SUD Support Newsletter

QUALITY MANAGEMENT SERVICES

September 2024

SUD Support Team

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Updates

Glitches in IRIS

As some of you are aware, there have been some errors happening in the billing system, such as only one unit being reflected as claimed when the 65-minute service warrants four units. We are aware that this has been happening randomly and it is no fault of the program billing specialists or the County billing unit. IT is working as quickly as possible to remedy the situation and manually correct

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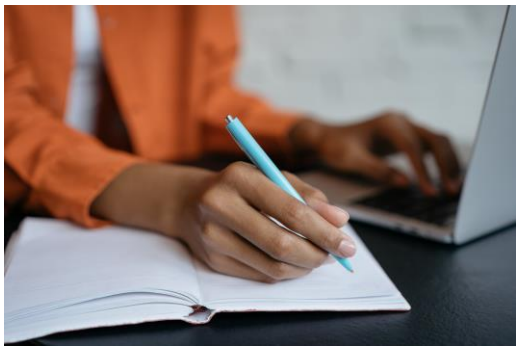
WHAT'S NEW?

There is a new Substance Use Disorder (SUD) Support Team (SST) member! We would like to introduce Ashlee Weisz, who will be in the role of Quality Improvement and Compliance Consultant. She will be one of the assigned consultants to some of our County and County-contracted providers to support compliance with State and Federal regulations. You will likely see her on-site at your programs for the Clinical Chart Reviews. Get to know Ashlee:

"I am a Licensed Marriage and Family Therapist, having worked in various levels of care in both substance use and mental health treatment. Previously, I had worked as a Crisis Clinician for Health Care Agency's CAT (Crisis Assessment Team) team where I was responsible for completing assessments of children and adults to determine appropriate level of care and current level of risk. I also maintain a small private practice specializing in trauma and hoping to develop a stronger niche in infertility and perinatal health. I have also worked as a primary therapist and group facilitator in detox, residential, PHP, and IOP treatment for substance use and eating disorders. I obtained both my B.S. and M.S. from California Polytechnic State University San Luis Obispo (Cal Poly SLO). In my spare time, I enjoy listening to true crime podcasts, riding my motorcycles, and spending quality time with friends, family, and my cats. I am thrilled to be part of the QMS SST and look forward to establishing collaborative relationships with our providers."



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)

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these errors. Thank you for your patience! If you have any questions or concerns, please feel free to reach out to your Front Office Coordination Team liaison bhsirisfrontofficesupport@ochca.com.

COUNTY PROVIDERS ONLY:

As a reminder, there should not be any clinical content in a Note-to-Chart (NTC). Some examples of the type of information that would be appropriate for a NTC include:

- Documenting an appointment confirmation or rescheduling;
- Documenting attempts to re-engage a client in services, such as leaving a voice message;
- Documenting that the client did not show up for a scheduled appointment; or
- Documenting receipt of correspondence (letter, voice message, etc.) from a client or other individuals involved in the client's treatment.

If what was supposed to be an encounter to reschedule the client's appointment turns into a more extensive conversation about how the client is doing, what they have been struggling with, their need for additional resources, etc. that requires clinical intervention, then this is a service that should be documented in a progress note with the appropriate billing code.

If a situation arises where you are uncertain as to whether it should be documented as a NTC or a progress note, be sure to reach out to your supervisor or Service Chief. You may also reach out to your program's assigned SST Consultant or email at aqissudsupport@ochca.com

SST Clinical Chart Review Update

To provide further technical assistance on billing for DMC-ODS services, the SST will be including a review of a small number of non-billable progress notes at the time of each program's Clinical Chart Review. The intent of this addition is to identify any services that could have been billed but were not. SST Consultants will provide clarification of what is billable vs. non-billable and feedback on documentation, as needed. In some cases, providers may be able to convert the service from a non-billable to billable service based on the reviews. This would depend on the nature of the activities provided and the window of time permitted for services to be billed.

Documentation FAQ

1. Why can't I bill for the ASAM assessment at NTP?

The State has made clear that a dosing service at the NTP includes the following:

- physical exam
- drug screening
- intake assessment
- medical director supervision
- TB, syphilis, HIV and Hepatitis C tests
- dosing
- ingredient costs

This means that if a dosing service is provided on the same day as the intake assessment (which may include the ASAM), there is no separate billing permitted. The cost of the intake assessment is included in the dosing service. Individual Counseling cannot be claimed for assessment activities such as the gathering of information for the purpose of completing the ASAM assessment. If a dosing service is not provided, the intake assessment may be billed using the SUD Assessment (70899-103) H0001 code.

2. Is helping the client's family with community resources billable as care coordination?

We must first be clear as to how this is related to the client's SUD treatment. Since we are treating the client, the need must be the client's in order to bill. All services claimed involving family or significant individuals in the client's life must center around the client and their treatment needs. If the community resource is something that is needed by the client and will also benefit the family, the assistance we provide may be a billable activity. The second point of clarification is the distinction between collateral services and care coordination. Although we may provide resources, referrals, and linkages to significant individuals in the client's life, such services are considered collateral services and

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Treatment Planning Activities

To fulfill the treatment planning activities requirement, providers can provide a brief description of "how" the client's problems or issues will be addressed in the treatment episode. With the State's move away from requiring standalone treatment plans to allowing for treatment planning activities, one way to think about this shift is the consolidation of treatment plan elements (e.g., goals, objectives, action steps, etc.) into a broader, more overarching description. There is no set format for how this description needs to look. It can be as brief as 1-2 sentences of what will be provided. Some things to consider including or to help formulate the description are:

- The type(s) of services (i.e., individual/family/group counseling, care coordination, drug testing, etc.) that are needed to address the client's identified needs
- Staff (i.e., Medical Director, LPHA, AOD Counselor, etc.) who will be part of the treatment team providing the services that will address the client's needs
- The frequency (i.e., 1x/week, 6-9 groups per week, 1x/month or as needed, etc.) with which services are needed to promote the best possible outcome for the client
- The interventions/treatment modalities (i.e., Cognitive Behavioral Therapy, Motivational Interviewing, Relapse Prevention, etc.) that are needed to target the client's needs

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 (continued)

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should not be billed as care coordination. Oftentimes, such activities are provided as part of discharge planning and supporting the client's preparation to leave treatment, return home, or simply reinforce what the client is gaining from treatment. It is likely that part of the discussion with the individuals in the client's life involves the ways that those individuals can aid in the client's ongoing recovery efforts outside of treatment. Be sure that the documentation makes clear how the encounter is medically necessary for the client's SUD treatment. The SUD Family Counseling (70899-116) T1006 code can be utilized for such encounters. For the residential and withdrawal management levels of care, family and collateral work is included in the daily bundle of services with no additional billing on top of the treatment day.

3. A client's assessment was started by a provider who is no longer with the agency. Can the new provider taking over the case, document the rest of the assessment?

Yes, the new provider may build upon the assessment that was started. If your agency's electronic health record (EHR) does not timestamp and delineate between different providers working on the same document, it is advised that an explanation be documented. This can be done on the actual assessment form or in a progress note. For example, the provider may explain in the session progress note where the assessment information was gathered that the client's case has been transferred to them and they are continuing with interviewing the client for information to complete the ASAM-based assessment or indicate in the next steps the plan to add the findings to the assessment document started by the previous counselor.

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.

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

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
- MCST provided guidance detailing the requirement to complete the three forms at the monthly QI Coordinators' Meeting for AOA, CYS and SUD in July and August 2024.
- The implementation of these new forms go into effect **9/1/24** for all applicable providers to submit to MCST by **9/30/24**. The three forms are currently posted and available on the QMS website.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

SUPERVISION REQUIREMENT FOR MEDICAL PROFESSIONALS

Some of the medical professionals who are licensed or certified are required to submit a Medical Professional Supervision Form to confirm they are under the general direction of a qualified provider who directs care, see below:

CERTIFIED NURSE ASSISTANT (CNA)

- CNAs are not an independent practitioner.
- CNAs are entry-level health care providers and practice under the direction of a physician, registered nurse or a licensed practical nurse.

MEDICAL ASSISTANT (MA)

- MAs are not an independent practitioner.
- MAs must meet all applicable education, training and/or certification requirements and provides administrative, clerical, and technical supportive services, according to their scope of practice.
- 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.

LICENSED VOCATIONAL NURSE (LVN)

- LVNs are not an independent practitioner.
- LVNs are entry-level health care providers who is responsible for rendering basic nursing care and practices under the direction of a physician or registered nurse.
- A LVN must provide nursing services under the direction of a registered nurse who directs nursing care and/or the patient's physician who directs medical care. The supervisor must be responsible for direction to the LVN regarding the respective nursing and medical procedures. The direction provided by the registered nurse or physician to the LVN must be available at least by telephone.(16 CCR § 2518.7).

PHYSICIAN ASSISTANT (PA)

- PAs are not an independent practitioner.
- Every PA must be supervised by a licensed physician and at minimum, be available by telephone or other electronic communication method at the time the PA examines the patient.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

SUPERVISION REQUIREMENT FOR MEDICAL PROFESSIONALS (CONTINUED)

LICENSED PSYCHIATRIC TECHNICIAN (LPT)

- LPTs are not an independent practitioner.
- LPTs practice under the direction of a physician, psychologist, social worker, registered nurse or other LPHAs.
- An LPT must provide patient care under the direction of a registered nurse who directs nursing care, the patient's physician who directs medical care, or be responsible to the director of the service in which the duties are performed. The registered nurse, physician or director of the service must be responsible for direction to the LPT regarding the respective nursing and medical procedures. The direction provided must be available at least by telephone. (16 CCR § 2576.7).

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)

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:

ochealth 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.

MANAGED CARE SUPPORT TEAM

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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E-MAIL ADDRESSES

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AQISManagedCare@ochca.com

MCST ADMINISTRATORS

Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II