MAY 2014

QI . . . UP TO THE MINUTE

ANNOUNCEMENTS

State Plan Amendment (SPA)

- A State Plan is a contract between a state and the Federal Government describing how that state administers its Medicaid program. It gives an assurance that a state abides by Federal rules and may claim Federal matching funds for its Medicaid program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative requirements that States must meet to participate.

- States frequently send a state plan amendment, otherwise referred to as a SPA, to the Centers for Medicare and Medicaid Services (CMS) for review and approval. There are many reasons why a state might want to amend their state plan. For example, the state may wish to implement changes required by Federal or state law, Federal or state regulations, or court orders. States also have the flexibility to request permissible program changes, make corrections, or update their plan with new information.

- To read through California's approved SPAs, go to http://www.dhcs.ca.gov/formsandpubs/laws/Pages/ApprovedSPA.aspx

Duplicate Client Entry Problems

- Duplicate client charts continue to be created. The consequences of these data entry errors are numerous, affecting:
  - the integrity of the data in the electronic health record (EHR);
  - ability to report accurate data from the EHR
  - accurate client searches in the EHR and coordination of client care.
- To avoid data entry errors:
  - Get complete, accurate client information (Name, DOB, SS#, alias. Ensure spelling of name is correct)
  - Do a thorough client search in Anasazi before adding a new client. Search by name, alias, SS#, DOB.
  - Enter client names correctly into Anasazi by following name entry conventions as specified in previous BHS communications.

Ending Diagnoses in Anasazi

- When two or more programs are providing services to a client at the same time, a program **may not** end a diagnosis in Anasazi without first consulting with the other treating programs.
- This is important for coordination of client care as well as for accurate billing of services.
- There are specific guidelines for Outpatient vs. Emergency Programs. Please review the "Diagnosis Practice Guideline for Electronic Health Record (EHR) document sent out by QI dated 6/1/13 for these specifics.

Coordination and/or Referral of Physician & Behavioral Health Form

- Reminder: this form is required for County Outpatient programs and it (or a QM approved replacement form) is required from Contractor programs within 30 days of the client's assignment date to your program.
- If you are unable to meet this requirement, clearly document the reason(s) why it was not completed in a progress note.

DOCUMENTATION STANDARDS

Documentation Standards for Completion of BHAs and Client Plans

- All initial BHAs and initial Client Plans (CP) must be completed and final approved within 30 days from the client's assignment opening to your program.
- There are no exceptions to this initial 30 day standard.
- For specific requirements for CPs within Adult and Children's Systems of Care, refer to the Combined Uniform Clinical Records Manual of October 2012, located at the Optum Public Sector Website.

BILLING

SC 998 vs. SC 999

- Recent discussions with the Optum Health Help Desk have indicated that programs are still unclear about when to use SC 998 and SC 999.
- SC 998 is a place holder for claimed services awaiting payment or denial that need correction, including re-entry of non-billable service codes.
- This service code is not used to void the progress note. That is SC 999.
- This service code is only used to void or replace the service while keeping the progress note intact.
- There is an Anasazi report available, "998 Client Progress Note Audit" report that can be used to track SC 998 entries.
- Programs are responsible for monitoring the claimed activity through the Client Service Maintenance window to determine the status of the claim (paid or denied).
- Once the service has been paid or denied, submit required documentation to the MHBU.
- Now the program can delete SC 998 and replace it with the ***correct service.***

Rehab Services

- In medical record reviews this year, QI Specialists are noticing that specific language is missing from the documentation supporting claims to Rehab service codes.

- Rehab services (and your documentation to support these claimed services) should reflect the interventions taken to help a client/family improve, maintain or restore functional skills.
- The need for these services should be reflected in the Client Plan.

DOCTOR'S HOMEPAGE (DHP)

Required Usage

- Programs are reminded that the use of DHP is required for all programs in the System of Care who are utilizing the clinical module of Anasazi.
- Medical staff still needing training in DHP should register online at https://www.regonline.com/builder/site/Default.aspx?EventID=1033841
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E-prescribing and Multum

- The Multum database checks for contraindications among medical conditions and physical health conditions as part of the e-prescribing process.
- In the event of a temporary Multum outage, e-prescriptions are temporarily disabled.
- If this happens, contact the Optum Help Desk at 800-834-3792
- New prescriptions should still be entered into the DHP during the outage, and a method other than e-prescription (or "Transmitted") is selected.
- You will have to enter the prescription information as "Free Text" (the Optum Help Desk can assist if you do not have your DHP reference materials available or have forgotten how to use these function).
- E-prescribing can resume once programs are notified by the Optum Help Desk of the Multum database connection being reestablished.

CLIENT PLANS AND PROGRESS NOTES

Outpatient Client Plans and TBS

- Outpatient programs are required to document TBS referrals on their Client Plans.
- If a client is referred for TBS services by an Outpatient Program, the program must document the referral in the narrative section of the appropriate existing Objective(s) on the Client Plan that relates to the need for TBS to assist the client in meeting that Objective.
- If an existing Objective does not address the need for TBS, a new Objective should be created and TBS services added to the narrative.
- In addition to the need for the service and the involvement of TBS, the name of the TBS program must also be identified in this Narrative.

Client Plan Signature Dates

- The date that the client and/or parent/guardian signs the hard copy Client Plan (CP) signature form for the Initial CP should be the signature date that is entered into the Anasazi CP. This

indicates that the client and/or parent/guardian have met in person with the program, participated in creating the CP, and is in agreement with the CP as documented.

- This is the standard of practice for Revising or Reviewing the CP in Anasazi as well, since programs have 30 days prior to the CP's expiration date to revisit the plan with the client and/or parent/guardian and make necessary adjustments to provide ongoing services (assuming clients still meet medical necessity).
- When a CP expires, services provided are not billable until a valid CP is created (with planning tiers documented, all signatures obtained, and the plan is final approved in Anasazi).
- Practically speaking, this is not problematic as billable services are often not being offered after the lapse of a CP (the client has missed several scheduled sessions for client planning, for example).
- However, there are circumstances when a client and/or parent/guardian cannot meet face-to-face prior to the CP's expiration date and billable services are indicated. This is especially true for "meds only" clients who are often only seen once every few months.
- In these circumstances, programs may complete a CP with the client/family over the phone within 30 days prior to the expiration date of the CP. The following steps should be followed:
    - Engage the client and/or parent/guardian by phone in participating in the planning process;
    - Obtain their agreement with the CP for ongoing services;
    - Instruct them that you will obtain their signatures on hard copy at the next face-to-face service;
    - Complete the Anasazi CP.
    - For the client signature line, select the "Document Client Non Signature" option.
    - You will be prompted to write a narrative about why the client signature has not been obtained. Document the reasons for not meeting face-to-face with the client (or client and parent/guardian, if applicable) as well as that the client (or family) participated in the planning process, is in agreement with the CP, and will sign the CP Signature Page at the next face-to-face service.
    - For the parent/guardian signature line (Children's Programs), delete the signature line. You will have documented the parent/guardian participation in the phone planning in the narrative for the client's non-signature.
    - Final approve the CP.
    - In the progress note for this planning session conducted by phone, document again that client (and parent/guardian, if applicable) participated in the planning process, is in agreement with the CP and will sign the CP Signature Page at the next face-to-face service.
    - At the next face-to-face service with the client and/or parent/guardian, obtain signatures on hard copy. The date of signatures on the hard copy form is the date tare physically signing the form.

UPCOMING DOCUMENTATION TRAININGS

- CHILDREN'S PROGRAMS DOCUMENTATION TRAINING: Friday, May 23, 2014
  9:00am – 12:00pm

- ADULT PROGRAMS DOCUMENTATION TRAINING: Thursday, June 5, 2014
  9:00am – 12:00pm

- Reserve your seat by emailing Linda Oliver at: Linda.Oliver@sdcounty.ca.gov

Save the Date! July 18, 2014: QM Updates for the System of Care

- All program managers and Organizational Provider QI staff are invited to attend a meeting with County QM to receive important information about Quality Improvement efforts in the next fiscal year.
- Attendees will choose from one of two sessions to attend: either 9 a.m. – 12 p.m., or 1:30 p.m. to 4:30 p.m.
- The meetings will be held at the County Operations Center, 5500 Overland Avenue, Room 120, San Diego, 92123.
- More details to follow!

Appointment Reminder Calls

- If you are interested in using the automated appointment reminder system for your client appointments, email QIMatters.hhsa@sdcounty.ca.gov

Is this information filtering down to your clinical and administrative staff?
Keep them Up To the Minute!
And remember to send all personnel contact updates to
QIMatters.hhsa@sdcounty.ca.gov