at our program. Do we need a new AOB/ATD?

Yes. There should be a new AOB/ATD for each treatment episode of care. Although it is within the same program, the transition is a change in level of care that necessitates a discharge from one level of care to admit to another. It is also an important aspect of providing informed care to the client who should be made fully aware of how their Medi-Cal is utilized.

Progress Note for Each Claim

All services claimed must have the appropriate, corresponding documentation in the client's chart. This means that there should be a progress note for each service that is claimed. Services claimed that are found to be missing this documentation will result in recoupment in a clinical chart review.

Both Parties Can Bill for Consultation

General consultations between providers (such as between the non-LPHA and LPHA for the assessment or the physician and the primary counselor, etc.) can be billed by both consulting parties if each completes their own documentation in a progress note to justify the service. This billing allowance does not apply to the Clinician or Physician Consultation (i.e., Medical Team Conference by Non-MD, 30 Min+ 99368-1 and Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, 30 Min+ 99367-1).

Evidence-Based MAT Assessment Outcome

Be sure to document the result of administering the evidence-based MAT assessment (e.g., whether the client needs a referral or not and subsequent plan). If the client needs to be linked to a local MAT program, there must also be documentation of this care coordination effort (e.g., what program was contacted, what relevant clinical information was shared, what was arranged or confirmed, whether the client has/received the necessary transportation, etc.). The linkage provided is billable as Targeted Case Management (70899-120) T1017. Consider also the potential need for ongoing collaboration with the client's MAT provider.

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

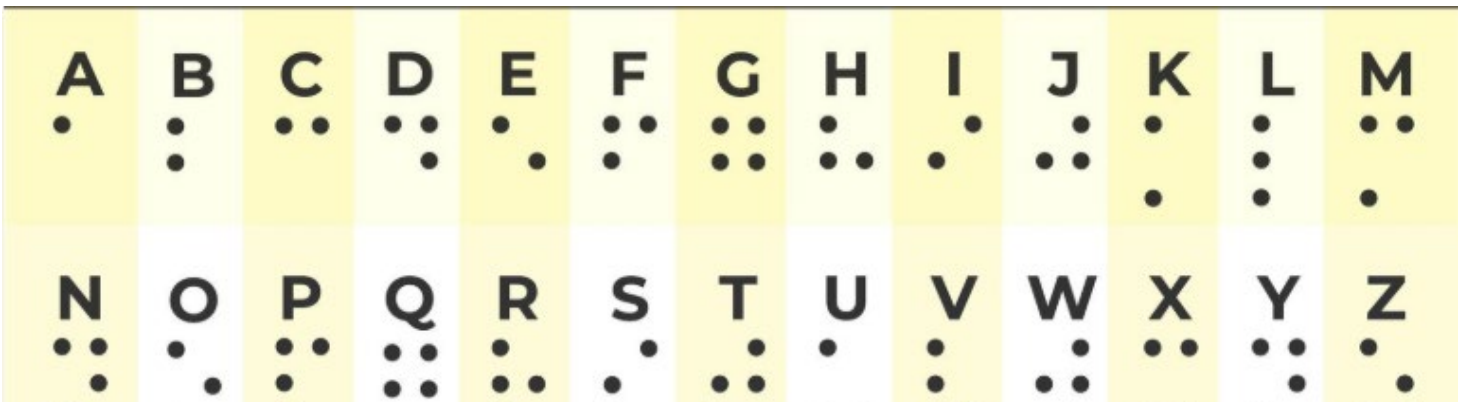
REMINDERS, ANNOUNCEMENTS & UPDATES

BRAILLE MATERIALS HAVE FINALLY ARRIVED!!!
The Department of Health Care Services (DHCS) requires the Behavioral Health Plan (BHP) to accommodate the communication needs of all members and be prepared to facilitate alternative format request for Braille, audio format, large print, accessible electronic format, and other auxiliary aids and services that may be appropriate.

The County has received the Braille grievance informing materials to meet the requirement for the:

- Grievance & Appeal Form
- Grievance & Appeal Poster (MHP)
- Grievance & Appeal Poster (DMC-ODS)

More information will be communicated to County and Contracted Programs via e-mail from BHPProviderDirectory@ochca.com with further instructions on disseminating the materials.



REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

SUPERVISION REPORTING FORMS

There are four types of supervision reporting forms the MCST oversees. Below is a grid listing all the provider types that must submit one of the required supervision reporting forms below:

- ✓ Clinician Supervision Reporting Form
- ✓ Counselor Supervision Reporting Form
- ✓ Medical Supervision Reporting Form
- ✓ Qualified Provider Supervision Form

SUPERVISION REPORTING FORMS

LIST OF PROVIDERS REQUIRED TO SUBMIT A SUPERVISION REPORTING FORM

CLINICIANS	COUNSELORS	MEDICAL PROVIDERS	QUALIFIED PROVIDERS
• Registered ASW • Registered MFT • Registered PCC • Registered/Waivered Psychologist • Psychologist Clinical Trainee • Clinical Social Worker Clinical Trainee • Marriage & Family Therapist Clinical Trainee • Professional Counselor Clinical Trainee • Associate Applicant – BBS 90 Day Rule	• Registered Counselors	• Nurse Practitioner • Nurse Specialist Trainee • Registered Nurse Trainee • Vocational Nurse Trainee • Psychiatric Technician Trainee • Occupational Therapist Trainee • Occupational Therapist Assistant • Pharmacist Trainee • Physician Assistant Trainee • Physician Assistant • Medical Assistant • Licensed Vocational Nurse • Licensed Practical Nurse • Licensed Psychiatric Technician • Certified Nurse Assistant	• Mental Health Rehabilitation Specialist • Other Qualified Provider I • Other Qualified Provider II • Certified Peer Support Specialist

REMINDER

- All required providers must submit the supervision form to the MCST upon commencement (e.g., new hire).
- Any status change requires an updated form to be submitted to the MCST (e.g., separation, change in supervisor, etc.).
- Supervision must be provided regularly.
- Provider's that require supervision are **prohibited** from delivering any Medi-Cal covered services if they have **NOT** submitted their supervision reporting form.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MCST GENERAL E-MAIL BOXES

QMS has renamed all the general e-mail addresses and created new ones to enhance the communication and efficiency with serving our providers and members. Please begin using the e-mail addresses listed below for questions and documents to be sent to the appropriate mailboxes. The old e-mail addresses will automatically be forwarded to the new ones for a short period of time. Please update our contact information, as soon as possible.

MCST MAILBOXES	OVERSEES
BHPGrievanceNOABD@ochca.com	Grievances & Investigations; Appeals/Expedited Appeals; State Fair Hearings; NOABDs; MCST Training Requests
BHPManagedCare@ochca.com	Access Logs, Access Log Entry Errors & Corrections; Change of Provider/2nd Opinion; County Credentialing; Cal-Optima Credentialing (AOA County Clinics); Expired Licenses, Waivers, Registrations & Certifications; PAVE (MHP Only); Personnel Action Notification (PAN)
new BHPProviderDirectory@ochca.com	Provider Directory Notifications; Provider Directory submission for SMHS and DMC-ODS programs by the 15th of every month.
new BHPSupervisionForms@ochca.com	Submission of the Supervision Reporting Forms for Clinicians, Counselor, Medical Professionals and Qualified Providers; Submission of updated Supervision Forms for Change of Supervisor, Separation, License/Registration Change, etc.

CAL-OPTIMA CREDENTIALING FOR AOA COUNTY CLINIC PROVIDERS ONLY

- OneCare and OneCare Connect are CalOptima's two Medicare health plans under the Certified Medicare Advantage Plans (CMAP), and the BHP has many members who have OneCare or OneCare Connect, with secondary Medi-Cal. OneCare and OneCare Connect are the only private insurances that are identified as "in network" in the BHP.
- In 2024, the legislation allowed LPCCs and LMFTs to bill Medicare directly for mental health diagnosis and treatment services. The MCST will be reaching out to the AOA county providers and Service Chiefs to begin the CalOptima credentialing process for the existing and new LMFT and LPCC providers.

MANAGED CARE SUPPORT TEAM

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **NEW** 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. Contact the 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 for new and existing providers. The 3-hour training is on NOABDs, Grievances, Appeals, State Fair Hearings, 2nd Opinion/Change of Provider, Supervision Reporting Forms and Access Logs.

Please e-mail BHPGrievanceNOABD@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

SUPERVISION REPORTING FORMS
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, LCSW

PAVE ENROLLMENT FOR MHP
Leads: Araceli Cueva & Elizabeth "Liz" Fraga (Staff Specialists)

CREDENTIALING AND PROVIDER DIRECTORY
Credentialing Lead: Elaine Estrada, LCSW & Ashley Cortez, LCSW
Cal Optima Credentialing Lead: Araceli Cueva & Elizabeth "Liz" Fraga
Provider Directory Leads: Esther Chung & Joanne Pham (Office Specialists)

PROVIDER TRANSACTION ACCESS NUMBER (PTAN)
Lead: Boris Nieto, Staff Assistant

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

BHPGrievanceNOABD@ochca.com
BHPManagedCare@ochca.com
BHPProviderDirectory@ochca.com
BHPSupervisionForms@ochca.com

MCST ADMINISTRATORS

Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II