Behavioral Health Compliance Office

Compliance Corner

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

May 2021

COMPLIANCE

PAVE ENROLLMENT

What is required?

Medi-Cal Enrollment: The Federal Cures Act (law which addresses the access, exchange and use of electronic health information) requires States to screen, enroll and periodically re-validate all network providers of managed care organizations, including County Mental Health Plans. To meet this requirement, DHCS is requiring all licensed practitioners and DMC clinics to enroll with Medi-Cal through PAVE.

What is PAVE?

The Provider Application and Validation for Enrollment (PAVE) system is an interactive, web-based application designed to simplify and accelerate enrollment processes, to enroll practitioners. Practitioners should utilize this online portal to complete and submit applications, report changes to existing enrollments, and respond to DHCS initiated requests for continued enrollment or revalidation.

Who does this apply to?

The following licensed practitioners in MH and DMC clinics/programs which are providing services to Medi-Cal beneficiaries: Physicians (MD and DO), Certified nurse practitioners, physician assistants (supervised), registered/licensed pharmacists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, occupational therapists, licensed /certified acupuncturists, and licensed psychologist.

June 4, 2021 Deadline

For enrollment:
https://pave.dhcs.ca.gov/sso/login.do

For NPI look up:
https://npiregistry.cms.hhs.gov/

We ask that licensed practitioners complete their PAVE enrollment as soon as possible. Once enrolled, please email proof of enrollment to Teresita.Francisco@sfdph.org. The Compliance office must track and monitor the enrollment of over 1200 licensed practitioners.

PAVE Helpdesk: 1 (866) 252-1949 (M-F; 8AM – 6PM)

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TIPS ON COMPLETING THE PAVE APPLICATION

1. Start by creating a PAVE account (User Profile) at https://pave.dhcs.ca.gov/sso/login.do. You will create a user name and password. Once you've set up a user profile, verification is required prior to logging into PAVE. If you provide your cell phone number, you will receive a text message with a 6-digit verification code valid for 15 minutes; otherwise, you will receive an email to complete the verification process.
2. Have your NPI number available. Make sure your NPI type is 1 – "individual." You can get your NPI at the following link: https://npiregistry.cms.hhs.gov/
3. Have a copy of your current active professional license (wall certificate or pocket copy – Breeze printout will not be accepted). You will be asked to upload a copy of your license.
4. Choose the **"ORP" (Ordering/Referring/Prescribing) application.**
5. If you are work in a **DMC-ODS program**, you would select "I'm a SUD MD or physician or surgeon or a DMC Clinician" under "individual who renders" (step 6 of the instructions).
6. When completing the "business information" section, use your program's/clinic's **legal name –** this is the name listed with the IRS and associated with the tax ID#. The legal name may be different from the "business name." All civil service programs/clinics should use "City and County of San Francisco" as the legal name. CBOs may need to check with their program administrators to obtain their programs' "legal names".
   For example: Citywide Community Focus is the "business name," but University of California, San Francisco is the "legal name".
7. If you work at more than one DPH clinic/location, list all practice locations/addresses.

MEDICAL RECORDS ARE MOVING!

Written By: Diane Lovko-Premeau, DPH HIMS Director

Behavior Health Services Medical Records transitioning to DPH Health Information Services.
In July, the Medical Record functions that Josette Berroteran has been supporting transitioned to be part of the DPH Health Information Services to increase support and have BHS aligned with the network of health information professionals to support the programs in both the paper, electronic (Avatar) and future state - EPIC environments.

Diane Lovko-Premeau, DPH HIMS Director will be visiting all the clinics and over the next month will transition chart delivery to Zuckerberg San Francisco General - to Josette's new office. Josette will continue to support the programs, while being introduced to some advanced document management functions.

If you have questions or ideas for improvement, please email diane.lovko-premeau@sfdph.org.

TUBERCULOSIS (TB) TESTING REQUIREMENT IN AOD FACILITIES DURING PHE

DHCS requires that AOD facilities personnel shall be screened for good health, including a test for tuberculosis, performed under licensed medical supervision not more than 60 days prior to or 7 days after employment with tuberculosis testing renewable every year. CCR, Title 9, Section 10567(b) states **"Every resident shall be tested for tuberculosis under licensed medical supervision within 6 months prior to or 30 days after admission and annually thereafter if continuous participation is maintained."**

During the pandemic, TB testing can be done before or at the same time as COVID-19 vaccination, or otherwise delayed for ≥4 weeks after the completion ofCOVID-19 vaccination. If TB testing is delayed as a result of complying with the CDC's guidelines for the COVID-19 vaccination, personnel and clients shall provide the AOD facility with their COVID-19 vaccination record for purposes of verifying their health status.

From DHCS IN No: 21-009: https://www.dhcs.ca.gov/formsandpubs/Documents/BHIN-21-009.pdf

DIAGNOSIS REQUIREMENT

Written by: Joseph Gorndt, JD Assistant Auditor

For adult clients under DMC-ODS, the diagnosis requirement is one half of the requirement for establishing medical necessity in order to bill for services. (Intergovernmental Agreement IV.A.58) After the first 30 days of an episode (IA III.PP.11.i.a), a client must have a DSM-5 diagnosis of a substance-related and addictive disorder other than a tobacco-related or non-substance-related disorder. In order to be payable, this diagnosis must be made by a practitioner working within their scope of practice, but can be made by a practitioner working in reliance on an assessment and intake information completed by a non-licensed staff member, so long as the practitioner and staff member have a face-to-face meeting (this staff member must be permitted to assess clients). (IA III.PP.11.i) The intergovernmental agreement between DHCS and the San Francisco Department of Public Health requires that this diagnosis be made by way of a "narrative summary based on DSM-5 criteria." (IA III.PP.11) DHCS has been very explicit that this narrative summary must be prepared by the licensed staff member and must not be written by a non-licensed staff member.

In practice, this means that a narrative summary should have both the diagnostic criteria that a client meets and how the criteria are met. So, rather than writing that a client "fails to fulfill major role obligations at work, school, or home," a narrative summary should say that, for example, the client "fails to fulfill major role obligations at home, as evidenced by his failure to pick up his son from school 'at least once a month' for the past six months due to being too drunk to drive." The LPHA may rely on an assessment completed by counselor, but the practitioner must be certain that this will meet the standards required by their licensing board and ethical obligations.

- ✓ Diagnosis must be made within 30 days of an episode
- ✓ Have a substance-related and addictive disorder DSM-5 diagnosis
- ✓ The diagnosis must be made by (or co-signed by) a practitioner working within their scope of practice
- ✓ The meeting must be face-to-face
- ✓ This diagnosis be made by way of a "narrative summary based on DSM-5 criteria." (IA III.PP.11)
- ✓ The narrative summary must not be written by a non-licensed staff member.
- ✓ In practice, this means that a narrative summary should have both the diagnostic criteria that a client meets and how the criteria are met.

SUD DOCUMENTATION FINDINGS

Since August 2020, the Compliance Department have audited 8 Substance Use. We wanted to share with you the findings here. Our hope is that this will serve as a guide to help you improve with the documentation for Assessment, Treatment Plan of Care and Progress Notes. We are overjoyed and proud to share that 6 out of the 8 Substance Use programs we audited have no fatal errors/ error rate.

A SHOUT OUT to the Substance Use Programs:

6 out of the 8 recent Substance Use audits have no disallowances/

0% error rate.

GREAT JOB!!!

SUBSTANCE USE DOCUMENTATION AUDIT FINDINGS

LIST OF COMMON ERRORS

- No continuing service justification (CSJ) / No LPHA signature on the CSJ
- No LPHA consult on the level of care (LOC)
- No diagnosis by a LPHA
- Missing or late ASAM
- Late continuing services justification
- Treatment plan signed late
- Missing LHPA signature on the treatment plan of care

MENTAL HEALTH DOCUMENTATION GUIDELINES

Written By: Maria Anne Viray, MSN, RN, PHN, Clinical Compliance Nurse Auditor

The Compliance Department has started auditing since August 2020. We have audited over 20 Mental Health programs in the past several months and wanted to share with you a few of the common errors. Our hope is that this will serve as a guide to help you improve with the documentation for Assessment, Treatment Plan of Care and Progress Notes.

Assessment	Possible Causes	Solution
No or late assessment	• Missed the initial/annual timelines from the episode opening	• Create self-reminders and follow the prompts in Avatar • Regular chart reviews • The initial assessment must be finalized 60 days from the episode opening • The annual assessment must be updated from the episode opening date
Assessment completed by unlicensed staff	• Lack of training/supervision	• Review the scope of practice & assignments • Regular chart reviews • If partially completed by unlicensed staff a LHPA must review and co-sign the assessment
Treatment Plan of Care	**Possible Causes**	**Solution**
Planned service (modality/proposed intervention) not in TPOC	• Modality excluded in the proposed interventions listed in the TPOC • Provided planned services prior to the finalization of	• All planned services (modality/proposed intervention) must be included in the TPOC • Regular chart reviews
No TPOC or late for a planned service	• Missed the initial/annual timelines (episode opening)	• The initial TPOC must be finalized 60 days from the episode opening or before a planned service claim • The annual TPOC must be updated annually

MH DOCUMENTATION GUIDELINES cont.

Treatment Plan of Care cont.	Possible Causes	Solution
Lack of evidence in client/ designee/guardian participation/consent with the treatment plan	• Missed documentation of the actual client/guardian agreement (as evidenced by a signature or a note in the body of the TPOC or a progress note) • Social Distancing/No in-person appointments	• Obtain a wet-signature in-person when feasible • If unable to get a signature, obtain a verbal consent, document in the body of the TPOC or a progress note. Get the wet-signature in the next in-person visit. • Do not backdate any documents.
For Residential Facilities: Not documenting Residential treatment services in the Intervention section of TPOC		• Per DHCS, "Residential Treatment Services" must be written in the intervention section of the TPOC
Progress Note	**Possible Causes**	**Solution**
Note did not support the claim/claimed service	• No intervention in the progress note • Intervention matched another modality	• Problem-Intervention-Response-Plan (PIRP) format • Review the service code claimed by definition in the documentation manual • Examine the note if there is an intervention during a review
Non-billable service	• Staff unaware that service is non-billable	• Review non-billable codes list in the documentation manual
No note from the second practitioner in a co-practitioner claim	• There is ONE intervention found from 1 provider	• Both providers' intervention must be evident in the progress note

The MH & SUD Audit Tools are Available online at:

https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/default.asp

Over **44%*** of the TPOC, Assessments, Annual Assessments audited were LATE.

24%* of the late progress notes that we reviewed were LATE, not finalized within 5 business days.

This item does not result in a deficiency or money recoupment, but this is a plan of correction item.

There are new E/M Documentation Changes for 2021

Check it out: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Here is additional information: *https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf*

5150 and 5151 Assessments conducted via Telehealth

5150 and 5151 assessments could be conducted via telehealth. More specifically, required 5151 assessments may now be completed face-to-face via a mode of telehealth that uses synchronous audio and visual components.

Here is the link to the DHCS Info Notice 21-003: *https://www.dhcs.ca.gov/formsandpubs/Documents/BHIN-21-003-Telehealth-for-Assessment-72-Hour-Involuntary-Detentions-Implementations-of-AB-3242.pdf*

*Data taken from the MH audits conducted Aug 2020 -Jan 2021.