Department of Public Health
Office of Compliance & Privacy Affairs (OCPA)

Behavioral Health Compliance Office

# Compliance Corner

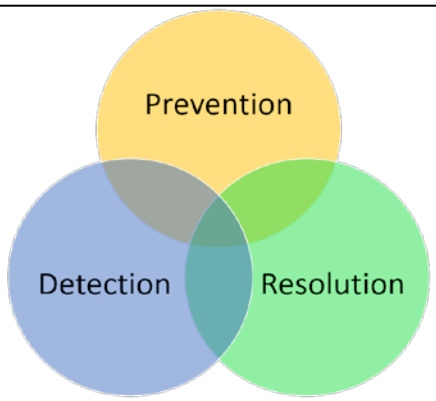
October 2018

## COMPLIANCE

### Defining Healthcare Compliance

Healthcare compliance can be defined as the ongoing process of meeting or exceeding the legal, ethical, and professional standards applicable to a particular healthcare organization or provider. The Department of Health and Human Services (HHS) Office of Inspector General (OIG) has helped to define healthcare compliance through their **compliance guidance documents**. This guidance calls for compliance efforts to **establish a compliance culture within organizations**. A culture of compliance promotes **prevention, detection and resolution** of instances of conduct that do not conform to government laws, public and private payor health care program requirements, and ethical and business policies. The scope of compliance extends to many areas including patient care, billing, reimbursement, managed care contracting, research standards, OSHA, The Joint Commission standards, and HIPAA privacy and security, to name a few. Healthcare compliance means meeting all of the rules and requirements applicable to an organization across a broad range of criteria, and that may vary considerably depending on the type of organization and the services it provides. The biggest challenge for healthcare organizations and their compliance officers is to **keep track of all the requirements and regulations**, which are extremely numerous.

**A culture that promotes:**




Effective compliance programs are defined as those that avoid or minimize liabilities, including legal or regulatory penalties and potential civil litigation. The challenge for developing an effective program is complicated by the ever-changing legal and regulatory environment. New laws and regulations come into play on a daily basis from all levels of government. To avoid having an ineffective compliance program, healthcare organizations and providers should develop effective processes, policies, and procedures to define appropriate conduct, train the organization's staff, and then monitor the adherence to the processes, policies, and procedures. For most organizations, the biggest challenge is to evidence compliance program effectiveness, especially using verifiable metrics, and identify any gaps in the program.

It is nearly impossible to define the extent or complexity of the ever changing healthcare compliance world. New laws and regulations come into play on a daily basis from all levels of government. Some of these have far ranging implications such as **the Anti-Kickback Statute, Stark Laws, False Claims Act, and HIPAA and HITECH laws** that are designed to protect the privacy of patient information. As noted above, compliance programs should promote not only compliance with these rules, requirements and standards of ethical conduct, **but also a culture that promotes prevention, detection, and resolution of conduct that does not conform to these requirements**.

*Source: US Dept. of Health & Human Services Office of Inspector General; and article by Richard Kusserow, Strategic Management Services, April 2018*

# COMPLIANCE

## Feedback for the 2017 Mental Health Documentation Manual?

An email was sent out recently from Chona Peralta asking for your input for updating the current Mental Health Documentation Manual (2017 Edition) that was published in October 2017.

Here are the list of items that are slated for the update:

- Errors and omissions: the first two pages of Appendix A (ICD 10 Qualifying Diagnoses) are missing and will be added
- New guidance for Adult Residential services: timeliness and frequency guidelines for Adult Residential services will be updated
- Updated Guidance for Medication-Only services: details for prescribers and Medication-Only services will be added.

### Errors, Questions & Updates: BHS' Outpatient Documentation Manual (2017 Ed.)

Thank you for reading the documentation manual and identifying any errors or questions and updates.

In the fields below, tell us what you are reporting (an error, a question, providing new content) and give us specific details about your report (page number of the manual, the correction, the new text, etc.).

BHS will review feedback at regular intervals. Providers will receive notifications regarding updates and corrections--these will be tracked and posted online as well. The exact timeline may vary depending on the specific item.

* Required

1. **Email address** *

2. **#1: What are you reporting?** *
   *Check all that apply.*
   - ☐ Error in the documentation manual
   - ☐ Question/clarification about content of the documentation manual
   - ☐ I am providing new content based on a new policy, new procedure, new regulation, etc.

3. **#2: Describe the error, question and/or request (be specific and identify the page number, the text, etc.)** *

4. **#3: Provide the correct information (if reporting an error) and/or provide the new content/text (to address the new policy, procedure, regulation)**

Since the 2017 Mental Health Documentation manual is a living document, we are always open to any feedback, new guidance, errors and omissions that you find, even after the initial 25th of September deadline.

**Click here** for Google form or visit **https://goo.gl/forms/gLPzOEuNpN29lFwL2**

# SUBSTANCE USE

## American Society of Addiction Medicine Level of Care (ASAM LOC) FAQ

*Written by: Joseph Gorndt, DPH OCPA Assistant Auditor. September 2018.*

1. **What is the purpose of the ASAM LOC?**
   The Organized Delivery System's focus is on providing a continuum of care through which a client can move as his or her needs evolve. Together with a careful assessment of the client, the ASAM LOC provides a framework to guide placement of the client into the level of care most appropriate for his or her needs at the time.
2. **Who can complete the ASAM LOC form?**
   A counselor or LPHA may complete the ASAM LOC. If a counselor completes the ASAM LOC, he or she may make a recommendation for the "Actual Level of Care", but the final determination of the appropriate level of care for a client is a clinical decision which must be made by an LPHA working within his or her scope of practice.
3. **Who must have an ASAM LOC completed?**
   An ASAM LOC must be completed for all clients seeking treatment at the provider.
4. **When does the ASAM LOC need to be completed?**
   For outpatient services, the ASAM LOC must be completed during intake and updated for continuing service justifications. In residential services, the ASAM LOC must be completed in order to receive authorization for the stay, and must be updated in order to receive reauthorization.
5. **How do I arrive at a severity rating for each dimension?**
   You must use the information collected in each dimension in order to determine the severity rating for that dimension. The answers you have given to the ASAM LOC questions must support the severity rating you have chosen. **Each dimension** has its own, more detailed criteria for each severity rating, but generally:
   - **Zero** indicates that that dimension is a non-issue, or very low-risk.
   - **One** means that that dimension is an area in which the client has mild difficulty, signs, or symptoms, or has a chronic issue that you believe will resolve soon.
   - **Two** indicates that the client is having moderate difficulty in functioning due to challenges in that dimension.
   - **Three** indicates that the client has a serious issue in this dimension, and is either high risk or in near-imminent danger.
   - **Four** is used when a client is in imminent danger in this dimension.
6. **How do I arrive at an "Indicated Level of Care"?**
   The indicated level of care is determined through the multidimensional assessment of needs and their severity, and of the client's level of functioning. Therefore, the process is that the assessment is used to determine the dimension severity rating, and the dimension severity ratings are used to generate an indicated level of care.
7. **What do I do if the "Indicated Level of Care" is not available at my site?**
   This indicates that the client most likely needs to be referred out to another site. Note that "Indicated Level of Care" is **not intended** to override clinical judgment or client choice. If the client is in pre-contemplation on readiness to change (Dimension Four), they may not be ready for residential treatment even if their "Indicated Level of Care" is for high intensity residential. In this case, the client may be appropriate for outpatient services because that is the level that they are ready to accept and the focus of treatment would be to move them from pre-contemplation to action.
8. **What happens if my "Indicated Level of Care" and "Actual Level of Care" are not the same?**
   If the actual level of care to which the client is being assigned is different than the one indicated by your ASAM, then the reason for that difference must be sufficiently justified on the ASAM LOC.
9. **What sorts of things should clinical supervisors be looking out for in the ASAM LOC?**
   Clinical supervisors must be monitoring their program's ASAM LOCs to ensure that the severity rating is well supported by the facts listed on the ASAM form. Also, the state has said that they think it is a red flag if every person who comes to a site is found to be appropriate for that site. Finally, clinical supervisors should also strive for consistency across raters in the ASAM LOC.

Questions about this FAQ may be sent to joseph.gorndt@sfdph.org. Updated 9/6/2018

# The Medical Necessity FAQ Under the (DMC-ODS) Drug Medi-Cal Organized Delivery System Waiver

*Written by: Joseph Gorndt, DPH OCPA Assistant Auditor. August 2018.*

1. **When is a face-to-face meeting required?**

   A face-to-face meeting is required if a counselor conducts the assessment of a newly-admitted client. If an LPHA working within his or her scope of practice assesses the client, then no face-to-face meeting is required; the LPHA simply documents the client's medical necessity determination on his or her own.

2. **When does the face-to-face meeting occur?**

   The face-to-face meeting relies upon the assessment of the client, so that must be completed first. One of the purposes of the meeting is to establish a diagnosis for the client, and the diagnosis must be documented within 30 days of admission, so the meeting must take place and be documented by the 30 day mark.

3. **Who has to be at the face-to-face meeting?**

   The counselor who assessed the client and an LPHA working within his or her scope of practice must be at the face-to-face meeting. The client is permitted to be at the meeting, but is not necessary.

4. **What occurs at the face-to-face meeting?**

   At the face-to-face meeting, the counselor and LPHA will review the client's assessment, and the LPHA will use his or her professional judgment in order to determine the medical necessity criteria for the client.

5. **What are the medical necessity criteria?**

   The medical necessity criteria are the existence of an appropriate DSM-5 substance use diagnosis and that the client meets the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

6. **What does the name "face-to-face" mean?**

   The name "face-to-face" is misleading. While it is possible that this meeting will be with both the counselor and LPHA in the same room, it is also allowable to have the meeting via **telehealth**.

7. **Is it possible to bill for the face-to-face medical necessity meeting between a counselor and an LPHA?**

   Yes! If the meeting is properly documented, this meeting may be billed to DMC-ODS by one of the participants as case management.

8. **How should the face-to-face meeting be documented?**

   The face-to-face meeting should be documented in the same way as any other case management service. There must be a progress note that documents the name of the client, the purpose of the service, a description of how the service relates to the client's treatment plan problems, goals, action steps, objectives, and/or referrals. This documentation must be completed within seven calendar days of the service.

Questions about this FAQ may be sent to joseph.gorndt@sfdph.org

# MENTAL HEALTH

## What are the Four Pathways and Four Elements of Medical Necessity?

*Created by Joseph A Turner, PhD, PSY22453 Clinical Documentation Specialist, BHS-QM. Dec 2017.*
*Information taken from SFMHP-BHS Clinical Documentation & Monitoring (Dec 2017).*

**Four elements** for SMHS medical necessity:

1. **Included diagnosis**
2. **Impairments resulting from diagnosis**
3. **Interventions to address impairment**
4. **Not a health-based disorder**

**Four "specials"** of SMHS medical necessity:

- Special diagnosis **(on the DHCS list of included diagnosis)**
- Special impairments **("today" vs. "tomorrow")**
- Special interventions ("today" vs. "tomorrow")
- Special setting **("not general health clinic")**

| **Four Clinical Pathways of Medical Necessity for Medi-Cal SMHS** | **Element #1: Covered Mental Health Diagnosis** | **Element #2: Functional Impairments Show…** | **Element #3: …Treatment Interventions Will** | **Element #4: Not Responsive to Physical Health Care Treatment** |
|---|---|---|---|---|
| **Client has current significant impairments** in life functioning… | Every Pathway must **have a Covered/ Included Diagnosis (on the DHCS list of included diagnosis)** | **A significant impairment** in an important area of life functioning…**(today)** | …**significantly diminish the impairment** in an important area of life functioning **(today)** | Every Clinical Story/ Pathway requires **the condition is not responsive to physical health-based treatment ("not general health clinic")** |
| **Client has probability of significant deterioration** in life functioning… | | **A probability of significant deterioration** in an important area of life functioning **(tomorrow)** | …**prevent significant deterioration** in an important area of life **(tomorrow)** | |
| **Probability child won't progress developmentally** as appropriate… | | **A probability of child will not progress developmentally** as individually appropriate | …**allow the child to progress developmentally** as individually appropriate | |
| **Child client has a condition that can be corrected or ameliorated** (and is full-scope Medi-Cal, <21 yrs.)… | | For full-scope Medi-Cal beneficiaries under 21, **a condition as result of mental disorder that SMHS can correct or ameliorate** | …**correct or ameliorate the condition** for full-scope Medi-Cal beneficiaries under the age of 21 years | |

*Medical Necessity is defined in Title 9 and BHS Documentation Manual reiterates this information. Some providers may find this tool helpful. You can access the 2017 BHS Documentation Manual **here**. Or go to:* https://www.sfdph.org/dph/files/CBHSdocs/610357-3788-2017-Documentation-Manual-Outpatient-SFDPH-BHS-vPublishedPdf-11-01-2017X.pdf

# MENTAL HEALTH

## TPOC (Treatment Plan of Care) Case Example

*Created by Joseph A Turner, PhD, PSY22453 Clinical Documentation Specialist, BHS-QM. Dec 2017.*
*Information taken from SFMHP-BHS Clinical Documentation & Monitoring (Dec 2017).*

**TPOC Case Example:**

1. **Medical necessity (What is the diagnosis?)**
   a. Schizophrenia
   b. Home/ living impairment
   c. Meds & skills building services will help
2. **Theoretical formulation: (What is the functional impairment?)**
   a. Client hears auditory hallucinations, interacts with them & then becomes confused & agitated;
   b. This leads to yelling & spitting
   c. Roommate & receiving care—risk of increased LOC- level of care.
3. **Course of treatment: (What is the Intervention?)**
   Plan to reduce interactions with auditory hallucinations (meds & CBT) to decrease & manage confusion/ agitation (calming skills)
4. **Not a health based disorder.**

### Example of TPOC (Treatment Plan of Care)

**Problem & Goal:** Schizophrenia; Restore functioning in living/home

**Objective:** Reduce the instance of interacting with auditory hallucinations. Initial step is helping client distinguish hallucinations from real voices (from a baseline of 0 times/day to 3 times/day per client's report)

**Interventions:**

a. **Medication Support Services** (MSS) (1 per week/ 15 mins for 12 months) to reduce hallucinations
b. **Cognitive Behavioral Therapy** (CBT) (1 per week/ 15 mins for 12 months) to increase reality orientation
c. **Rehab** (1 per week/ 30 mins for 12 months) to build distress tolerance & calming skills
d. **Collateral with mother** (1 per month/ 30 mins for 12 months) to teach her to implement reality orientation or calming skills

| Two Settings | Type of Functional Impairment in Life Functioning Domains | | |
|---|---|---|---|
| | Home/ Living | School/ Work | Community |
| Traditional Outpatient | Client cannot maintain housing due to cognitive & behavioral impairments from Schizophrenia | Client cannot maintain employment because he is withdrawn & cannot maintain hygiene due to Schizophrenia | Client cannot engage in community activities (support group) because he is so confused & disorganized |
| Outpatient with Residential | Resident cannot maintain roommate due to paranoia & risk of assault related to Schizophrenia…risk of losing placement | Client cannot pursue interests & hobbies (e.g., listening to music) because he is distracted by hallucinations that stem from Schizophrenia…risk of social isolation & decreased quality of life | Client cannot engage in community activities (e.g., lunch; movie night) because of the risk of aggressiveness that stems from paranoia…risk of social isolation & cognitive decline |