


CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Documentation Redesign for Community Based Organization Substance Use Disorders (SUD) Providers

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CalAIM - California Advancing and Innovating Medi-Cal
Access to the Right Care, at the Right Place, at the Right Time



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Agenda

- I. Welcome & Introductions
- II. Guiding Principles and Goals of CalAIM
- III. Difference between Fraud, Waste and Abuse and Quality
- IV. Assessment, Problem List & Progress Note
- V. Complete Evaluation
- VI. Q & A
- VII. Adjourn

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Learning Objectives

- I. Define Fraud, Waste and Abuse and differentiate from Quality
- II. Understand the use of new documentation/forms
- III. Identify how policies and procedures impact providers, reviewers and administration
- IV. Recognize the significance of documentation and policy changes as they relate to the intention and spirit of CalAIM

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Guiding Principles of CalAIM

- CalAIM is moving Medi-Cal towards a population health approach that **prioritizes prevention and whole person care.**
- The goal is to **extend supports and services beyond hospitals and health care settings** directly into California communities.
- The vision is to **meet people where they are** in life, **address social drivers** of health, and **break down the walls** of health care.
- CalAIM will offer Medi-Cal enrollees **coordinated and equitable access to services** that address their **physical, behavioral, development, dental and long-term care needs**, throughout their lives, from birth to a dignified end of life.

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Primary Goals of CalAIM

MANAGE RISK



REDUCE COMPLEXITY

IMPROVE OUTCOMES



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Leaner Documentation

- More time with the client
- Emphasis on client care and outcomes of treatment
- Treating the whole person rather than a fixed treatment plan, the problem list is dynamic
- Decrease of recoupments: disallowances for fraud, waste and abuse
- Importance of quality in terms of documentation

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Fraud, Waste and Abuse Definitions

- **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. §1347).
- **Waste** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **Abuse** includes actions that may, directly or indirectly, result in:
 - Unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.
 - Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

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What Constitutes Fraud, Waste and Abuse?

- Medicaid fraud and abuse negatively impacts health care use by wasting limited resources and potentially endangering patients through unnecessary care or preventing access to medically necessary services.
- Most providers try to work ethically, provide high-quality patient medical care, and submit proper claims.
- Most mistakes made in clinical documentation are **not** fraud, waste or abuse.
- More details to come in the DHCS 2022-2023 Annual Review Protocol (coming later in 2022).

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What is NOT Fraud, Waste and Abuse?

- Selecting the incorrect service code/CPT
- Entering incorrect service/documentation/travel time
- Billing when the client was a “no show” or the session was cancelled
- The content of the progress note does not justify the amount of time billed
- The note that was billed is not present in the chart
- The date of service of the progress note does not match the date of the service claimed
- Documenting non reimbursable services or including mention of “non-billable” interventions during an otherwise billable note
- Service provided was not within scope of the person delivering the service
- Documentation was completed but not signed
- Group services not properly apportioned to all clients present

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What Conduct Can Raise An Inference of Fraud, Waste or Abuse?


- Repeated pattern of unnecessary services
 - Example: “assembly line” non-individualized treatment patterns, or “cookie-cutter” progress notes
- Pattern of knowingly false statements on billings, or corresponding progress notes
 - Example: deliberately listing wrong location of service or provider to conceal license/eligibility issues
 - Intentional concealment of known errors or overpayments
 - Example: use of inaccurate statements, or deliberate failure to disclose adverse facts, in response to audit questions

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Assessment

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Assessment

- Remains American Society of Addiction Medicine (ASAM) Criteria based
- Timelines
 - Residential SUD Providers
 - Up to 10 Days
 - Outpatient SUD Providers
 - Up to 30 Days for Beneficiaries 21 and over
 - Up to 60 Days for Beneficiaries under 21
 - Up to 60 Days for Beneficiaries over 21 who are experiencing homelessness, which MUST be documented in order to allow for 60 Days

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 <p>CONTRA COSTA ALCOHOL & OTHER DRUGS SERVICES A Program of Behavioral Health Services</p>		<h2 style="text-align: center;">Level of Care Placement Assessment</h2>		<div style="border: 1px solid black; padding: 5px;">NAME / MRN</div>	
Program Name: <input style="width: 100%; height: 20px;" type="text"/>		Type of Assessment:			
Facility ID: <input style="width: 100%; height: 20px;" type="text"/>		Program ID: <input style="width: 100%; height: 20px;" type="text"/>		<input type="checkbox"/> Initial Admission <input type="checkbox"/> Date: <input style="width: 100px;" type="text"/>	
				<input type="checkbox"/> Continued Stay/Extension <input type="checkbox"/> Date: <input style="width: 100px;" type="text"/>	
				<input type="checkbox"/> Transfer of Level of Care/Service <input type="checkbox"/> Date: <input style="width: 100px;" type="text"/>	
				Service Code: <input type="checkbox"/> 115 Level of Care Placement Assessment	
Client Information					
Beneficiary Name:		Age:		DOB:	
<input style="width: 100%; height: 20px;" type="text"/>		<input style="width: 100px;" type="text"/>		<input style="width: 100px;" type="text"/>	
Address: <input style="width: 100%; height: 20px;" type="text"/>					
Phone Number:		Is it okay to leave voicemail?		SSN:	
<input style="width: 100%; height: 20px;" type="text"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input style="width: 100px;" type="text"/>	

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<h2 style="margin: 0;">Z Codes</h2> <ul style="list-style-type: none"> For use in Outpatient Programs ONLY per BHIN 22-013 Z Codes are ICD-10 Codes Based on Social Determinants of Health (SDOH) Z55-Z65 may be used by any provider 	

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Z Codes



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Z Code Examples

Z55.0	Illiteracy and low-level literacy
Z59.02	Unsheltered homelessness
Z59.41	Food insecurity
Z59.7	Insufficient social insurance and welfare support
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.72	Alcoholism and drug addiction in family
Z65.2	Problems related to release from prison
Z65.8	Other unspecified problems related to psychosocial circumstances (religious or spiritual problem)

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Problem List

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Why the Change to a Problem List?

- Treatment Plans were often viewed to be overly rigid
- Services were restricted to what was indicated on the Treatment Plan
- The problem does not have to live on the Problem List before it is treated
- Movement from “treating the plan” to “treating the person”

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What is a Problem List and What are the Requirements?

- A list of symptoms, conditions, diagnoses and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters
- A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list
- The problem list **shall** be updated on an ongoing basis to reflect the current presentation of the beneficiary

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What is a Problem List and What are the Requirements? (cont.)


- Problems can be identified by the provider, the beneficiary and/or a beneficiary's significant support person
- Indicates who identified the problem (Name and Title) and date identified
- Indicates who removed/resolved the problem (Name and Title) and date the problem was resolved/removed

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Progress Note

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Progress Note

per BH IN 22-019

- The type of service rendered
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
- The date that the service was provided to the beneficiary
- Duration of the service, including travel and documentation time
- Location of the beneficiary at the time of receiving the service
- A typed or legibly printed name, signature of the service provider and date of signature
- ICD-10 Code (**attached to the claim**)
- CPT or HCPCS Code (**attached to the claim**)
- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

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Progress Note-Timeframes

per BH IN 22-019

- Providers **shall** complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which **shall** be completed within 24 hours
- Providers **shall** complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation).

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Progress Note-Group Services

- When rendered, a list of participants is **required** to be documented by the plan or the provider
- Should more than one (1) provider render a group service, one (1) progress note may be completed for a session and signed by one (1) provider
 - While one (1) progress note with one (1) provider signature is acceptable for a group activity where multiple providers are involved, the progress note **shall** clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time
- All other progress note requirements listed **shall** be met

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PROGRESS NOTE (IF MORE THAN ONE RENDERING PROVIDER WAS SELECTED, INDICATE THE AMOUNT OF TIME EACH PROVIDER RENDERED EACH SERVICE)		
DRAFT		
Service Provider Printed Name:	Service Provider Signature (with credentials):	Date Service Provider Printed & Signed:

AODC-013 SUD Progress Note and Service Entry Form-DRAFT 06-2022

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DATA: The scheduled intake was completed at the treatment program. This client presented for intake as a single, 30 yr old Caucasian male, no children, employed part time who lives with family. He self-referred because his drinking has been interfering with his employment, relationships and has caused legal issues. He reports a 14 yr history of Alcohol and Cannabis use. The client is currently receiving monthly Naltrexone injections to help manage his cravings. The client signed the required intake paperwork, completed the health questionnaire, and was provided a Beneficiary Handbook, a list of referrals, the Grievance/Appeals documents and was offered a copy of the Contra Costa County Plan Practice Guidelines.

An orientation to the program was provided that included all treatment expectations, an individualized program schedule and CFR 42 requirements. An initial Problem List was developed with client input.

Based on the LOCPA results this client is appropriate for treatment and is in the correct level of care. (1.0) He presents in the preparation stage of change.

ASSESSMENT: The LOCPA identified multiple treatment issues including lack of understanding of the addiction cycle, relapse triggers, coping skills, relationship issues, health concerns and criminal justice involvement related to his DUI. These issues are included on the initial Problem List. To address these concerns the client will attend

- Matrix Relapse Prevention group Mondays and Wednesdays from 6pm-7:30pm (3 hrs)
- Hazelden Living in Balance group Tuesdays and Thursdays from 6pm-7:30 pm (3 hrs)
- Individual Counseling Session on Wednesdays to address his progress and discuss and other treatment issues that may arise. 6pm-7pm (1 hr)
- Care Coordination sessions up to 1 hr weekly as needed. (1 hr)

PLAN: The client will attend 7-8 clinical hours weekly. Hours and groups will be adjusted to meet the client needs. This counselor will add and resolve issues on the Problem List, provide ancillary referrals and collaborate with the LPHA, family, and program staff as needed. The client will attend his first group on Wednesday 6/8/22 at 6pm.

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DATA: The beneficiary attended Matrix Group Session 5, 9-10:30am; Topic Internal/External triggers; (Dimension 5) Hazelden Living in Balance Group Module 30, The Family in Recovery (Dimensions 5 and 6) 11:30am-1pm; Individual Care Coordination session 1:15-1:45pm. (see separate care coordination note) All sessions were held at the program. He attended 3.5 hours of treatment.

ASSESSMENT: The beneficiary did well in treatment today. He had a positive attitude and was friendly with his peers in the milieu. He is addressing his Problem List by attending and participating in groups and meeting with the care coordinator. He is open to feedback and suggestions from his peers. He completed his homework assignment on habits. He shared in Matrix group that drinking after work on Fridays is a habit. He is working on an alternative behavior and activity. The beneficiary actively participated in both groups by volunteering to read from text, sharing his homework in both groups and participating in a role play exercise during the Living in Balance Group. He was able to identify an emotional warning sign (anger) and an external trigger (watching sports on TV). The beneficiary is working on learning communication skills he can use with his family. He shared that being accountable for his actions is a difficult lesson. He remains in the Preparation Stage of Change.

PLAN: The beneficiary will continue to attend 12 clinical hours weekly. He will meet with his counselor weekly to discuss barriers and areas of concern. The beneficiary will meet with the care coordinator as needed for services and update his counselor and care coordinator on his progress. This counselor will continue to add and resolve issues on the Problem List as they arise and collaborate with the treatment team. The beneficiary is to continue working on building an outside support system as his primary focus for the week. No changes to the Problem List today.

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Beneficiary (B) is in his third week of 3.1 residential treatment. Today, he attended relapse prevention and seeking safety group. He volunteered in the kitchen and attended a medical appointment. He took meds as prescribed. ROI signed for AA sponsor. He did not share any concerns with staff. These services addressed his Alcohol Use Disorder symptoms, as well as increased interpersonal relationship skills and treated medical conditions.

B was an enthusiastic participant today. He had a positive attitude and contributed appropriately in groups. He is learning specific relapse prevention skills and identifying self-care techniques. A referral was provided for Vocational Services to assist with employment.

B will participate in daily activities per the weekly schedule. He will meet with Primary Counselor at least weekly. He will complete chores and attend appointments as scheduled. Primary Counselor will collaborate with client daily.

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The Beneficiary attended his weekly individual session at the program. Problem List concerns were discussed. Specifically, continuing Naltrexone and drinking while on Naltrexone. (Dimension 2) Developing a Relapse Prevention Plan and Identifying coping skills. (Dimension 5) Stress caused by his DUI, establishing a support system and his relationship with his family. (Dimension 6) This counselor reviewed effects of drinking while taking Naltrexone.

The beneficiary is new to treatment and is adjusting to his schedule and the program. He reports that he will be continuing Naltrexone and is working with his MD however he still drinks a beer or two with his family when they are watching sports on TV. He has insight regarding drinking while taking Naltrexone but is having difficulty with complete abstinence. The beneficiary is experiencing stress caused by his DUI. The stressors are finances, feeling overwhelmed about making his classes, attending treatment, working part time, finding full time work, and transportation because his license has been suspended for 30 days. He understands the importance of additional support for his recovery and is open to exploring different options, The beneficiary is willing to make the necessary changes however he is not sure how. Stage of change is Preparation.

This counselor provided a list of community support groups. He agreed to attend an AA meeting and share next session. He will ask his family to drive him to work, class and treatment until his license has been reinstated. His long-term goals are to secure full-time work so he can pay off his court fees and move in with a friend. He decided to drink soda from a can and put it in a coolie while he is with his family. Next session: This counselor will role play a conversation with a family member explaining that pressuring him to drink when he is trying to stop makes him uncomfortable and he wants their support. The beneficiary agreed to add financial stress and feeling overwhelmed to the Problem List.

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Utilization Review & Quality

- Problematic or absent UR paperwork (Level of Care Placement Assessments, Problems Lists for example) will not result in denial of authorization
- Issues related to quality will be addressed through appropriate and ongoing communication
- Repeated quality problems for SUD services will be brought to the attention of the program managers/supervisors/coordinators
- More thorough reviews may call for a formal Quality Improvement Plan for individuals or programs.

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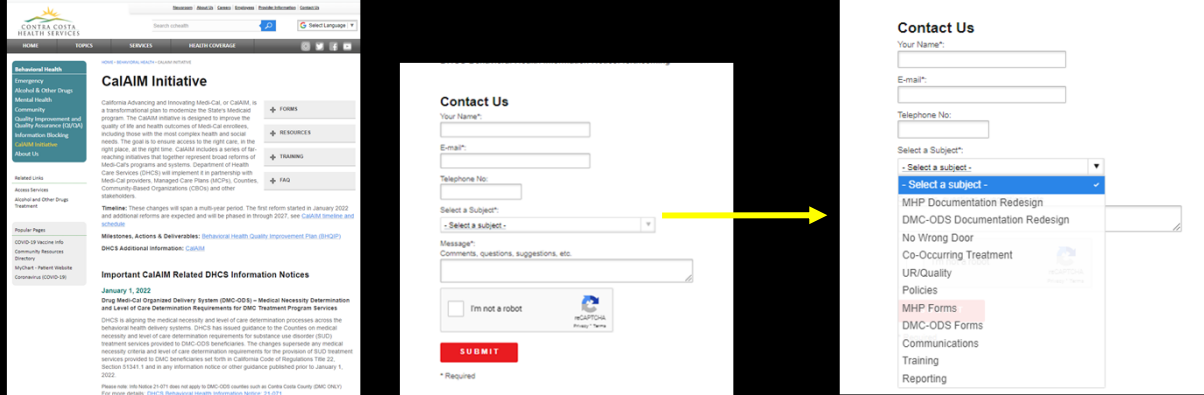
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Resources

CCBHS CalAIM Website: <https://cchealth.org/bhs/calaim>

Email: CCBHSCalAIM@cchealth.org



CalAIM Initiative

California Advancing and Innovating Medi-Cal, or CalAIM, is a transformational plan to modernize the State's Medicaid program. The CalAIM initiative is designed to improve the quality of life and health outcomes of Medi-Cal enrollees, including those with the most complex health and social needs. The goal is to ensure access to the right care, in the right place, at the right time. CalAIM includes a series of interlocking initiatives that together represent local returns of Medi-Cal programs and systems. Department of Health Care Services (DHCS) will implement it in partnership with Medi-Cal providers, Managed Care Plans (MCPs), Counties, Community-Based Organizations (CBOs) and other stakeholders.

Timeline: These changes will span a multi-year period. The first return started in January 2022 and additional returns are expected and will be phased in through 2023. See [CalAIM timeline and schedule](#).

Milestones, Actions & Deliverables: [Behavioral Health Quality Improvement Plan \(BHQIP\)](#)

DHCS Additional Information: [CalAIM](#)

Important CalAIM Related DHCS Information Notices

January 1, 2022

Drug Medi-Cal Organized Delivery System (DMC-ODS) - Medical Necessity Determination and Level of Care Determination Requirements for DMC Treatment Program Services

DHCS is aligning the medical necessity and level of care determination processes across the behavioral health delivery systems. DHCS has issued guidance to the Counties on medical necessity and level of care determination requirements for substance use disorder (SUD) treatment services provided to DMC-ODS beneficiaries. The changes align with medical necessity criteria and level of care determination requirements for the provision of SUD treatment services provided to DMC beneficiaries set forth in California Code of Regulations Title 22, Section 51341.1 and in any information notice or other guidance published prior to January 1, 2022.


Please Note: Info Notice 21-071 does not apply to DMC-ODS counties such as Contra Costa County (DMC-ODS). For more information, see [DHCS Behavioral Health Services and Support for Counties](#).

Contact Us

Your Name*
 E-mail*
 Telephone No:
 Select a Subject*
 - Select a subject -
 MHP Documentation Redesign
 DMC-ODS Documentation Redesign
 No Wrong Door
 Co-Occurring Treatment
 UR/Quality
 Policies
 MHP Forms
 DMC-ODS Forms
 Communications
 Training
 Reporting

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Resources (contd.)


CalMHSA Resources:

<https://www.calmhsa.org/calaim-support-for-counties/>

CalMHSA Documentation Guides: (available May 2022-new) role specific guides for both MH and SUD that encompass all clinical documentation standards. Will be updated in Jan 2023 to include CPT codes as part of payment reform.

Department of Health Care Services CalAIM:

<https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx>



Outpatient Drug Medi-Cal and Drug Medi-Cal Organized Delivery System Services
 Clinical Staff

CLINICAL DOCUMENTATION MANUAL
 2022

California Mental Health Services Authority (CalMHSA)

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Evaluation

<https://forms.office.com/g/9tDE14JMih>



Up Next
Q & A Session

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