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Top 5 SUD myths
you need to debunk now!

Behold, the hydra! A terrifying mythical creature—if you believe in that sort of thing.

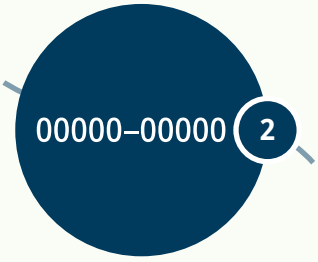
This installment of **compliance myths you need to debunk now** deals with one challenge that has many ugly heads that may rear up if you don't have strong defenses (processes and procedures) in place. Substance Use Disorder has been a hot topic the last several years and since the pandemic has grown into an outright inferno. Opioid treatment programs have been popping up everywhere, and in their rush to start treating patients, numerous providers ignored compliance and have had to pay substantial fines.

MYTH #1

A HIPAA authorization form is sufficient for disclosures from a SUD treatment facility.

42 Code of Federal Regulations ("CFR") Part 2 applies to any substance abuse treatment facility that is federally funded. The regulations restrict any disclosure that identifies an individual as having a current or past drug or alcohol problem. With few exceptions, 42 CFR Part 2 requires written patient consent for disclosures of Protected Health Information (PHI) even for the purposes of treatment, payment, or healthcare operations.

Translation: Get a signed authorization for every intended use and disclosure.



MYTH #2

Physicians can select their own Evaluation and Management (E/M) codes without rationale.

We have had some major changes in the criteria for E/M code selection in 2021—levels are now assigned based on MDM or time spent. If the provider chooses to bill based on time, the time must be (truthfully) documented in the progress note. If time is not used as a factor when selecting an E/M code, your billing/coding policies should dictate the auditing or verification process prior to claim submission.

Translation: Do NOT use the same E/M code for all patient encounters. This is an enormous red flag that will attract unwanted attention.

MYTH #3

I can order a Urine Drug Test (UDT) on every visit.

All patients on long-term opioid therapy should have periodic UDTs. UDTs should be determined on a case-by-case basis and ordered at the physician's discretion and supported by documentation.

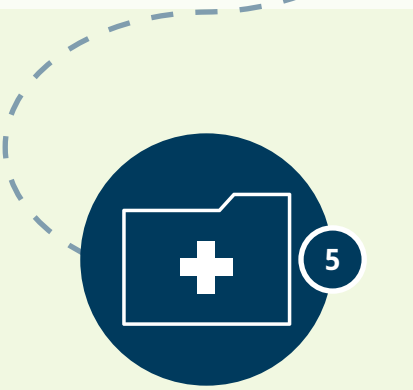
Translation: Do NOT order a UDT on every patient visit, review it days later, and acknowledge it was necessary to update the treatment plan. Remember that red flag from myth #2? Here's another one!

MYTH #4

If I have not met my annual prescribing limit, I can prescribe opioid therapy for anyone.

There are several criteria that must be met before a practitioner can accept a patient for opioid therapy. Firstly (and with few exceptions), the patient must be addicted to an opioid drug for at least 1 year prior to admission for treatment. Next, the patient must provide written consent to treat. Lastly, there must be documentation stating that every effort was made to review whether the patient is enrolled in any other opioid treatment program.

Translation: Document, document, then document some more.



MYTH #5

If I simply attest to reviewing this patient's medical record, I do not actually have to review it.

It is safe to say that most health information management professionals have seen a canned statement of attestation, inserted and electronically signed by a physician. In opioid treatment programs the authorized prescriber must be the primary provider for the patient. That prescriber must review the patient's notes to determine if they are eligible to receive opioid treatment. The documentation and prescription must be signed the same day.

Translation: Although canned statements are efficient, they are not individualized and should not be used solely when attesting to patient care.

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