

BHG UPDATE

Five Months to HIPAA Privacy Compliance

Time is quickly running out!! There are fewer than five months left for BHG Boards and providers to get ready for the April 2003 deadline for compliance with HIPAA Privacy rules. If your organization has not yet started the process to achieve compliance or is falling behind in its compliance activities, the Ohio Department of Mental Health compliance consultant offers the following tips:

- Form a HIPAA compliance workgroup and get some training for the group.
- Develop a job description and designate a Privacy Officer
- Designate responsibility for physical security of protected health information (PHI).
- Quickly locate HIPAA Policy and Procedure templates and begin to adapt them to your organization.
- Perform a quick assessment of the major uses of PHI in your organization. Focus on internal and external uses of PHI.
- Identify business associate relationships and begin

looking at the contracts you have with those organizations.

- Develop a Notice of Privacy Practices.
- Evaluate your current information system's capacity to meet the required EDI transaction standards, especially if one or more of your major payers will require electronic transactions.
- Conduct an analysis of the best way to train your "workforce". This will be your first line of defense so place special effort here as you get closer to the compliance date.

A BHG workgroup has been at work for nearly 12 months, developing materials and strategies for compliance. Privacy notices for both boards and providers as well as policy and procedure templates for many of the Privacy rules have been drafted. If your organization would like to participate in the workgroup or receive templates already developed, contact Larry Bosserman, BHG CEO at 513-759-6345 or bosserman@bhg.org.

Behavioral Health Generations

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Special points of interest:

- *Only 5 Months to HIPAA Compliance Date*
- *Standard Code Sets Approved*
- *CMS Enforces Transaction & Code Sets Standards*
- *FY 02 Summary of Level of Care Audits and Peer Review*

Inside this issue:

<i>5 Months to HIPAA</i>	1
<i>Code Sets Approved</i>	2
<i>CMS Enforces Standards</i>	2
<i>Level of Care Review</i>	3

Standard Code Sets Approved for Mental Health and Addiction Services

After months of waiting, new service codes and new modifiers to be used for ODMH and ODADAS services were approved October 7, 2002. The new set of codes released by the Centers for Medicare and Medicaid Services (CMS) addresses at least some of the behavioral health needs of the Ohio public system. These codes represent the result of an intensive code set request process that involved agencies from around the country lobbying for codes to meet their system's clinical and business needs.

The new codes are currently under review by ODMH and ODADAS to determine which

codes will be used in MACSIS. The code set changes will affect everyone involved with MACSIS. Many of the mental health and AoD local codes currently in use for billing will be replaced with national standard codes. In addition to many new codes and modifiers, several of the new codes will be using a unit of service of fifteen minutes. This is different from current use of units of service of an hour with billing allowed at tenths of an hour. No specific date has been given for the release of the codes to be used in MACSIS, however, it is possible that additional information may be available by the end of November.

CMS to Enforce HIPAA Transaction and Code Set Standards

On October 15, 2002, Health and Human Services (HHS) Secretary Tommy G. Thompson announced that CMS will be responsible for enforcing the transaction and code set standards. A new office will be created within CMS that will bring together all of its responsibilities under HIPAA including enforcement. This action signifies the seriousness with which the federal government will move to enforce the adoption of HIPAA standards.

The new CMS office will establish and operate enforcement processes and develop regulations related to the HIPAA standards for which CMS is responsible including transactions, code sets, security, and identifiers for providers, insurers and employers for use in EDI. Enforcement activities will focus on obtaining voluntary compliance through technical assistance. The process will be primarily

compliant driven and will consist of progressive steps that will provide opportunities to demonstrate compliance or submit a corrective action plan.

Federal law requires most health plans, clearing houses, and those providers that conduct certain transactions electronically to be compliant with the HIPAA EDI standards by October 16, 2002, unless they filed for a one-year extension by October 15, 2002. Those who are not compliant and did not file for the extension may be subject to statutory penalties. Exactly what action, if any, CMS will take in the short run against both payers and providers who did not file for the extension and are not compliant with the EDI standards is unclear. However, this position taken by CMS should be viewed as a clear indication that HIPAA compliance will be required and enforced.

Summary of ODADAS Level of Care and Independent Peer Review for BHG Members—FY 02 *by Mike Witzky, LISW, CCDC III E*

During Fiscal Year 2002, the author conducted Level of Care audits and independent peer review for a number of providers serving BHG member Boards. The reviewer's procedures were consistent with ODADAS standards for peer review and Level of Care (LOC) protocols. A total of 647 records were reviewed for six agencies across BHG that provide alcohol and drug abuse services. The records included admissions, discharges and continued stays for 224 clients. Client demographics were as follows:

Male	162	Female	62
White	200	Non-white	24
Alcohol Diagnosis			158
Drug Diagnosis			128
MH Diagnosis			39
2 or More Diagnoses			99

These numbers suggest that non-white, non-male clients may be underserved in BHG Board areas or the sample for review was somehow skewed. Ninety-nine (99) clients (44% of total clients) presented with more than one diagnosis. Of this number, thirty-nine (39) had at least one mental health diagnosis along with their substance abuse disorder. The literature suggests that the existence of a dual diagnosis may be significantly higher. It is the reviewer's perception that under diagnosis of coexisting mental health and substance abuse problems may relate to the diagnostic skill of the assessor which may link to the degree to which an agency's alcohol and drug program incorporates mental health services.

Summary of Findings

1. Generally, providers use Levels of Care with adult clients consistently and appropriately. Consistent and appropriate use of LOC for adolescents is not as widespread.
2. The sample for review was overwhelmingly white and male. Although consistent with State statistics, this reality offers significant opportunities to increase access to services for non-white males and both white and non-white females.
3. Nearly half of the clients in the sample presented with multiple substance abuse diagnoses. Agency programs appear to focus primarily on alcohol abuse. Are these alcohol focused interventions effective in treating abuse and addiction to other substances?
4. Only one-third of the sample was identified as having a dual diagnosis. The literature suggests a much higher percentage of individuals in the general population with coexisting mental health and substance abuse problems. Improving diagnostic accuracy may be a function of the skill sets and/or training of agency staff. Additional training and focus on programs for the dually diagnosed may also improve treatment effectiveness.

General Recommendations

Opportunities exist to improve access to culturally diverse populations and to women of all races and ethnicities. Similarly, improvement efforts might be focused upon programming for clients abusing more than one substance, and the diagnosis and programming for individuals with coexisting mental health and substance abuse disorders.

In addition, the author's experiences at 10 agency sites in five Board areas suggested that better integration of client assessment, treatment planning and documentation of progress

Continued on page 4

Behavioral Health Generations

Promoting Improved Performance and Outcomes Through Collective Voice and Action

Member Boards:

Brown County ADAMH, Georgetown, OH
Hancock County ADAMH, Findaly, OH
Logan Champaign Counties MHDAS, West Liberty, OH
Seneca Sandusky Wyandot Counties MH & RS, Tiffin, OH
Union County MH & R, Marysville, OH
Warren Clinton Counties RS, Lebanon, OH

7372 Kingsgate Way
West Chester, OH 45069
Phone: 513 759 2666
Fax: 513 759 6326
E-mail: bosslerlz@bhg.org

COMMUNICATION LINKS:

BHG Main Number	513-759-2666
Bosserman, CEO	513-759-6345
Kirschner, MIS Director	513-759-6346
Medley, Claims	513-759-6347
Gentry, Enrollment	513-759-6348
PC Anywhere Remote	513-759-6328 or
	888-636-8281
Fax:	
BHG Main	513-759-6326
MACSIS Enrollment	513-759-6329 or
	888-780-0242
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Summary of ODADAS Level of Care and Independent Peer Review for BHG Members—FY 02 (*Cont'd*)

Could contribute significantly to the quality of programming across the collaborative. Assessment forms vary among agencies, but, in spite of the assessment, the treatment plan often reflects the core elements of the agency's treatment program rather than client needs. Subsequently, progress notes seem to focus on the activities of the treatment plan rather than client outcomes resulting from treatment activities and related to the needs identified in the assessment. It is the author's recommendation that treatment plans be developed with specific client goals related to the assessment and to expressed client needs. Treatment interventions should be selected to achieve each of the client goals. Documentation of progress would relate the treatment to a specific goal and describe the outcome for the client (i.e. did the treatment intervention move the client toward achieving the goal and how?) .

Achieving greater integration of assessment, treatment planning, and progress reporting requires flexibility in programming. Although we may approach treatment in a standard way, we must have the flexibility within the program to individualize treatment elements to meet individual client needs. Programs with standard goals for all clients must include the capability for individualized goals determined in collaboration with the client. Alcohol and drug treatment programs across BHG are amazingly homogeneous in spite of the literature and national demonstration projects that have increased our knowledge and understanding of the recovery process. Tapping into this body of knowledge and creating some program diversity may also contribute to better outcomes for our clients and greater effectiveness for our programs.