October 2021 | VOL. 1 | NO. 30

QRTips

Behavioral Health Services
Authority and Quality Improvement Services
Quality Assurance & Quality Improvement Division
AOABH / CYPBH / Managed Care / Certification and Designation Support Services Teams

Medication Consent Update

The Department of Health Care Services (DHCS) issued an updated Information Notice, BHIN 21-046, which includes information regarding the ongoing flexibilities due to COVID-19. The flexibility regarding the ability to obtain verbal consent for medication consents on anti-psychotic medications expired on September 30, 2021. This means that prescribers are now required to obtain a physical signature for all anti-psychotic medications prescribed. Prescribers are not expected to obtain physical signatures on medication consents for anti-psychotics prescribed prior to September 30, 2021 in which verbal consent was obtained. Please note this requirement only applies to anti-psychotic medications, not general psychotropic medications, however, best practices would be to obtain a physical signature whenever possible.

Annual Re-Assessment Reminder

Information was provided to programs in March 2020 QRTips that the Periodic Re-Evaluation is to no longer be used as it does not contain all of the required elements for a re-evaluation. Recent audits with AOABH have indicated the Periodic Re-Evaluation form is still in use in some programs. Please note that the use of the Periodic Re-Evaluation form will result in recoupment. This does not appear to be an issue for County programs due to the Periodic Re-Evaluation form being removed from the EHR. Contract programs who might still be using this form are to immediately start using the Psychosocial for all annual reassessments. Providers are expected to complete all required elements. Please refer to the Documentation Manual or January 2020 QRTips for additional information on the required elements.

TRAININGS & MEETINGS

AOABH Online Trainings

New Provider Training (Documentation & Care Plan)

2020-2021 AOABH Annual Provider Training

AOABH MHP QI Coordinators' Meeting

WebEx Mtg. 12/2/21 10:30-11:30am

CYPBH Online Trainings

2020-2021 CYPBH Integrated Annual Provider Training

CYPBH MHP QI Coordinators' Meeting

WebEx Mtg.10/14/21 10:00-11:00am

**More trainings on CYPBH ST website*

HELPFUL LINKS

AQIS AOABH Support Team

AQIS CYPBH Support Team

BHS Electronic Health Record

Medi-Cal Certification

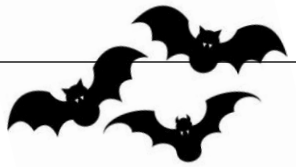
CPT Modifiers

The AQIS CYPBH Support Team would like to provide a refresher regarding CPT modifiers. Providers have the ability to include CPT modifiers in their progress notes as they can serve multiple purposes for documentation, billing and auditing/data collecting. Please be aware that the use of certain CPT modifiers, such as Evidence Based Practices modifiers, have specific criteria and/or training requirements that need to be met before using. This requirement is in place to avoid practicing out of scope. It is advised to consult with your direct supervisor and review program protocol before use of a CPT Modifier. A complete detailed guide on all the CPT modifier requirements and criteria is provided **here** as a resource. Below are some helpful reminders and tips pertaining to commonly used CPT modifiers seen in past AQIS CYPBH program audits:

- CPT Modifiers can be separated into three categories
  - Evidence Based Practices
  - Service strategies
  - Other modifiers
- If using a CPT modifier, the documentation should support its use.
- CPT Modifiers tied to billing such as telehealth (GT) should be given priority over those that are descriptive of Services Strategies or Evidence Based Practices.
- Commonly used CPT Modifiers
  - Telehealth (GT): Used when providing services via Telehealth through a visual and audio platform. Please note this modifier is not chosen when services are provided when only using audio, e.g., telephone, VOIP, videoconferencing without the video).
  - CFT meetings (MCFT): Used when participating in Child and Family team meeting.
  - Ethnic Specific Service Strategy (60): Used when a service is culturally tailored to persons of diverse culture in order to eliminate disparities. Used when a service is tailored to meet the cultural needs of the beneficiary/client.
  - Age Specific Service Strategy (61): Used when a service is tailored to specific age groups and performed to reach specific age groups in order to eliminate disparities.
  - Cognitive Behavioral Therapy (99H): Used when a service is provided in which the interventions focus on challenging and changing unhelpful cognitive distortions and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems.

Documentation of Non-Billable Services

Providers are expected to adhere to the documentation standards identified in the various training materials made available to them. It is important to document services in accordance with these standards to prevent recoupment and ensure accuracy of billing. Providers who conduct billable and non-billable services during a visit are expected to document these services separately. County providers in the IRIS EHR have the option to separate the non-billable activities within the non-billable tab of a billable service as long as the non-billable service is the same modality and service location as the billable activity, i.e., billable and non-billable Case Management Services. A separate progress note would need to be completed for the non-billable activity if the non-billable activity occurred in a different encounter location from the billable service i.e., telephone and clinic. Blending billable and non-billable services within the same progress note, but failing to identify the non-billable activities separately will result in the recoupment of that service.



Documentation and Billing Reminders

- Providers who conduct a telehealth/telephone service are required to obtain the location and address of the beneficiary/client and need to document this information within the progress note. This information was provided to programs in April 2020 along with handouts on guidance regarding the provision of telehealth/telephone services. This guidance is the standard for all services that occur by telehealth/telephone and not dependent on COVID-19. Please be sure to obtain this information at the start of the service and document appropriately within all progress notes.

- Providers should be aware of and know the billable/non-billable locations. A recent inquiry into this issue identified a number of services that were billed while a beneficiary/client was receiving services with a Crisis Residential Program (CRP). All services except Case Management Services (CMS) are to be dropped as non-billable while a beneficiary/client is receiving services at a CRP. Billing is allowed for all services on the day of and prior to admission, and upon discharge from the CRP. This is one reason why it is important to obtain the current location of the beneficiary/client during the telehealth/telephone service.

Certification and Designation Support Services Updates (CDSS)

- **Certification Updates**
  - COVID Waiver lifted
    - DCHS lifted the COVID waiver as of 6/30/21. What this means: For programs that were re-certified under the COVID waiver, CDSS will be conducting the site and binder review and program needs to obtain a fire clearance
      - CDSS has 180 days from 6/30/21 to go back and complete all site and binder reviews
      - Timeline will be expedited. 1-2 week notice to SC/PD to prepare binder prior to site visit
  - Soft (electronic) copy of Medi-Cal binder, organized by category, per DHCS
    - Program to submit binder electronically in the future (not this round due to expedited timeline). Stayed tuned for more information
- **Reminders**
  - Programs need to update CDSS when changes occur
    Change of: address, access to services problems, service disruption, new head of service (SC), significant incident occurs that impacts service delivery

Managed Care Support Team

REMINDERS

EXPIRED LICENSES, CERTIFICATION AND REGISTRATION

- Credentialing has rolled out with several programs thus far.
  The County's Credential Verification Organization, VERGE, e-mails notifications to provider at least two months in advance about expiring licenses, certifications and registrations.
- After VERGE's multiple attempts to obtain an updated credential, MCST and IRIS intervenes to suspend and deactivate the provider. The provider is no longer permitted to deliver services requiring licensure for the Orange County Health Care Agency.
- The provider must immediately petition for their credentialing suspension to be lifted and provide proof of the license, certification and/or registration renewal to MCST and IRIS. The reinstatement is **NOT** automatic.
- **HELPFUL TOOL**: The Provider Directory spreadsheet contains the "License Expiration Date" column to help supervisors/managers track and monitor credentialed staff before it expires.

PROVIDER DIRECTORY

- All Medi-Cal Certified Sites are required to provide an updated provider list to MCST **every month by the 15th**.
- The most current spreadsheet is e-mailed every month and must **NOT** be modified. The fields contains formulas and DHCS required columns that should not be altered.
- Submit your spreadsheet even if there are NO changes to your program and/or provider tab and update the "Date Revised."

PERSONNEL ACTION NOTIFICATION (PAN) FORM

- **CLARIFICATION**: New providers who are licensed waivered are required to submit the following items with the PAN **FIRST** before IRIS can allow the provider to begin billing for Medi-Cal covered services:

APCC, ACSW, AMFT:

1. Clinical Supervision Report Form (CSRF)
2. BBS Responsibility Form
3. Written Oversight Agreement (if applicable)

Psychological Candidates, Psychological Assistants, Registered Psychologist

1. CSRF
2. Mental Health Professional Licensing Waiver Request

Managed Care Support Team Cont.

REMINDERS CONT.

NOABD – TIMELY ACCESS

Providers are required to consult with the MCST before issuing an NOABD for Timely Access.

- MHP
  - ✓ If the provider is unable to offer a beneficiary a timely access appointment (Emergent: 4 hours, Urgent: 24 hours, Routine: 10 business days) they must contact ALL providers within the MHP (nearest to farthest) to schedule an appointment to meet the timeframe before they can issue an NOABD for timely access. For example, if the provider determines the appointment is urgent then an appointment needs to be scheduled within 24 hours.
  - ✓ The initial provider must document all attempts with linking the beneficiary with an appointment on the Access Log.
  - ✓ If the beneficiary indicates they want an appointment outside of the 10 business days the provider is still required to offer and locate an appointment within the MHP. Once an appointment is offered the beneficiary has the right to decline and accept an appointment outside of the 10 business days. An NOABD for timely access does NOT need to be issued.
- DMC-ODS
  - ✓ When a new beneficiary is requesting services and the provider is unable to offer a timely access appointment (Urgent: 48 hours, Routine: 10 business days) the provider must contact the Beneficiary Access Line (BAL) with the beneficiary to schedule an appointment with another provider in the DMC-ODS plan. For example, if the provider determines the appointment is routine then an appointment needs to be scheduled within 10 business days.
  - ✓ The BAL can schedule and locate an available appointment across the DMC-ODS plan. If the BAL is unable to locate an available appointment within 10 business days, the provider will issue an NOABD for timely access.
  - ✓ If your program operates business hours on weekends, as well, the 10 business days would apply to those weekend days.

USE OF NOABDS FOR BENEFICIARIES REQUESTING A SPECIFIC MODALITY OF TREATMENT

When the beneficiary is requesting a specific modality of treatment (i.e. DBT, EMDR, Equine Therapy, Eating Disorder Treatment, etc.) they have the right to be assessed by a provider with subject matter expertise and offered an appointment in the MHP network to determine medical necessity within 10 business days of the request. If an appointment is not able to be provided within the timeframe then an NOABD for timely access must be issued.

When the beneficiary is assessed by a provider with the subject matter expert for the requested modality of treatment and then concludes an authorization is needed, the provider must immediately contact their respective AQIS Support Team and route all clinical documentations, records and history of treatment efforts to determine authorizing services within 10 business days. If AQIS requires additional time to authorize the requested modality the program will be notified to issue an NOABD – Delay in Processing Authorization of Services (see definition below). If AQIS denies the authorization for the modality of treatment the program will be given direction to issue an NOABD Denial or NOABD Modification. The NOABD Modification is for existing beneficiaries in treatment. It will reiterate the authorization denial of the requested service and provide an alternative treatment (i.e. PACT) and the frequency/duration (i.e. 2 x month for Medication Support Services, 1 x week for Individual Therapy). If AQIS approves the authorization for the modality of treatment, the MHP must secure and locate a program within the MHP or a program out-of-network within 10 business days or else an NOABD Timely Access must be issued by the program.

Managed Care Support Team Cont.

REMINDERS CONT.

NOABD – DELAY IN PROCESSING AUTHORIZATION OF SERVICES

- This type of NOABD is used when there is a delay in processing a provider's request for authorization of services. When the provider extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, and when the extension is in the beneficiary's interest.

CLINICAL SUPERVISION

- **UPDATE:** A Written Oversight Agreement is to be submitted to MCST on the letterhead of the employer when a licensed waivered individual is receiving clinical supervision from a licensed clinical supervisor that is **NOT** employed by the same company/organization/agency *(aka Legal Entity)* as the supervisee.
- **OC HCA EMPLOYEES**: If you are receiving clinical supervision through a clinical supervisor that is employed by OC HCA you are required to do the following when submitting your completed clinical hours to the Board of Behavioral Sciences:

1. Complete the In-State Experience Verification Form with the applicant's Employer name as ***Orange County Health Care Agency*** and the address as ***405 W. 5th St., Suite #410 Santa Ana, CA 92701.***
2. Have the clinical supervisor complete his/her section of the Supervisory Plan (if applicable) with the Employer Name as ***Orange County Health Care Agency*** and the address as ***405 W. 5th St., Suite #410 Santa Ana, CA 92701.***

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- If you and your staff would like a specific or a full training about MCST's oversight and updates on the State and Federal regulations governing Managed Care please e-mail the Program Manager, Annette Tran at anntran@ochca.com.

New Required MHP 1st Treatment Appointment Type

There is a new State **requirement** that we must begin reporting the date of the client's first **treatment service along with the 1st, 2nd and 3rd offered dates for that appointment**.

The purpose of capturing these fields is to measure our timeliness standards from the beneficiary/client's initial request for services, to first assessment offer date and first treatment offer date.

The State looks at treatment in a fairly linear fashion and is working from the model that the beneficiary/client will be fully assessed and then treatment will start. However, we may often provide needed treatment during the course of the assessment.

New Required MHP 1st Treatment Appointment Type Cont.

- If providing a treatment service during the 60-day assessment phase prior to completing the Care Plan, treatment services such as Case Management need to be authorized on the Interim Care Plan and should only be provided and authorized if there is an urgent need.
- Treatment is considered any face-to-face service besides Assessment, Crisis or Non-Billable Case Management. The only way that we can measure the start date of treatment as well as the offer dates for the treatment is to utilize a special appointment type.
- You will only use this appointment type once per MHP EOC. It does not matter if the assessment is not complete or you will continue to do assessment services after that treatment service was conducted, it will still be considered the start of treatment. Even if the client is in your office doing an assessment appointment and you find out they need housing so you do some case management, that would count as the first treatment service, and you would need to use the appointment type below.
- These dates will be reported monthly along with dates for the initial request for services, assessment appointment offer and accepted dates, and date of the client's first assessment service.

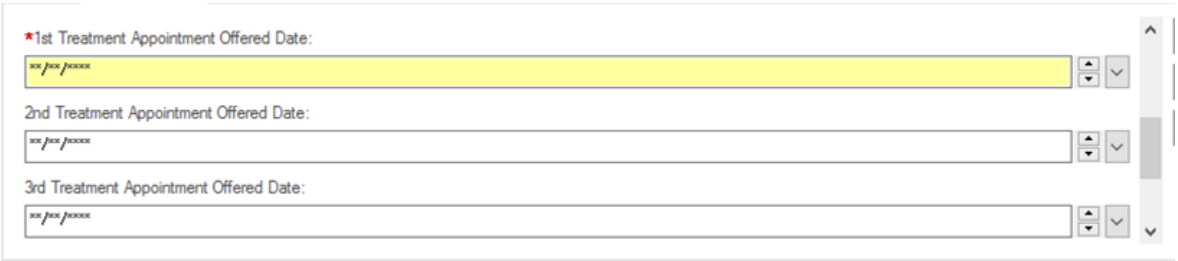
Step-by-Step: Capturing the MHP 1st Treatment Appointment

- Please start using the 1st Treatment Appointment type when scheduling a beneficiary/client for their first treatment service and accurately capture the offer dates.
- If the beneficiary/client accepts the first offer date, you do not need to complete the 2nd and 3rd offer date fields. If the beneficiary/client refuses all three offer dates, still capture them within the appointment type and schedule the appointment for the date the beneficiary/client accepts.
- If the client no shows you do not have to use this appointment type for the next session, it only needs to be used once, regardless of whether the appointment is kept.

Please remember that a treatment appointment is any face-to-face service other than Crisis, Assessment, or non-billable Case Management. This does not apply to medication services.

The new appointment type names per division are as follows:

- **AMHS CC 1st Treatment Appointment – Clinic**
- **AMHS CC 1st Treatment Appointment- Field**
- **CYS 1st Treatment Appointment – Clinic**
- **CYS 1st Treatment Appointment – Field**
- **PEI Clinic 1st Treatment Appointment**
- **PEI Field 1st Treatment Appointment**



ANNOUNCEMENTS

AQIS would like to welcome Andrew Parker, LMFT, to the AQIS Certification and Designation Support Services Team! Andrew is a transfer from the Data Analytics Team.

Please join us in welcoming him to the team!

REMINDERS

Service Chiefs and Supervisors:

Please remember to submit monthly program and provider updates/changes for the Provider Directory and send to: AQISManagedCare@ochca.com

Review QRTips in staff meetings and include in meeting minutes.

Thank you!

***Disclaimer**: The AQIS Quality Assurance (QA) and Quality Improvement (QI) Division develops and distributes the monthly QRTips newsletter to County and County Contracted Behavioral Health providers as a tool to assist with compliance with various QA/QI regulatory requirements. IT IS NOT an all-encompassing document. Programs and providers are responsible for ensuring their understanding and compliance with all local, state, and federal regulatory requirements.*

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