Merced County DMC-ODS Services

Provider Manual and Documentation Guidelines 2018-2019

- *This is a live document and any changes to this document will be completed and uploaded to the BHRS SUD Website.*

T.Haywood
County of Merced

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MISSION, VISION AND VALUES

Mission Statement

Inspiring Hope and recovery for those we serve as the premier provider for quality whole person care

Vision Statement

Behavioral Health and Recovery Services is committed to empowering our diverse community with hope, recovery and wellness by providing comprehensive holistic care.

Core Values

Humility, Integrity, Compassion, Customer Service, Inclusion and Innovation

WELCOME

Welcome to the Merced County Drug Medi-Cal Organized Deliver System also referenced as DMC-ODS. Merced County's DMC-ODS paves the way for increasing access to substance use disorder (SUD) treatment services for youth and adults who are Medi- Cal eligible and/or participating in another County funded program. It also provides an opportunity for the County to fully integrate physical and mental health service needs with SUD services; raise quality standards to improve health outcomes; provide the right services, at the right time, in the right setting, for the right duration; establish a single benefit package for qualified publicly funded SUD services regardless of referral source or insurance plan; and overall solidify SUD's status as a chronic health condition rather than as an acute condition. These enhancements will enable SUD patients to receive quality services that match their individualized needs, preferences, and improve overall health and social outcomes.

This document, along with other federal, state and local regulations including 42 Code of Federal Regulations (C.F.R.) Part 2 Confidentiality of Substance Use Disorder Patient Records; 42 C.F.R. Part 428 Managed Care; Health Insurance Portability and Accountability Act (HIPAA); California Code of Regulations (CCR) Title 9 Counselor Certification the California Code of Regulations; CCR Title 22 Drug Medi-Cal; Drug Medi-Cal Organized Delivery System Special Terms and Conditions; Department of Health Care Services Perinatal Services Network Guidelines and Youth Treatment Standards; Merced County DMC-ODS Implementation Plan and Finance and Rates Plan; and the Contract including but not limited to the Specific Services to be Provided and Bulletins; govern delivery of SUD treatment services in Merced County. The Provider Manual is specifically designed to be used by all administrative and direct service staff to ensure understanding of guiding principles of the Merced County DMC-ODS network of care and adherence to the clinical and business expectations meant to ensure delivery of quality and outcome based services.

SUD BENEFIT PACKAGE

What Are DMC-ODS Services?

DMC-ODS services are health care services for people who have at least one substance use disorder diagnosis that the regular primary care doctor cannot treat.

DMC-ODS services within the Merced County DMC-ODS network include:

- Outpatient Services: ASAM 1.0
- Intensive Outpatient Treatment: ASAM 2.1
- Residential Treatment (subject to prior authorization by the county) ASAM 3.1. Other levels of residential treatment will be available in year 2 of the DMC-ODS waiver.
- Withdrawal Management: ASAM WM-1
- Opioid Treatment

- Medication Assisted Treatment (some primary care clinics in Merced County offer this service)
- Recovery Services
- Case Management

If you would like to learn more about each DMC-ODS service that may be available to you, see the descriptions below:

- **Outpatient Services ASAM 1.0**
  - Counseling services are provided to members up to nine hours a week for adults and less than six hours a week for adolescents when determined to be medically necessary and in accordance with an individualized consumer plan. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community.
  - Outpatient Services includes intake and assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, crisis intervention services, and discharge planning.
  - There is no limit of services as long as the treatment is medically necessary and in accordance with the individualized treatment plan.

- **Intensive Outpatient Services ASAM 2.1**
  - Intensive Outpatient Services are provided to members (a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined to be medically necessary and in accordance with an individualized consumer plan. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community.
  - Intensive Outpatient Services include the same components as Outpatient Services. The increased number of hours of service are the main difference.
  - There is no limit of services as long as the treatment is medically necessary and in accordance with the individualized treatment plan.

- **Residential Treatment ASAM 3.1** (subject to authorization by the county)
  - Residential Treatment is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services to members with a SUD diagnosis when determined as medically necessary and in accordance with an individualized treatment plan. Each member shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve SUD related problems. Goals include sustaining

abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

- Residential services require prior authorization by the County Plan. Each authorization for residential services can be for a maximum of 90 days for adults and 30 days for youth. Only two authorizations for residential services are allowed in a one-year-period. It is possible to have one 30-day extension per year based on medical necessity. Pregnant women can receive residential services through the last day of the month that the 60th day after delivery occurs. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible members (under the age of 21) will not have the authorization limits described above as long as medical necessity establishes the need for ongoing residential services.
- Residential Services includes intake and assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, safeguarding medications (facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication), crisis intervention services, transportation (provision of or arrangement for transportation to and from medically necessary treatment) and discharge planning.

- **Withdrawal Management**
  - Withdrawal Management services are provided when determined as medically necessary and in accordance with an individualized consumer plan. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized consumer plan prescribed by a licensed physician, or licensed prescriber and approved and authorized according to the State of California requirements.
  - Withdrawal Management Services include intake and assessment, observation (to evaluate health status and response to any prescribed medication), medication services, and discharge planning.
  - Withdrawal Management Level 1 services shall be provided up to 14 days of service per episode and only available to adults as medically necessary.

- **Opioid Treatment**
  - Opioid (Narcotic) Treatment Program (OTP/NTP) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized consumer plan determined by a licensed physician or licensed prescriber, and approved and authorized according to the State of California requirements. OTPs/NTPs are required to offer and prescribe medications to members covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.
  - A member must receive, at a minimum, 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.
  - Opioid Treatment Services include the same components as Outpatient Treatment Services, with the inclusion of medical psychotherapy consisting of a face-to-face discussion conducted by a physician on a one-on-one basis with the member.

- **Recovery Services**
  - Recovery Services are important to the member's recovery and wellness. The treatment community becomes a therapeutic agent through which members are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.
  - Recovery Services include individual and group counseling; recovery monitoring/substance abuse assistance (recovery coaching, relapse prevention, and peer-to-peer services); and case management (linkages to educational, vocational, family supports, community-based supports, housing, transportation, and other services based on need).
  - Available to youth and adults who have completed substance use treatment. The benefit is generally available for up to six months.
  - Youth (Ages 12 to 17) shall receive no more than 6 hours per month.
  - Adults (18+) shall receive no more than 8 hours per month.

- **Case Management**
  - Case Management Services assist a member to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care especially for members with a chronic SUD, and interaction with the criminal justice system, if needed.
  - Case Management Services include a comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; transitions to higher or lower levels of SUD care; development and periodic revision of a consumer plan that includes service activities; communication, coordination, referral and related activities; monitoring service delivery to ensure member access to service and the service delivery system; monitoring the member's progress; and, member advocacy, linkages to physical and mental health care, transportation and retention in primary care services.
  - Case management shall be consistent with and shall not violate confidentiality of any member as set forth in Federal and California law.
  - Case management is available to both youth and adults for up to 6 hours per month for all service levels expect recovery support services.

NOTICE OF ADVERSE BENEFIT DETERMINATION

What Is A Notice Of Adverse Benefit Determination?

A Notice of Adverse Benefit Determination, sometimes called a NOABD, is a form that your county DMC-ODS plan uses to tell you when the plan makes a decision about whether or not you will get Medi-Cal SUD treatment services. A Notice of Adverse Benefit Determination is

also used to tell you if your grievance, appeal, or expedited appeal was not resolved in time, or if you didn't get services within the County Plan's timeline standards for providing services.

When Will I Get A Notice Of Adverse Benefit Determination?

You will get a Notice of Adverse Benefit Determination:

- If your County Plan or one of the County Plan providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD service and asks the County Plan for approval, but the County Plan does not agree and denies your provider's request, or changes the type or frequency of service. Most of the time you will receive a Notice of Adverse Benefit Determination before you receive the service, but sometimes the Notice of Adverse Benefit Determination will come after you already received the service, or while you are receiving the service. If you get a Notice of Adverse Benefit Determination after you have already received the service you do not have to pay for the service.
- If your provider has asked the County Plan for approval, but the County Plan needs more information to make a decision and doesn't complete the approval process on time.
- If your County Plan does not provide services to you based on the timelines the County Plan has set up. Call your County Plan to find out if the County Plan has set up timeline standards.
- If you file a grievance with the County Plan and the County Plan does not get back to you with a written decision on your grievance within 90 calendar days. If you file an appeal with the County Plan and the County Plan does not get back to you with a written decision on your appeal within 30 calendar days or, if you filed an expedited appeal, and did not receive a response within 72 hours.

Will I Always Get A Notice Of Adverse Benefit Determination When I Don't Get The Services I Want?

There are some cases where you may not receive a Notice of Adverse Benefit Determination. You may still file an appeal with the County Plan or if you have completed the appeal process, you can request a state fair hearing when these things happen. Information on how to file an appeal or request a fair hearing is included in this handbook. Information should also be available in your provider's office.

What Will The Notice Of Adverse Benefit Determination Tell Me?

The Notice of Adverse Benefit Determination will tell you:

- What your County Plan did that affects you and your ability to get services.
- The effective date of the decision and the reason the plan made its decision.
- The state or federal rules the county was following when it made the decision.
- What your rights are if you do not agree with what the plan did.
- How to file an appeal with the plan.

- How to request a State Fair Hearing.
- How to request an expedited appeal or an expedited fair hearing.
- How to get help filing an appeal or requesting a State Fair Hearing.
- How long you have to file an appeal or request a State Fair Hearing.
- If you are eligible to continue to receive services while you wait for an Appeal or State Fair Hearing decision.
- When you have to file your Appeal or State Fair Hearing request if you want the services to continue.

What Should I Do When I Get A Notice Of Adverse Benefit Determination?

When you get a Notice of Adverse Benefit Determination you should read all the information on the form carefully. If you don't understand the form, your County Plan can help you. You may also ask another person to help you.

You can request a continuation of the service that has been discontinued when you submit an appeal or a request for State Fair Hearing. You must request the continuation of services no later than 10 calendar days after the date the Notice of Adverse Benefit Determination was post-marked or personally given to you, or before the effective date of the change.

PROBLEM RESOLUTION PROCESSES

What If I Don't Get The Services I Want From My County DMC-ODS Plan?

Your County Plan has a way for you to work out a problem about any issue related to the SUD treatment services you are receiving. This is called the problem resolution process and it could involve the following processes.

1. The Grievance Process – an expression of unhappiness about anything regarding your substance use treatment services, other than an Adverse Benefit Determination.
2. The Appeal Process – review of a decision (denial or changes to services) that was made about your substance use treatment services by the County Plan or your provider.
3. The State Fair Hearing Process – review to make sure you receive the Substance use treatment services which you are entitled to under the Medi-Cal program.

Filing a grievance or appeal, or a State Fair Hearing will not count against you and will not impact the services you are receiving. When your grievance or appeal is complete, your County Plan will notify you and others involved of the final outcome. When your State Fair Hearing is complete, the State Hearing Office will notify you and others involved of the final outcome.

Learn more about each problem resolution process below.

Can I Get Help To File An Appeal, Grievance Or State Fair Hearing?

Your County Plan will have people available to explain these processes to you and to help you report a problem either as a grievance, an appeal, or as a request for State Fair Hearing. They

may also help you decide if you qualify for what's called an 'expedited' process, which means it will be reviewed more quickly because your health or stability are at risk. You may also authorize another person to act on your behalf, including your SUD treatment provider.

If you would like help, call 1-888-334-0163.

What If I Need Help To Solve A Problem With My County DMC-ODS Plan But Don't Want To File A Grievance Or Appeal?

You can get help from the State if you are having trouble finding the right people at the county to help you find your way through the system.

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

THE GRIEVANCE PROCESS

What Is A Grievance?

A grievance is an expression of unhappiness about anything regarding your substance use treatment services that are not one of the problems covered by the appeal and State Fair Hearing processes.

The grievance process will:

- Involve simple, and easily understood procedures that allow you to present your grievance orally or in writing.
- Not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the County Plan might ask you to sign a form authorizing the plan to release information to that person.
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous levels of review or decision-making.
- Identify the roles and responsibilities of you, your County Plan and your provider.
- Provide resolution for the grievance in the required timeframes.

When Can I File A Grievance?

You can file a grievance with the County Plan at any time if you are unhappy with the substance use treatment services you are receiving from the County Plan or have another concern regarding the County Plan. The *Complaint and Grievance Form* is available in all lobbies of network providers. The County Plan cannot take away your health care benefits or retaliate in any way if you file a grievance.

How Can I File A Grievance?

You may call your County Plan's toll-free phone number at 1-888-334-0163 to get help with a grievance. The county will provide self-addressed envelopes at all the providers' sites for you to mail in your grievance. Grievances can be filed orally or in writing. Oral grievances do not have to be followed up in writing.

How Do I Know If The County Plan Received My Grievance?

Your County Plan will let you know that it received your grievance by sending you a written confirmation.

When Will My Grievance Be Decided?

The County Plan must make a decision about your grievance within 90 calendar days from the date you filed your grievance. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the County Plan believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay might be for your benefit is when the county believes it might be able to resolve your grievance if the County Plan had a little more time to get information from you or other people involved.

How Do I Know If The County Plan Has Made A Decision About My Grievance?

When a decision has been made regarding your grievance, the County Plan will notify you or your representative in writing of the decision. If your County Plan fails to notify you or any affected parties of the grievance decision on time, then the County Plan will provide you with a Notice of Adverse Benefit Determination advising you of your right to request a State Fair Hearing. Your County Plan will provide you with a Notice of Adverse Benefit Determination on the date the timeframe expires.

Is There A Deadline To File A Grievance?

You may file a grievance at any time.

To obtain more information on the BHRS Grievance Process you can reference the county's Problem Resolution Process Policy # I.C.05.

THE APPEAL PROCESS (Standard and Expedited)

Your County Plan is responsible for allowing you to request a review of a decision that was made about your substance use treatment services by the plan or your providers. There are two ways you can request a review. One way is using the standard appeals process. The second way is by using the expedited appeals process. These two forms of appeals are similar; however, there are specific requirements to qualify for an expedited appeal. The specific requirements are explained below.

What Is A Standard Appeal?

A standard appeal is a request for review of a problem you have with the plan or your provider that involves a denial or changes to services you think you need. If you request a standard appeal, the County Plan may take up to 30 calendar days to review it. If you think waiting 30 calendar days will put your health at risk, you should ask for an 'expedited appeal.'
The standard appeals process will:

- Allow you to file an appeal in person, on the phone, or in writing. If you submit your appeal in person or on the phone, you must follow it up with a signed written appeal. You can get help to write the appeal. If you do not follow-up with a signed written appeal, your appeal will not be resolved. However, the date that you submitted the oral appeal is the filing date.
- Ensure filing an appeal will not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the plan might ask you to sign a form authorizing the plan to release information to that person.
- Have your benefits continued upon request for an appeal within the required timeframe, which is 10 calendar days from the date your Notice of Adverse Benefit Determination was post-marked or personally given to you. You do not have to pay for continued services while the appeal is pending. If you do request continuation of the benefit, and the final decision of the appeal confirms the decision to reduce or discontinue the service you are receiving, you may be required to pay the cost of services furnished while the appeal was pending;
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous level of review or decision-making.
- Allow you or your representative to examine your case file, including your medical record, and any other documents or records considered during the appeal process, before and during the appeal process.
- Allow you to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Allow you, your representative, or the legal representative of a deceased member's estate to be included as parties to the appeal.
- Let you know your appeal is being reviewed by sending you written confirmation.
- Inform you of your right to request a State Fair Hearing, following the completion of the appeal process.

When Can I File An Appeal?

You can file an appeal with Merced County BHRS:

- If your county or one of the county contracted providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD treatment service and asks the county for approval, but the county does not agree and denies your provider's request, or changes the type or frequency of service.

- If your provider has asked the County Plan for approval, but the county needs more information to make a decision and doesn't complete the approval process on time.
- If your County Plan doesn't provide services to you based on the timelines the County Plan has set up.
- If you don't think the County Plan is providing services soon enough to meet your needs.
- If your grievance, appeal or expedited appeal wasn't resolved in time.
- If you and your provider do not agree on the SUD services you need.

How Can I File An Appeal?

You may call your County Plan's toll-free phone number at 1-888-334-0136 to get help with filing an appeal. The county plan will provide self-addressed envelopes at all provider sites for you to mail in your appeal.

How Do I Know If My Appeal Has Been Decided?

BHRS will notify you or your representative in writing about their decision for your appeal. The notification will have the following information:

- The results of the appeal resolution process.
- The date the appeal decision was made.
- If the appeal is not resolved wholly in your favor, the notice will also contain information regarding your right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

Is There A Deadline To File An Appeal?

You must file an appeal within 60 calendar days of the date on the Notice of Adverse Benefit Determination. Keep in mind that you will not always get a Notice of Adverse Benefit Determination. There are no deadlines for filing an appeal when you do not get a Notice of Adverse Benefit Determination; so you may file this type of appeal at any time.

When Will A Decision Be Made About My Appeal?

BHRS must decide on your appeal within 30 calendar days from when the County Plan receives your request for the appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the County Plan believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay is for your benefit is when the county believes it might be able to approve your appeal if the County Plan had a little more time to get information from you or your provider.

What If I Can't Wait 30 Days For My Appeal Decision?

The appeal process may be faster if it qualifies for the expedited appeals process.

What Is An Expedited Appeal?

An expedited appeal is a faster way to decide an appeal. The expedited appeals process follows a similar process to the standard appeals process. However,

- Your appeal must meet certain requirements.
- The expedited appeals process also follows different deadlines than the standard appeals.
- You can make a verbal request for an expedited appeal. You do not have to put your expedited appeal request in writing.

When Can I File An Expedited Appeal?

If you think that waiting up to 30 calendar days for a standard appeal decision will jeopardize your life, health or ability to attain, maintain or regain maximum function, you may request an expedited resolution of an appeal. If BHRS agrees that your appeal meets the requirements for an expedited appeal, your county will resolve your expedited appeal within 72 hours after BHRS receives the appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if BHRS shows that there is a need for additional information and that the delay is in your interest. If BHRS extends the timeframes, BHRS will give you a written explanation as to why the timeframes were extended.

If BHRS decides that your appeal does not qualify for an expedited appeal, BHRS must make reasonable efforts to give you prompt oral notice and will notify you in writing within 2 calendar days giving you the reason for the decision. Your appeal will then follow the standard appeal timeframes outlined earlier in this section. If you disagree with BHRS's decision that your appeal doesn't meet the expedited appeal criteria, you may file a grievance.

Once BHRS resolves your expedited appeal, BHRS will notify you and all affected parties orally and in writing.

To obtain more information on the BHRS Appeal Process you can reference the county's Problem Resolution Process Policy # I.C.05.

THE STATE FAIR HEARING PROCESS

What Is A State Fair Hearing?

A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the SUD treatment services to which you are entitled under the Medi-Cal program.

What Are My State Fair Hearing Rights?

You have the right to:

- Have a hearing before the California Department of Social Services (also called a State Fair Hearing).
- Be told about how to ask for a State Fair Hearing.

- Be told about the rules that govern representation at the State Fair Hearing.
- Have your benefits continued upon your request during the State Fair Hearing process if you ask for a State Fair Hearing within the required timeframes.

When Can I File For A State Fair Hearing?

You can file for a State Fair Hearing:

- If you have completed the County Plan's appeal process.
- If your county or one of the county contracted providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD treatment service and asks the County Plan for approval, but the County Plan does not agree and denies your provider's request, or changes the type or frequency of service.
- If your provider has asked the County Plan for approval, but the county needs more information to make a decision and doesn't complete the approval process on time.
- If your County Plan doesn't provide services to you based on the timelines the county has set up.
- If you don't think the County Plan is providing services soon enough to meet your needs.
- If your grievance, appeal or expedited appeal wasn't resolved in time.
- If you and your provider do not agree on the SUD treatment services you need.

How Do I Request A State Fair Hearing?

You can request a State Fair Hearing directly from the California Department of Social Services. You can ask for a State Fair Hearing by writing to:

State Hearings Division
California Department of Social Services
744 P Street, Mail Station 9-17-37
Sacramento, California 95814

You can also call 1-800-952-8349 or for TDD 1-800-952-8349.

Is There A Deadline For Filing For A State Fair Hearing?

You only have 120 calendar days to ask for a State Fair Hearing. The 120 days start either the day after the County Plan personally gave you its appeal decision notice, or the day after the postmark date of the county appeal decision notice.

If you didn't receive a Notice of Adverse Benefit Determination, you may file for a State Fair Hearing at any time.

Can I Continue Services While I'm Waiting For A State Fair Hearing Decision?

Yes, if you are currently receiving treatment and you want to continue your treatment while you appeal, you must ask for a State Fair Hearing within 10 days from the date the appeal decision notice was postmarked or delivered to you OR before the date your County Plan says services will be stopped or reduced. When you ask for a State Fair Hearing, you must say that you want to keep receiving your treatment. Additionally, you will not have to pay for services received while the State Fair Hearing is pending.

If you do request continuation of the benefit, and the final decision of the State Fair Hearing confirms the decision to reduce or discontinue the service you are receiving, you may be required to pay the cost of services furnished while the state fair hearing was pending.

What If I Can't Wait 90 Days For My State Fair Hearing Decision?

You may ask for an expedited (quicker) State Fair Hearing if you think the normal 90-calendar day time frame will cause serious problems with your health, including problems with your ability to gain, maintain, or regain important life functions. The Department of Social Services, State Hearings Division, will review your request for an expedited State Fair Hearing and decide if it qualifies. If your expedited hearing request is approved, a hearing will be held and a hearing decision will be issued within 3 working days of the date your request is received by the State Hearings Division.

To obtain more information on the BHRS State Fair Hearing Process you can reference the county's Problem Resolution Process Policy # I.C.05.

IMPORTANT INFORMATION ABOUT THE STATE OF CALIFORNIA MEDI-CAL PROGRAM

Does Medi-Cal Cover Transportation?

- If you have trouble getting to your medical appointments or drug and alcohol treatment appointments, the Medi-Cal program can help you find transportation.
- For children, the county Child Health and Disability Prevention (CHDP) program can help. You may also wish to contact your county social services office at (209) 385-3000. You can also obtain information at Merced Country Human Service Agency website at http://www.co.merced.ca.us/458/Medi-Cal . You can also get information online by visiting www.dhcs.ca.gov, then clicking on 'Services' and then 'Medi-Cal.'
- For adults, your county social services office can help at (209) 385-3000. You can also obtain information at Merced Country Human Service Agency website at http://www.co.merced.ca.us/458/Medi-Cal. Or you can get information online by visiting www.dhcs.ca.gov, then clicking on 'Services' and then 'Medi-Cal.'
- If you are enrolled with a Medi-Cal Managed Care Plan (MCP), the MCP is required to assist with transportation according to Section 14132 (ad) of the Welfare and Institutions

Code. Transportation services are available for all service needs, including those that are not included in the DMC-ODS program.

- ALL TRANPORTATION REQUEST SHALL BE SUBMITTED TO THE CA ALLIANCE No later than 7 days before the consumer's next appointment:
- Network Providers may facilitate this request by faxing the consumer's request to Central California Alliance for Health → **(831) 430-5850** fax
- When network providers fax the requests to Alliance for Health, the fax confirmation will be placed in the consumer's chart.
- Consumer is responsible for coordinating and verifying that transportation is in place. Merced County Alliance members can seek assistance with medical transportation information at the following link https://www.ccahalliance.org/pdfs/member_newsletters/MSNewsletter_201709_E.pdf

DOCUMENTATION STANDARDS

PURPOSE

Merced County BHRS and its network of providers, provide Substance Use Disorder (SUD) services to adults who have a substance use disorder and to adolescents who have or may be at risk of developing a substance use disorder.

Merced County has opted in to participate in the State's Drug Medi-Cal Organized Delivery System (DMC-ODS), which allows greater coordination of care for consumers as they move from one level of care to another, thereby increasing the likelihood of successful treatment outcomes.

Participation in the DMC-ODS also means a new set of regulations that we must abide by. Documentation is vital to maintaining a record of the quality of the services that are provided to SUD consumers. It is our responsibility to our consumers to accurately describe the services provided, which also includes the need to understand how to code services properly. This manual is designed to help provide guidance on documentation standards to all clinical staff who work directly with our consumers in our SUD programs so that we may work towards maintaining compliance with the regulations. BHRS will also be providing a documentation training PowerPoint for all providers working within the DMC-ODS system.

DISCLAIMER
This manual is a living document and will be amended as needed, based on changes made by the State as well as any internal program requirements implemented. Please keep in mind that the State sets the minimum requirements and the County can impose standards above and beyond the State's guidance. This current version is based on the current understanding of the State regulations as well as the County's agreement with the State on what will be provided.

MEDICAL NECESSITY

What Is Medical Necessity And Why Is It So Important?

One of the conditions necessary for receiving SUD treatment services through your county's DMC-ODS plan is something called 'medical necessity.' This means a doctor or other licensed professional will talk with you to decide if there is a medical need for services, and if you can be helped by services if you receive them.

The term medical necessity is important because it will help decide if you are eligible for DMC-ODS services, and what kind of DMC-ODS services are appropriate. Deciding medical necessity is a very important part of the process of getting DMC-ODS services.

What Are The 'Medical Necessity' Criteria For Coverage Of Substance Use Disorder Treatment Services?

As part of deciding if you need substance use treatment services, the county DMC-ODS plan will work with you and your provider to decide if the services are a medical necessity, as explained above. This section explains how Merced County BHRS will make that decision.

In order to receive services through the DMC-ODS, you must meet the following criteria:

- You must be enrolled in Medi-Cal.
- You must reside in a county that is participating in the DMC-ODS.
- You must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a Substance-Related and Addictive Disorder. Any adult, or youth under the age of 21, who is assessed to be "at-risk" for developing a SUD will be eligible for Early Intervention services if they do not meet medical necessity criteria.
- You must meet the American Society of Addiction Medicine (ASAM) definition of medical necessity for services based on the ASAM Criteria (ASAM Criteria are national treatment standards for addictive and substance-related conditions).
- For Title 22 Medical Necessity is defined as: Physician shall determine whether SUD services are medically necessary based on Title 22, Section 51303 "*(a) Health care services…which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury are covered by the Medi-Cal program…*"

ASAM & Levels of Care

The American Society of Addiction Medicine (ASAM) is a professional medical society, well established in representing professionals in the field of addiction medicine. The ASAM focuses on education, research, access, and improving the quality of treatment. The ASAM has developed a comprehensive guideline for placement of individuals seeking and continuing substance use treatment services, which is commonly referred to as the ASAM Criteria. The

ASAM Criteria has become the industry standard in the assessment and treatment of addiction. Thus, it is one of the requirements of DMC-ODS.

The ASAM Criteria takes into consideration various factors of an individual's life to help streamline the determination of what level of care would be most appropriate. As we know, there are many stages within recovery and it is a fluid, lifelong process to maintain a sober lifestyle for many of our consumers. The ASAM Criteria offers to improve treatment outcomes by accurately assessing the consumer's needs and ensuring that the services provided meet those needs. The consumer's needs are assessed through each of the six dimensions of the ASAM Criteria, which are as follows:

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and/or Complications
- Emotional, Behavioral, and/or Cognitive Conditions and/or Complications
- Readiness to Change
- Relapse and/or Continued Use Potential
- Recovery/Living Environment

Based on how severe the consumer's functioning is in each of these six dimensions, consumers will receive services at the corresponding levels of care that we offer in Merced County. Please note that if a consumer meets a level of care that is not offered in Merced County such as 24 hour hospitalization, we must work diligently to ensure consumers are referred to that level of care. The ASAM Levels of Care that are provide in Merced County are as follows:

Continuum of Care Services within DMC-ODS		
Level 0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Level 1.0	Outpatient Services	Less than 9 hours of service/week (adults); Less than 6 hours of service/week (adolescents)
Level 2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours of service/week
Level 3.1	Clinically Managed Low-Intensity Residential Treatment Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week
Level 3.3 (Coming Soon)	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors; less intense milieu for those with cognitive or other impairments
Level 3.5 (Coming Soon)	Clinically Managed High-Intensity Residential	24-hour care with trained counselors
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder

Withdrawal Services within DMC-ODS		
Level 1-WM	Ambulatory withdrawal management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision
Level 3.2-WM (Coming in Year 2 of Waiver)	Clinically managed residential withdrawal management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

SCOPE OF PRACTICE

All staff are expected to provide treatment services within his or her scope of practice. An individual's scope of practice is dependent on education, training, and experience.

A "Licensed Practitioner of the Healing Arts," or "LPHA," includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Professional staff or "counselors" are either licensed, registered, certified, or recognized under California State scope of practice statutes. This includes LPHA and those registered or certified as an Alcohol and/or Drug (AOD) Counselor.

The link below is a helpful grid provided by the State to clearly show what types of services are allowed to be provided and by whom:

http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/ODS_Staffing_Grid_Revised_031518_Final.pdf

DMC-ODS also requires that counselors receive training in ASAM -A and ASAM- B prior to assessments being conducted. Training in two Evidence-Based Practices (EBP) are also required.

INITIAL ASSESSMENT

For SUD services, the initial assessment that is completed upon the consumer's admission to treatment, is where the documentation of medical necessity begins. As with any standard assessment, it is a compilation of information that is gathered from interviewing the consumer and, if applicable, with information from significant others that may be involved with the consumer's treatment or referral for treatment. The assessment must include information about the following aspects of the consumer's life:

1. Drug and/or alcohol use history;
2. Medical history;
3. Family history;
4. Psychiatric/psychological history;
5. Social/recreational history;
6. Financial status/history;
7. Educational history;
8. Employment history;
9. Criminal history, legal status; and
10. Previous SUD treatment history

Since the initial assessment is where medical necessity must first be documented, it incorporates the six dimensions of the ASAM Criteria. All of the above information that is addressed in a standard assessment will be addressed in our ASAM Assessment form through each of the dimensions. As we get to know our consumers during the assessment period, we should always keep in mind one thing:
"How does this relate to the substance use?"

This is because we need to demonstrate how the problems in the consumer's life is a result of the substance use. These are the problems that we will be addressing in the consumer's treatment. Therefore, what is relevant to the substance use is what we need to clearly document. So, for the purposes of our initial assessment, it is not enough just to gather information about the consumer's life. It is a purposeful gathering of information, directed at identifying how the substance use has effected the consumer.

With the information gathered, we must first determine whether the consumer meets the DSM-5 criteria for a substance use disorder. It is important to keep in mind the criteria for a substance use disorder that can be our guide for the questions that we ask the consumer during the assessment. It is not enough to say that since Johnnie has been drinking every night for the past 2 years, that he has an Alcohol Use Disorder. Use alone is not enough to warrant a diagnosis. We must identify the impact of the substance use.

Below is a table showing how each of the above information that needs to be included in an assessment would fall within our ASAM Assessment form, as well as where information related to the DSM-5 criteria can be included:

#	Aspect of Consumer's Life	#	Aspect of Consumer's Life
1	Drug and/or alcohol use history	6	Financial status/history
2	Medical history	7	Educational history
3	Family history	8	Employment history
4	Psychiatric/psychological history	9	Criminal history and legal status
5	Social/recreational history	10	Previous SUD treatment history

ASAM Criteria Dimensions	State Required Assessment Information	DSM-5 Criteria for SUD Diagnosis Justification
Dimension 1 – Acute Intoxication and/or Withdrawal Potential	• Drug and/or alcohol use history (1) • Previous SUD treatment history (10)	➢ Tolerance ➢ Needing to use more to get the same effect ➢ Using the same amount but not getting the same effect ➢ Using more or for longer than anticipated ➢ Withdrawal
Dimension 2 – Biomedical Conditions and/or Complications	• Medical history (2)	➢ Keeps using even when it is physically dangerous to do so ➢ Keeps using even though the consumer knows there are physical problems caused by/or made worse by the use
Dimension 3 – Emotional, Behavioral, and/or Cognitive Conditions and/or Complications	• Psychiatric/psychological history (4)	➢ Keeps using even though the consumer knows there are psychological problems caused by/ or made worse by the use ➢ Keeps using even when it is psychiatrically dangerous to do so
Dimension 4 – Readiness to Change	• Previous SUD treatment history (10) (as it relates to motivation and willingness for treatment) • Criminal history and legal status (9) (as it relates to severity of problems impacting desire to change)	➢ Ongoing use is impacting work, school, home; interpersonal problems ➢ Keeps using despite knowing it is causing problems ➢ Desires to discontinue, but unable to
Dimension 5 – Relapse and/or Continued Use Potential	• Previous SUD use and treatment history (10) (as it relates to number of occurrences of relapse)	➢ Desires to discontinue, but unable to ➢ Keeps using despite knowing it is causing problems or is a danger ➢ Inability to tolerate withdrawal (using to avoid withdrawals)
Dimension 6 – Recovery/Living Environment	• Family history (3) • Social/recreational history(5) • Financial status/history (6) • Educational history (7) • Employment history (8) • Criminal history, legal status (9)	➢ School, work, home situation has suffered as a result of use ➢ Not following through or taking care of responsibilities at home, school, or work because of use ➢ A lot of time and energy going towards trying to get, use, or recover from the use

The ASAM Assessment tool is required for **every** intake. *This includes for those consumers who may transition from one level of care to another within the same program (e.g. Intensive Outpatient Treatment to Outpatient Drug Free).* Therefore, each treatment episode should have, at minimum, one completed ASAM Assessment form.

BHRS ASAM FORMS

ASAM Initial Screening- This form serves for multiple functions. On the top of the form staff will see that they will be required to select either the Initial Screening and Placement, Update or Transitional Placement radio buttons.

- The" **Initial Screening and Placement**" will be used in our ACCESS 24/7 Call Log, at Court for our Court Ordered Programs when determining the level of care needs for consumers being sentenced to treatment and for youth at Juvenile Hall being screened for placement once released from Juvenile Hall.
- The **"Update"** button should be selected when assessments are being updated every 90 days along with the treatment plan.
- The "**Transitional Placement"** button should be used when a consumer is transitioning from one level of care to another. For example going from a 1.0 to a 3.1 or a 2.1 to a 1.0.

The ASAM Adult Assessment should be used for all Intake appointments on all consumers entering treatment services who are 18 and over.
The ASAM Youth Assessment should be used for all Intake appointments on all consumers entering treatment services who are 12 to 17 years of age.

How to Formulate a DSM Diagnosis

According to the DSM-5, it is a pattern of substance use that results in clinically significant impairment (minimum of 2), within 12 months:

1. Substance is taken more or for longer than anticipated
2. Have wanted to use less or stop or have tried to, but could not
3. A lot of time and energy going towards trying to get, use, or recover from the use
4. Craving to use
5. Not following through or taking care of responsibilities at home, school, or work because of use
6. Keep using even though responsibilities at home, school, or work are neglected
7. Less or stopped involvement in social, work, or pleasurable activities
8. Continuing to use even though there have been instances of it being physically dangerous
9. Knowing that the use is causing physical or psychological problems, but continuing anyway
10. Signs of tolerance – needing more than you used to in order to get the same feeling OR using the same amount you used to does not achieve the effect it used to
11. Signs of withdrawal – specific to substance or substance is taken to avoid withdrawal

TOTAL: **Mild** = 2-3 of the criteria are met **Moderate** = 4-5 of the criteria met
Severe = 6 or more of the criteria are met

Format: Due to consumer's_(symptoms of SUD), consumer_____(behaviors) resulting in_____ _____(impairment).

Example: "Due to consumer's dependency on sustaining his meth use, consumer attempted to sell a car he stole, resulting in his arrest, incarceration, and current probation status."

Think about what it is about the consumer's use of substance(s) that makes them take a particular action, which results in a significant impairment in an important area of life functioning.

How to Document the Connection between Substance Use and the Impairment

Although you may write it however you like, one suggestion is to use the following formula:

"Due to consumer's (symptoms of SUD), consumer (behaviors) resulting in (impairment/s)."

As you can see, this structure clearly shows the connection between substance use and the impairment or problem. It is important to remember that substance use alone cannot lead to the impairment or problem. For example, Susie may be drinking alcohol all throughout the day, but this fact alone does not lead to her job loss. Something occurred as a result of Susie drinking all day. Perhaps she was caught drinking at work or was often showing up late for work or not following through with her work assignments or getting into verbal altercations with her co-workers. There is a behavior that results from the use that leads to the problem. Another way to think about this is how actions lead to consequences.

These statements help to concisely document how the consumer meets medical necessity and is most helpful to use in the Rationale sections of each dimension on the ASAM Assessment form.

Sample Format to document medical necessity

"Consumer meets criteria for _____ (DSM-5 SUD diagnosis). Severity is _____(mild, moderate, severe) as he/she meets _____ (number of DSM-5 criteria for SUD diagnosis) of the criteria. Consumer endorses _____ (criteria). (Continue with all criteria). Consumer has had a pattern of problematic use over/within the last _____(duration of use).
Consumer meets medical necessity based on the above diagnosis and significant impairment in dimensions _____ (numbers with most severe risk ratings) of the ASAM Criteria. Due to consumer's _____(symptoms of SUD), consumer _____(behaviors) resulting in _____(impairment). (Continue with other dimensions with the most severe risk ratings).
Consumer is most appropriate for _____(level of care) and will need _____(services that will address consumer's problems)."

Important Reminders about the ASAM Assessment Form

- For Residential Treatment, the ASAM initial screening is to be faxed to BHRS within 24 hours for approval. The full ASAM assessment is to be submitted to BHRS within 10 days.

- For Outpatient ASAM 1.0 and Intensive Outpatient ASAM 2.1 the ASAM assessment is to be completed upon intake and signed within 3 business days per the BHRS policy.

- For all ASAM assessments at all levels of care, If the assessment is completed by a non-LPHA counselor, there must be a face-to-face consultation between the non-LPHA counselor and the LPHA who will review the assessment. This interaction needs to be documented by either the non-LPHA counselor or the LPHA to show that this consultation took place. The LPHA must then complete the Diagnosis Form within the EHR section to document the basis of medical necessity and DMS justification. The LPHA must complete and sign this within 30 calendar days of the consumer's admission.

- If the ASAM Assessment form is unable to be completed within the timeframe specified above, the reason(s) should be documented in the progress notes.

- If the ASAM Assessment form is completed over multiple sessions, the initials and date on the particular page of the assessment that was worked on should match the date of the progress note completed that documents the time you worked on it. This is to show that what was stated as completed in the progress note was actually completed on that date.

If it is discovered that a person conducting assessments has not completed ASAM A and B trainings prior to providing the assessment services, then the entire assessment service, treatment plan and all subsequent services will be considered non-compliant and will be disallowed. The corrective action would be to have someone else who has completed the required training complete an assessment (at the point at which the issue is discovered) and to put a treatment plan in place.

DISCLAIMERAbove timeframes are determined by the State as well as any internal program agreements made between the County and the State. Please keep in mind that the State sets the minimum requirements and the County can impose standards above and beyond the State's guidance.

TREATMENT PLAN

Once the ASAM Assessment has been completed, you now have the basis for building the consumer's treatment plan. The treatment plan is the consumer's roadmap for his or her time in this current treatment episode or level of care. The risk ratings that are indicated for each dimension of the ASAM Assessment form will help you to identify and prioritize the areas that need to be addressed in treatment. If a consumer has a problem in every dimension, this does not necessarily mean that every problem must be treated. We must take into account what will be feasible for the consumer as well as what the priorities are for the consumer. In order to develop a meaningful treatment plan, it must be a collaborative process that includes the input of the

consumer. In the progress note for the session in which you collaborated with the consumer on the treatment planning process, it can be documented as to why a particular area will or will not be addressed on the treatment plan.

The following are the four required components of a treatment plan:

- Statement of the Problem
- Statement of the Goal
- Objectives / Interventions (Also Known As Actions Steps)
- Target Dates

Statement of the Problem

These are based on the dimensions with the highest risk ratings that will need a goal on the treatment plan. Since treatment planning is a collaborative process with the consumer, it is important to explore with the consumer what problems he or she would like to resolve or what he or she is looking to achieve. What the consumer expresses may or may not be related to substance use ("I want to be a rock star" versus "I want to get clean"). With a statement that seems unrelated to substance use, it will then be our job to work with the consumer on breaking it down to what has been identified as the key problems in the assessment process.

Key Notes:

- Anything listed on the ASAM Assessment with a Risk Rating of 1 or higher must be on the treatment plan.
- For BHRS ASAM 1.0 and 2.1 levels of care, Within the Problem Statement of the Addiction Narrative, BHRS staff must include the DSM Diagnosis code, Diagnosis Name listed out along with the ICD-10 Code / ICD-10 Name as well as list the "Primary Counselor".

Statement of the Goal

The goal is the broken down, more manageable piece of the problem that we will address in this treatment episode. So, given the identified problem that corresponds to the dimensions of the ASAM Assessment form, we will want to determine "what do we need to work on first to get you to where you want to be?"

A formula for writing a goal statement such as the one below can be used as an option to guide you:

"In the next_____(timeframe), consumer will_____(behavior change desired)) from_____ _____to_____(baseline and target) in order to (how it addresses the problem)."

OBJECTIVES (BHRS Outpatient)

Objectives are what the counselor and/or the consumer will do to work towards achieving the identified goal. The objectives should refer to the behaviors, related to the identified symptoms that the consumers will demonstrate in their move towards recovery (ie: "What the consumer will do")

Example Formula:

"In the next_____(timeframe), consumer will_____(behavior change desired)) from____ _____to_____(baseline and target) in order to____(how it addresses the problem)."

"Consumer will (increase/decrease) (*symptom)* as demonstrated by (*behavior)* from (*x* to *x)* within (*x) (*days/weeks/months) in order to _____ (how it addresses the problem)".

INTERVENTIONS (BHRS Outpatient)

The interventions should be the specific methods or activities that the AOD Counselor/LPHA will offer and/or facilitate to support the consumer's recovery (ie: "What the AOD Counselor/LPHA will do"). It needs to include the type of service that will be provided and by whom so that it is clear what service our program is capable of providing and is being authorized. It also needs to include the frequency of the service or how often it will be provided.

Interventions must be clinical and within the scope of practice of the individual who will be providing it. It should also be written with enough specificity to provide an outside reader with a good idea of what will be provided. For example, saying that "The counselor will provide individual counseling to help consumer manage cravings" is pretty vague. It begs the question, "*How* will you help the consumer to do this?" The "how" is what distinguishes the counselor from the layperson because the counselor can provide clinical interventions based on his or her education and training on how to treat consumers with a substance use disorder. A better intervention would be, "The counselor will provide individual counseling to educate consumer on the physiological and psychological effects of addiction," or "The counselor will provide individual counseling to help the consumer identify changes in thoughts, feelings, and behaviors associated with the experience of cravings."

Example Formula:

Staff will provide _____ to address (behaviors), (x) times per (week/month/quarter).

TARGET DATES

The target date is the anticipated date of completion for the particular goal. In the past, target dates were considered to be program-specific or generally, the length of the particular program. However, with the shift of treatment being more consumer-centered, the target date is now reflective of the likelihood of achievement for that consumer. It will be dependent on a variety of factors like the consumer's capabilities or level of motivation. This also means that there is no need for identifying specific short and long-term goals.

Important Reminders about the Treatment Plan

1. For Residential Treatment, it is to be completed, signed, and dated within 10 calendar days of the consumer's admission.
2. For Outpatient 1.0 and Intensive Outpatient 2.1, it is to be completed, signed, and dated within 30 calendar days of the consumer's admission.
3. If the treatment plan is completed by a non-LPHA counselor, the LPHA must review, sign, and date this within 15 calendar days of the counselor's signature.
4. The primary counselor's name must be indicated on the treatment plan.
5. For Residential Treatment, the consumer must review, sign, and date the treatment plan within 10 calendar days of the consumer's admission.
6. For Outpatient 1.0 and Intensive Outpatient 2.1, the consumer must review, sign, and date the treatment plan within 30 calendar days of the consumer's admission.
7. If the consumer refuses to sign or was unable to sign the treatment plan, **it should be documented in the progress note along with a plan for how to engage the consumer to participate in treatment.**
8. If the treatment plan is unable to be completed within the timeframe specified above, the reason(s) should be documented in the progress notes.
9. The consumer's diagnosis or diagnoses **must** be on the treatment plan and must match what was indicated within the assessment and listed on the diagnosis form.

DISCLAIMER
Above timeframes are determined by the State as well as any internal program agreements made between the County and the State. Please keep in mind that the State sets the minimum requirements and the County can impose standards above and beyond the State's guidance.

CONTINUING SERVICES JUSTIFICATION & TREATMENT PLAN REVIEW

As we know, treatment does not happen in a bubble. Life still happens and circumstances change. All while the consumer is going through their own change process in respect to their substance use. Clinically, we know that an assessment is not final once the treatment plan is created. Assessment is ongoing. We want to continue to assess (i.e. reassess) the consumer for changes in need. This too is a part of individualizing services to the consumers. For Naltrexone Treatment Programs, Intensive Outpatient Treatment, and Outpatient Drug Free levels of care,

the way that this will need to be documented is on the Continuing Services Justification form. Although we are looking at the consumer's progress in treatment on a regular basis, we need to have documentation that the consumer is being reassessed using the ASAM Criteria. WHY? It is a quality check to make sure that we are addressing the consumer's needs, taking into consideration their progress or lack of progress and any new issues that may have come up in their lives that may impact their recovery. This documentation helps to show that we are in tune with how the consumer is doing and what the consumer needs. Is it clinically appropriate for the consumer to continue on the course of treatment he/she has been on? Or do we need to change our approach or maybe even the program and level of care to meet the individual needs of the consumer?

WHEN DOES IT NEED TO BE DONE?

For Intensive Outpatient and Outpatient Drug Free, the first Continuing Services Justification form will need to be completed 90 days from the date of the consumer's admission to treatment and every 90 days thereafter. For the Residential Treatment, the first Continuing Services Justification form will need to be completed 30 days from the date of the consumer's admission to treatment and every 30 days thereafter.

DISCLAIMER
Above timeframes are determined by the State as well as any internal program agreements made between the County and the State. Please keep in mind that the State sets the minimum requirements and the County can impose standards above and beyond the State's guidance.

WHAT NEEDS TO BE IN THE CONTINUING SERVICES JUSTIFICATION?

The following are the required elements for justifying continuing services for a consumer:

- Consideration of the consumer's personal, medical, and substance use history.
- Whether the consumer has received a physical exam. If so, there is a copy in the chart.
- Taking into account the consumer's progress on treatment plan goals based on progress note documentation.
- Consideration of the LPHA or counselor's recommendations.
- Statement about the consumer's prognosis.

If the form is completed by a non-LPHA counselor, the LPHA will need to review, document the basis for the need of continued services, and sign to show that the consumer meets medical necessity for the level of care indicated. If, upon review, the LPHA finds that the consumer does not meet medical necessity, the consumer will need to be discharged and arrangements made for alternative care or resources. Or the situation may be that the consumer does not meet criteria for the current level of care, in which case, arrangements will need to be made to transfer or refer the consumer to the appropriate level of care.

DOES A NEW TREATMENT PLAN NEED TO BE CREATED?

Yes. In conjunction with the Continuing Services Justification form, there will need to be a treatment plan review and update. The information obtained for the Continuing Services Justification form will provide guidance on what changes, if any, need to be made on the

consumer's treatment plan. The primary counselor and the consumer will work together to review progress and discuss whether the goals are still relevant or if modifications are needed. For example, if there is no progress made on a goal, perhaps the frequency needs to be changed, interventions modified, and the target date re-set. Or it may be more appropriate to create a brand new goal that will better serve the consumer. There may even be situations where the consumer has acquired new areas of need since the time of admission that needs attention and should be added to the treatment plan. Even if there are no changes and the same goals still apply, we must show that the consumer's needs were reassessed and that the appropriateness of the treatment plan was taken into consideration. New signatures will need to be obtained to show that this was discussed and collaborated on with the consumer. Once the counselor and the consumer establish an updated treatment plan, it will need to be signed by the consumer within 30 calendar days from the counselor's signature. If the consumer refuses to sign the treatment plan, this needs to be documented. We also need to document what our plan is for trying to engage the consumer and get the signature in the future.

If the update to the treatment plan is done by a non-LPHA counselor, it must be reviewed by an LPHA to determine whether continuing services are medically necessary. If approved, the LPHA needs to sign the updated treatment plan within 15 calendar days of the counselor's signature.

PROGRESS NOTES

Per state guidelines all progress notes shall include:

- The topic of the session or the purpose of the session
- Description of the progress or lack of progress towards treatment plan
- Date of service with the actual start and end time of the session and if a break was provided that must be documented in the note.
- Identify if the services were provided in person, by phone or by telehealth
- Identify whether the services were provided in the consumers preferred language and if there was an interpreter/ CyraCom/ ATT Language line used, please ensure you document that as well.
- If the service was provided in the community, identify the location and how the provider ensured confidentiality.
- The LPHA and/or AOD Counselor shall print and sign their name.
- Progress notes shall be completed within 3 days per department policy and will be unbillable within seven days per the state requirements.
- Signatures shall be adjacent to the typed or legibly printed name.
- For Residential Services progress note must address the residential services that were provided each day.

The BIRP format for progress note documentation is shown below. Please consult with your county administrator for documentation styles indicated for your facility. BHRS will monitor providers based on BIRP unless otherwise agreed upon by a particular provider.

B	Behavioral	• Topic or purpose of the session • Goal(s) from the treatment plan that will be addressed in this session
I	Intervention	• Description of what the counselor did to help the consumer towards the goal of the session and goal(s) on the treatment plan • Clinical, within the scope of practice of the individual providing it • Related to the SUD
R	Response	• Description of how the consumer responded to the counselor's interventions • Stay objective and state the facts
P	Plan	• Description of what will be addressed in the next session • Can include any follow up that may be needed prior to the next session and/or miscellaneous information about stage of change, new problems, overall progress • toward treatment goals

BIRP NOTE EXAMPLES

Individual Counseling Progress Note

B: Consumer seen today at the clinic to address her SUD symptoms (alcohol use) and how they interfere with her being active in the community: socializing, working, shopping, etc.
I: Writer processed with consumer about ways to cope with her feeling "on edge" and restless due to triggers of being in social situations and large crowds of people. Role played situations in which consumer is able to manage triggers using visualization and relaxation techniques of deep breathing and grounding. Encouraged her to continue to practice applying these skills at least 2 times per day so that when she is presented with a trigger, she can readily access techniques.
R: Consumer was able to process about possible coping skills with some prompting. As the session progressed she became more at ease and showed reduced psychomotor agitation (stopped tapping foot). She seemed to enjoy the role play and stated that she likes noticing "feeling lighter" after using the relaxation techniques of deep breathing and grounding. Consumer initially expressed low confidence in her abilities to utilize techniques on her own, but agreed that regularly practicing them outside of the moments when she is triggered will help her to use them more easily.
P: Consumer will continue to practice coping skills 2 times per day. Next session to follow up on her independent use of coping skills as well as to process any actual instances of being triggered and how it is managed. Consumer seems to be gaining more self-awareness and making slight progress towards her treatment plan goal to increase use of coping skills to manage triggers.

Case Management Service Progress Note

B: To meet with the sober living manager in an effort to coordinate services to help consumer to improve relationships with other residents and prevent loss of housing that could threaten recovery efforts.
I: Spoke with sober living manager about consumer's recent verbal altercation with another resident. Also inquired about his general observations of consumer's behaviors and potential risks to sobriety.
R: Consumer was not present for this service. Sober living manager reported that consumer is particularly agitated around one of the residents and sees that he often avoids interacting with him. He acknowledged that he does need to intervene at times to prevent escalation of conflict between the two, but on most recent encounter, consumer seemed to be instigating. Sober living manager expressed frustration with consumer and possibility that he may not be a good fit for the house. Sober living manager shared that consumer seems to need help managing his anger and impulsivity, saying that he has some concern that these may prompt consumer to return to using.
P: Follow up with sober living manager over the next few weeks for monitoring of changes in consumer's behaviors and interactions with peers. Plan for next session with consumer is to develop strategies for maintaining a conflict-free home environment and discuss its benefits to his recovery. Coordination of care continues to be needed to help consumer make progress towards his treatment goal to reduce altercations with others that perpetuate behaviors associated with use.

Group Counseling Service Progress Note

B: To encourage discussion around the behavior of lying during substance use and allow the group to reflect on its effects and what it means to live a more honest life in order to help consumer maintain sobriety.
I: This writer explored with the group the importance of honesty in recovery. The group was encouraged to give input on what honesty in recovery means for them. This writer discussed how lying is a significant behavior in the life of an individual using substances and how it evolves over time. This writer helped normalize common thoughts and feelings surrounding the act of lying during use and how it changes with the stopping of use. Group members were asked to share personal experiences of what has helped them to break out of the cycle of lying after use and manage feelings of guilt that may remain after use has stopped. In closing, this writer had group members identify what new opportunities and positive outcomes have come about from embracing honesty in their recovery journey.
R: Consumer was more withdrawn in this session than usual, but participated with prompting. Consumer was able to share that he continues to feel guilty for lying to his family during his use. Consumer seemed to be listening and reflecting on what his peers shared. Consumer was more engaged towards the end of the session and verbalized that he wished to continue to work on being honest with himself and others, but that it was still difficult at times to face the feelings without using so that he does not have to feel difficult emotions.
P: For consumer to continue to engage in groups and work towards increasing self-awareness and verbalization of thoughts and feelings. Consumer seems to be making adequate progress toward his goal to effectively communicate his needs so that he does not bottle up emotions, which is a prominent trigger for him to use.

Using the BIRP format, the following are required elements that need to be in the content of each note:

1. Topic or purpose of the session or service
2. The date of the session and the start and end times
3. A description of the consumer's progress toward the treatment plan goals
4. Whether the service was provided in-person, by telephone, or telehealth
5. If services were provided in the community, the location must be identified as well as an explanation as to how the consumer's confidentiality was protected in that setting

At least one of the following must also be included:

1. A description of the consumer's progress toward the treatment plan goals
2. The consumer's attitude towards change
3. Any new issues or problems that need to be addressed
4. The types of support or interventions that were provided
5. A Plan for the upcoming session

DO I HAVE TO WRITE DOWN EVERYTHING THAT HAPPENED IN THE SESSION?

No. We want to protect the consumer's privacy and confidentiality so we do not need to write everything that happened or was said. It is about quality over quantity. Remember that the primary purpose of a progress note is to document the service provided. It is not only necessary for maintaining a good clinical record according to standard practice, but also necessary for reimbursement. It is a record of what we are doing to help the consumer make progress toward his or her treatment goals. Therefore, it must tie back to the substance use and effectively show how the service is necessary to address this. Medical necessity must be evident and should be the focal point of the documentation. Keeping this in mind will help focus the content of the progress notes and keep your notes clear and concise.

HOW MUCH TIME DO I HAVE TO GET MY PROGRESS NOTE DONE?

Progress notes must be completed and signed within 3 calendar days of the session. Date of the session counts as day one and anything written after the 7th day is not able to be billed to Medi-Cal. If a note is written and signed beyond the 7 days, the note will need to be made non-compliant. If you are documenting a late note after 3 days, it should start with (Late Note for xx/xx/xx). The date entered should be the date that the service was provided.

OTHER COMPONENTS OF A PROGRESS NOTE:

Face-to-Face Time is time with the consumer, in person. If the session or service was provided by telephone, there would be no face-to-face time.

Non-Face-to-Face Time is billable time spent on a service activity that does not include interaction with the consumer.
Example: Analyzing information to determine risk rating levels for the dimensions of the ASAM Criteria outside of the session with the consumer. The time spent working on this is billable.

Service Time is the total time (face-to-face and/or non-face-to-face, travel, and documentation) that is billable.
Example: 45 minutes of face-to-face time with the consumer in a session to obtain information on family, educational/vocational, legal, and social history. 45 minutes of non-face-to-face time spent after session, without the consumer, working on conceptualizing the level of risk for dimension 6 of the ASAM Assessment. The service time would be 90 minutes.

Documentation Time is the time it took to complete the progress note. This should never exceed the length of the session and should correspond to what is reasonable in comparison to the interventions provided. This does not include typing or writing speed. It also does not include technical difficulties. If the computer freezes and it took 10 minutes to restart and get back to the note, this time cannot be accounted for in the documentation time.

Travel Time is the time it takes to travel from one location to another to meet with consumer or provide a service. Transporting a consumer does not count for this. If solely transporting a consumer from point A to point B, this time is non-billable (Medi-Cal will not reimburse for us to simply drive a consumer places). However, if during the course of transporting the consumer from point A to point B, some billable service is provided (such as discussing recent response to triggers and use of coping skills), this is considered Service Time because you provided a service. It may be helpful to think of travel time as time in the car ***without*** a consumer and transportation time as time in the car ***with*** a consumer when there is no service being provided.

- *Billable Travel Time* is time that can be billed when providing a billable service.
- *Non-Billable Travel Time* is when billable services are not provided or if solely transporting the consumer (e.g., picking up a consumer to take to a doctor appointment).

CALOMS

In order to fulfill the federal mandate that substance abuse treatment programs provide outcome data, Merced County Behavioral Health and Recovery Services (BHRS) shall ensure that BHRS staff and contract providers of substance abuse treatment services in Merced County shall process California Outcomes Measurement System (CalOMS) data forms accurately and in a timely manner. CalOMS treatment data submissions shall be submitted to DHCS no later than 45 days from the end of the last day of reporting. Late submissions are not to exceed 5% for each reporting month.

Admission Form

The clinical staff at the treatment program shall complete the *CalOMS Admission Form* when the consumer presents for program admission.

a. All questions on the form shall be completed. Any questions that cannot be answered by consulting the CalOMS Tx Data Collection Guide can be directed to the designated staff services analyst or program manager.
b. The clerical staff shall ensure that the form has been completed correctly.
   - If the form has not been completed correctly, the clerical staff member shall return the form to the assigned clinical staff for correction.
   - If the form has been completed correctly, the *Admission Form* shall be input in the CalOMS Data Collection System within two business days of receipt.
c. Following input, the completed *Admission Form* shall be filed in the consumer's chart.
d. When all data entry is completed please make sure you final approve the document.

Annual Update

All programs that provide services lasting longer than twelve months shall need to complete an *Annual Update*. The *Annual Update* may be completed by the clinical staff no earlier than sixty days prior to the consumer's admission annual date and no later than the consumer's admission annual date.

a. All questions on the form shall be completed. Any questions that cannot be answered by consulting the CalOMS Tx Data Collection Guide can be directed to the designated staff services analyst or program manager.
b. The clinical staff shall forward the completed form to the clerical staff within the allocated timeframe for entry into the CalOMS Data Collection System.
c. The clerical staff shall ensure that the form has been completed correctly.
- If the form has not been completed correctly, the clerical staff shall return the form to the primary clinical staff for correction.
- If the form has been completed correctly, the updated *Annual Update* shall be input in the CalOMS Data Collection System within two business days of receipt.

d. Following input, the completed *Annual Update* shall be filed in the consumer's chart.
e. When all data entry is completed please make sure you final approve the document.

Discharge Form

a. Clinical staff shall complete the *Discharge Form* as part of the consumer discharge process. See Discharges policy (ADD1.45) for more information on discharges.

b. For consumers who have either completed or left before completion, but received a program referral, all CalOMS questions must be completed.
c. For consumers who left the program prior to completion and received no referrals or for consumers who were incarcerated or deceased, consult the CalOMS Tx Data Collection Guide (pages 102-105) for clarification.
d. Any questions that cannot be answered by consulting the CalOMS Tx Data Collection Guide can be directed to the designated staff services analyst or program manager.
e. Because CalOMS discharges must be dated based on the last face to face it is very important that these are completed timely to ensure they fall within the 45 days period.
f. The program clerical staff shall ensure that the form has been completed correctly.
   - If the form has not been completed correctly, the program clerical staff shall return the form to the clinical staff for correction within the same business day.
   - If the form has been completed correctly, the *Discharge Form* shall be input in the CalOMS Data Collection System within two business days of receipt.
   - Following input, the completed *Discharge Form* shall be filed in the consumer's chart.
   - When all data entry is completed fully please make sure you final approve the document.

Timeliness

CalOMS records are due to the State 45 days after the end of the month. To know when something is due, use the following approach:

- **Admissions:** Add 45 days to the last day of the month in which the admission is dated. For example, any admission in January is due 45 days after January 31

- **Annual Updates:** Add 45 days to the last day of the month in which the Annual Update is dated. Do NOT backdate. The CalOMS Data Collection Guide indicates the Annual Update should be dated the day it was actually done. Back-dating the record to the Anniversary Date will almost always result in a late record. As an example, any Annual Update in January is due 45 days after January 31. If the Anniversary Date were in November, the Annual Update would have been due 45 dates after November 30. Using the Anniversary Date would not only reflect the wrong date of collection, but would make the CalOMS record several months late.

- **Discharges:** Add 45 days to the last day of the month in which the discharge (aka last face-to-face contact) is dated. This one gets tricky. Since the CalOMS Data Collection Guide requires the last face-to-face contact, you actually have less time to complete this record. For example, if today is January, but the last face-to-face was in December, the record is due 45 days after December 31 and NOT 45 days after January 31.

CalOMS allows up to 30 additional days for resubmissions, which occurs when information that was transmitted (and accepted) is revised, such as updating an SSN, DOB, or response to a CalOMS question.

Helpful Hints

1. Changing the Admission Date on an Assignment does not change the CalOMS Admission record. It can actually create a duplicate record on the Open Admissions report.
2. Merging Clients can be problematic. The system only retains the CalOMS transactions for one client. In the event that both records have CalOMS information, the CalOMS records may need to be voided and resent to avoid duplication
3. Monitoring of the Open Admissions happens on the county end. We only know which clients are open/closed in the system, not which clients should actually be open/closed to services.
4. Action Schedules (in Cerner) or the Open Admissions Report (BHIS) can be used to track Annual Update due dates. There is no other system report that does this. The Client Action Schedules/Notifications Reports are the available options in the Cerner solution (if configured)
5. Overlapping Types of Service are not allowed. A client is not allowed to be open to the same type of service (e.g. Outpatient, Intensive) with different providers. When this happens in the Cerner product, CalOMS records may inadvertently not be sent.

Note: Recent ODS documentation may imply otherwise, but this note/hint is based upon the Cerner Design Document and CalOMS Data Collection Guide which both indicate service types, particularly the same type, should not overlap.

CODES & SERVICES

In this next section, we will take a look at the different codes that correspond to the type of service that can be provided. Broadly, the services we provide to our SUD consumers fall under either individual counseling, case management, or group counseling.

DOES THIS MEAN THAT I CAN'T BILL FOR SERVICES IF I HAVEN'T CREATED THE TREATMENT PLAN YET?

No. In order to truly attend to the individual consumer's needs, there will be times when services need to be provided to the consumer before his or her treatment plan is created (or during the 30 day window between admission to treatment and when the treatment plan is due for an outpatient program, for example). In such cases, the services can be billable as long as the documentation for that service justifies medical necessity. In other words, the progress note for that session or service will need to show how that service was necessary for addressing the consumer's SUD and impairments.

Intake- Code 308

The following are billable intake activities:

- Gathering psychosocial information for the ASAM Assessment

- Interviewing the consumer about his or her substance use and its impact on functioning
- Formulating a DSM-5 diagnosis
- Determining the appropriate level of care

I HAVE TO WRITE A LOT FOR THE ASAM ASSESSMENT, CAN I BILL FOR THAT?

We cannot bill for simply "completing the ASAM Assessment form," so we would want to avoid words like "writing" or "typing" that may make it sound like we are doing the clerical aspect of the assessment. Clerical tasks are **not billable** to Medi-Cal. The "completing" of the ASAM Assessment form needs to show that it took a counselor to do this and that some level of clinical judgment was required. Therefore, we want to use words like "formulating," "synthesizing," "conceptualizing," etc.

MY CONSUMER HAS A LOT OF PAPERWORK FROM OTHER AGENCIES THAT I NEED TO REVIEW. CAN I BILL FOR MY TIME?

"Reviewing," "reading," or "referring to" another document (i.e., discharge paperwork, psychological evaluation, previous assessment, progress notes, etc) is also **not billable**. These can be noted in the progress note, however, it needs to be made clear that the time spent on it was not billed for. For example, "time spent on reviewing assessment from previous treatment center not billed for."

I WORKED ON THE ASAM ASSESSMENT OVER MULTIPLE SESSIONS. HOW DO I DOCUMENT IT?

Here is where the initials and date on each page of the ASAM Assessment form becomes important. If the counselor worked on Dimensions 1 and 2 on pages 2-4, the initials/date on those pages should match what is documented on the note. The corresponding progress note may indicate, "This Counselor obtained information from consumer about Dimensions 1 and 2 (pages 2-4) on the ASAM Assessment…" If the initials/date indicate those pages were done on 11/11/17, then the corresponding progress note on 11/11/17 should document the counselor's work on this part of the assessment.

WHAT ABOUT ASSESSING FOR DANGER TO SELF (DTS), DANGER TO OTHERS (DTO), AND GRAVE DISABILITY (GD)?

Risk assessments, such as for DTS, DTO, and GD do not fall under Assessment. Unless it was during a session where the counselor was working on the assessment. In that case, the documentation for the risk assessment should be included in the progress note for that assessment session or service. But the risk assessment alone does not necessitate a separate document as an assessment note. For example, if during a

regularly scheduled individual counseling session, the consumer discloses thoughts about self-harm that requires further evaluation to determine intent, means, and plan, it would be documented in the individual counseling session progress note.

Since assessment is ongoing and can be done at any point in the treatment process and applies to all consumers, the service does not need to be specifically identified on the treatment plan.

ASSESSMENT –Code 309

For consumers that are screened while in custody or when an individual comes in for an intake and is found to not meet medical necessity, please make sure to change your service code to 309 Assessment so that this does not bill Drug Medi-Cal and does not bill the client.

CRISIS- Code 306

The following are billable crisis activities:

- Relapse
- Unforeseen event/circumstance presenting an imminent threat of relapse

The focus of the session or service is on alleviating the crisis problem and limited to the stabilization of the consumer's emergency situation. The above example of a consumer who discloses thoughts of self-harm perhaps through overdose during a regularly scheduled individual counseling session would constitute a crisis if it is determined that the consumer is at imminent threat of relapse. If the counselor were to receive a phone call from the consumer who states that he or she has just been kicked out of the home and is reporting thoughts and plans to relapse, this would be considered a crisis situation. It would now require the counselor to stop what he or she may be doing to address this situation and de-escalate the consumer to prevent relapse. Another type of situation may be where the counselor is called out to the consumer's place of residence because the consumer has relapsed. The activities involved with arranging potential medical attention and prevent ongoing use would be considered crisis intervention activities.

DURING OUR SESSION, MY CONSUMER DISCLOSES THOUGHTS OF HARM TO OTHERS. IS THIS A CRISIS?

Not necessarily. Thoughts of harm to others does not, by itself, necessitate a crisis intervention. Additionally, since it happened during the course of a regular session, the risk assessment is just a part of that session. Standard procedures for assessing risk would be followed (i.e. determining the lethality based on whether there is intent, a plan, and means). Obviously, if the consumer is truly a danger to others based on assessment, the protocol for getting immediate help will need to be followed. If this is related to the substance use because it poses "an imminent threat of relapse," it is

billable as crisis intervention. “Imminent threat of relapse,” means that relapse is likely within the next few hours if there is no intervention.

I WENT TO THE CONSUMER’S HOUSE BECAUSE HIS MOM SAID HE WAS RELAPSING, BUT WHEN I GOT THERE, HE WAS NOT. IS THIS STILL A CRISIS NOTE?

Crisis intervention can be billed up to the point that the counselor determines that the situation is no longer a crisis because the intent of this service is to stabilize the situation. The frantic call from the mother of the consumer, travel to the consumer’s home to address the potential crisis, and the assessment to determine the nature of the crisis would be billed as crisis intervention. Upon assessment of the consumer, where the counselor decides that the situation is no longer a crisis (i.e. no actual relapse and/or no imminent threat of relapse), the billing for this service would stop. Additional work done after this point (for example, speaking with the mother and the consumer together to process the situation and work on effective communication around potential relapse issues or triggers) would become a different type of service (in the prior example, it would be a family counseling session).

Crisis intervention does not need to be a service that is specifically authorized on the treatment plan because it is available to any consumer at any time it becomes necessary.

Crisis intervention services can be provided in-person, by telephone, or by telehealth.

TREATMENT PLANNING- Code 303

The following are billable treatment planning activities:

- Collaborating with the consumer on problems, goals, action steps, and target dates for the treatment plan
- Developing an individualized treatment plan based on assessment information gathered
- Reviewing and/or updating the treatment plan goals

It will be helpful to think of determining needs and services as two different tasks. All information related to addressing the needs of the consumer and what he or she will work on while in treatment is considered treatment planning. The aspect of determining what services would best accommodate those needs, is considered case management.

Since treatment planning can happen at any time, even after a treatment plan has been established, it does not require a specific authorization on the treatment plan.

Treatment planning services can be provided in-person, by telephone, or by telehealth.

** Helpful Reminders

Revising the Treatment Plan = Revising the treatment plan refers to changing a Treatment Plan prior to the End Date.

Reviewing the Treatment Plan = Reviewing the Treatment Plan refers to reviewing the consumer's progress and adding a subsequent Treatment Plan period.

Billing for Completion of the Treatment Plan: In order to bill for the Treatment Plan, a new individual progress note must be completed. You can bill for treatment plans using the appropriate service code if the consumer was present, they participated in the revision/update of the treatment plan in which new problems, goals, objectives and interventions were identified and documented. You cannot bill for a treatment planning session if the consumer was not present, if you are making minor changes to the treatment plan such as modifying dates or adding/correcting information that does not have a significant impact in the change of service delivery.

COLLATERAL – Code 300

The following are billable collateral activities:

- Sessions with other therapists or counselors
- Sessions with significant people in the consumer's life

Session with other therapists or counselors within the same agency or program would be like a consultation to discuss course of treatment or changes in the consumer's presenting problems, for example. This does not include clinical supervision.

Significant persons are those who have a personal, not official or professional, relationship with the consumer. The focus of the session or service is on the treatment needs of the consumer and what would support the consumer in achieving his or her treatment goals.

Collateral services can be provided in-person, by telephone, or by telehealth. Collateral services can be provided with or without the presence of the consumer. Collateral services do need to be identified as a specific service on the treatment plan.

FAMILY THERAPY – Code 301

Only an LPHA working in their scope of practice can provide this service. The following are billable family therapy activities:

- Family therapy brings the family into the treatment process to identify unhealthy family dynamics that enable the addiction to continue. As unhealthy behaviors are identified, families can then work on positive and healthy interactions with each other. Family therapy can continue long after treatment is completed through referrals to licensed practitioners. Family therapy is a self-discovery process for the entire family unit and does not focus solely on the needs of the beneficiary.

Family therapy services can be provided in-person, by telephone, or by telehealth. Family therapy services can be provided with or without the presence of the consumer. Family therapy services **do need to be identified** as a specific service on the treatment plan.

WHAT IS THE DIFFERENCE BETWEEN COLLATERAL SESSIONS AND FAMILY COUNSELING?

Collateral sessions involves counselors meeting with a consumer's family or significant others that can support their treatment needs. This service focuses on the treatment needs of the consumer, and how loved ones can support the consumer during treatment and their recovery process. These services are mostly educational or information gathering process.
Family therapy is a therapeutic process that can also address the needs of the family and the larger, systemic issues contributing to the substance use or hindering the consumer's recovery.

INDIVIDUAL COUNSELING- Code 301

The following are billable individual counseling activities:

- Working with the consumer on skill-building for the purposes of maintaining sobriety and relapse prevention
- Educating the consumer on issues related to substance use, such as concepts of withdrawal, recovery, an alcohol and drug-free lifestyle
- Increasing the consumer's awareness and understanding about the recovery process and utilization of supports like becoming familiar with related community resources
- Interventions provided in an individual counseling session must be within the scope of practice of the counselor providing the service. If Evidence-Based Practices (EBP's) are referenced, it should be clear how it is addressing the consumer's treatment goals in order to individualize the treatment to the needs of the consumer.

Individual counseling services can be provided in-person, by telephone, or by telehealth.

INDIVIDUAL/GROUP COUNSELING:					
Assessment:	*Tx Planning:*	*Crisis:*	*Individual/family/group:*	*Collateral:*	*DC Planning:*
Asked	Analyzed	Assessed	Acknowledged	Consulted	Developed
Assessed	Created	Assisted	Assisted	Collaborated	Discussed
Ascertained	Developed	Attempted	Attempted	Coordinated	Explored
Attempted	Established	Coordinated	Challenged	Shared	Reviewed
Clarified	Formed	De-escalated	Coached	Exchanged	Formulated
Determined	Formulated	Empathized	Discussed	Discussed	Established
Developed	Generated	Empowered	Demonstrated	Reviewed	Set
Elicited	Produced	Ensured	Described	Prepared for	Prepared
Evaluated	Synthesized	Evaluated	Empathized	Planned	Revised
Explored		Facilitated	Educated	Developed	Coordinated
Formulated		Focused on	Elicited	Inquired	Collaborated
Gathered		Fostered	Empowered	Asked	
Gauged		Helped	Encouraged	Questioned	

Inquired Obtained information about… Probed Questioned Reviewed Synthesized		Intervened Monitored for Obtained Offered Promoted Provided Reassured Recommended Responded to Stabilized Supported Showed	Engaged Explained Explored Expressed Fostered Helped Introduced Inquired Maintained Modeled Motivated Normalized Offered Practiced Processed Prompted Promoted Provided Recommended Redirected Reinforced Reiterated Reviewed Role played Shared Supported Showed Taught Validated Verbalized	Followed up Elicited	

DISCHARGE PLANNING- Code 305

The following are billable discharge planning activities:

- Collaborating with the consumer on creating the discharge plan
- Discussing plans for post-discharge and reintegration back into the community
- Preparing the consumer for referral into another level of care

There are two ways that you will document discharges. You with either use a discharge plan or a discharge summary.

Discharge Plan

A discharge plan is when the consumer is being discharged and is present in the office.

Discharge plans should be completed within 30 days prior to the date of the last face to face with the treatment provider, signed by the consumer and the consumer should be given a copy of the plan. The discharge plan should also include the following:

- A description of the clients relapse triggers and a plan for the clients to avoid relapse when confronted with each trigger.
- A support plan
- Current alcohol and/or other drug usage.
- Vocational and educational achievements.
- Legal status.
- Reason for discharge and whether the discharge was involuntary or a successful completion.
- Consumer's continuing recovery, support plan and treatment exit plan.
- Transfers and referrals.
- Consumer comments.
- Consumer's prognosis.

Discharge Summary

A discharge summary shall be completed when a consumer loses contract with the program. The discharge summary should be completed within 30 calendar days of the providers last face to face treatment contact with the consumer and should include at a minimum of the following:

- Duration of the consumers treatment as determined by the dates of admission and the dates of discharge.
- The reason for discharge
- A narrative summary of the treatment episode
- The consumers prognosis

DISCHARGE PLANNING STARTS AT ADMISSION!

No matter the level of care the consumer is at, the eventual goal is to help the consumer on his or her path to returning to the larger community as a productive member without the need for the support of treatment services. Within each level of care, we are working to help improve the consumer's functioning enough to prepare the consumer for the transition to a less restrictive setting. Therefore, as soon as the consumer enters treatment, we should be looking at how we are going to help them transition out of treatment.

By working collaboratively with the consumer on this, will also serve to help the consumer become more self-sufficient and avoid treatment dependence when the time does come for a planned discharge. Additionally, the reality is that we never know when our last contact with our consumer will be. The consumer may leave prematurely after two months of treatment or two days. It is good practice to start the work of preparing for discharge in the early stages of treatment. It should be an ongoing discussion and having a document that the consumer can reference is a great tool for them.

CASE MANAGEMENT – Code 307

The following are billable case management activities:

- Assessment and reassessment of case management needs
- Transition to a higher or lower level of care
- Developing and/or revising services on a treatment plan
- Communication, coordination, referral activities
- Monitoring service delivery to ensure access
- Monitoring the consumer's progress
- Advocacy and linkages to physical and/or mental health care, transportation, etc.

The focus of case management is on the coordination of care for SUD and integration around primary care. Our consumers with a chronic substance use disorder and/or involvement with the criminal justice system are likely going to need greater case management services.
Keep in mind that the case management needs must be related to the substance use in order for the service to be billable to Medi-Cal. This will need to be clearly documented in the progress note. Case management services do need to be identified as a specific service on the treatment plan. Case management services can be provided in-person, by telephone, or by telehealth.

CASE MANAGEMENT:					
Advised	Collaborated with	Devised	Followed up	Inquired	Referred
Aided	Communicated	Directed	Furnished	Instructed	Reinforced
Answered	Connected	Discussed	Guided	Linked	Reminded
Arranged	Consulted	Educated	Helped	Offered	Reviewed
Assigned task	Contacted	Encouraged	Helped plan	Planned	Set up
Assisted	Coordinated	Explained	Highlighted	Prepared	Suggested
Attempted	Demonstrated	Explored options	Identified	Provided	Talked about
Checked in	Developed	Facilitated	Informed	Recommended	Worked on

GROUP COUNSELING- Code 302

Group counseling services must be provided face-to-face with a minimum of 2 and a maximum of 12 consumers. One of those consumers must be a Medi-Cal beneficiary in order for the group to be billed to Medi-Cal. More than one therapist or counselor is allowed in the group, however, this does not allow for changes to the maximum number of consumers allowed in the group.

Groups will be limited to 12 participants only. If it ever happens that a person is overbooked and there are more than 12 people present (even 1 extra), then the clinic will pull other staff and split up the groups into 2 or the consumer will be seen individually for a one-on-one session. This is because the entire group would be non-compliant if it was run with more than 12 people. As usual, any non-Medi-Cal participants in the group will still count toward the 12 max and at least

1 Medi-Cal consumer needs to be present. If this was found to be a deficiency during reviews, the entire group would be disallowed and marked non-compliant.

ARE ALL TYPES OF GROUPS BILLABLE?

Depending on what the group is addressing. According to the regulations, only "clinical" groups are billable to Medi-Cal. This means that the group content must address a need related to the substance use that helps the consumer towards achieving his or her treatment goals.

Groups such as house meeting would not be considered "clinical" groups. However, we know that part of the purpose of the Residential setting is to provide structure for the consumers to begin learning and practicing sober life skills in a safe and contained environment. Therefore, if the purpose is to build skills necessary to prepare for reintegration back into the larger community, time spent on activities like chores, can be considered service hours that count towards the daily required number of hours. It is helpful to focus on what the intention of the activity is and ask ourselves, "how is this relevant to the consumer's substance use treatment?" and "how might this be beneficial for the consumer's recovery?"

GROUP LOGS

Group logs should be printed out each day and the counselor running the group shall be responsible for ensuring that the group logs are fully completed with the following elements prior to the end of group:

- The client must print and sign the group log. If the log is preprinted with the clients name, the client will still need to sign next to his/her name. Please do not allow clients to sign in pencil. Clients MUST sign for themselves. Staff or other clients cannot sign on behalf of the client.
- The counselor name shall be printed and signed at the bottom on the group log. The state is requiring to print and sign adjustment to one another. This means that if the log is preprinted with the counselor name at the top, the counselor will still need to print and sign the bottom of the log.
- Group logs must also include the date of service, start and stop time.
- Group logs must also include the topic of that groups session. This does not mean the title of the group. You have to document the topic that is being discussed in that particular group session.

PHYSICIAN CONSULTATION- Code 310

Physician Consultation will be sought through addiction medicine physicians, addiction psychiatrists, or clinical pharmacists by our current BHRS Medical Director, as needed in order to provide guidance for DMC physicians with treatment plans, level of care considerations, medication selections and dosing, side effect management, adherence to prescriptions, and possible drug interactions.

1-WITHDRAWL MANAGEMENT- Code 311

Withdrawal Management level 1 services are habilitative and rehabilitate services provided to consumers when medically necessary and determined by the Medical Director or Licensed Practitioner of the Healing Arts (LPHA). The components of Withdrawal Management services are intake, observation, medication services, and discharge services.

RECOVERY SERVICES- Code 319

Recovery Services are a part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, consumers will be linked to applicable medically necessary recovery services. Consumers may access recovery services after completing their course of treatment, whether they are triggered, have relapsed, or as a measure to prevent relapse.

Recovery services may be provided face-to-face, by telephone, or telehealth with the consumer and may be provided anywhere in the community. The components of recovery services include: outpatient individual or group counseling; recovery monitoring/coaching; peer-to-peer assistance; linkages to services to enhance education and job skills; and linkages to support groups, after care groups, and ancillary services.

BILLING

It is important for all services to be coded appropriately. In order to do this, we must understand what services are not billable and when a chart is out of compliance (thereby not allowing us to bill Medi-Cal).

NON-BILLABLE SERVICES:

Non-Billable services are defined as services that an outside third-party payer would NEVER reimburse. Non-Billable services can include but are not limited to the following:

- Review of records (of any kind)
- Waiting time
- Translating/Interpreting
- Clerical Services: Faxing, Scheduling appointments, Photocopying
- Searching for a missing consumer
- Checking messages
- Leaving messages
- Providing transportation
- Supervision with a supervisor/service chief
- Completion of bus pass application
- Completion of immigration form
- Conducting internet searches
- Most letter writing is not billable

- Services for the sole purposes of addressing anything other than the substance use disorder impairment. This can include solely dealing with: Mental health and/or other excluded diagnoses and/or Health care
- Any service while the consumer is in Jail/Juvenile Hall, Psychiatric Hospitalization, or an Institute for Mental Disease (IMD)
  - Exceptions to this rule: Day of admission, Placement services provided during the 30 calendar days immediately prior to the day of discharge for a maximum of 3 non-consecutive periods of 30 days. These notes should be clearly labeled **"Placement Services."**

Rule of thumb: If the service you're providing cannot be linked to the substance use or impairments caused by the substance, it's probably non-billable.

NON-COMPLIANT SERVICES

Non-Compliant services are defined as services that would normally be reimbursable but because something is wrong with the chart (e.g., a failed treatment plan, late documentation, etc.) we are not authorized to submit the services for billing. Additionally, services would be deemed non-compliant if written after 7 calendar days or longer from the date of service.

A chart can be deemed out-of-compliance for several reasons. Most commonly, charts are out of compliance due to a failed treatment plan. Treatment plans may fail for the following reasons:

1. Not signed by the consumer/conservator/legal guardian *(Exception: If the consumer refuses to sign, the plan will still pass if documented appropriately. However, mere refusal to sign because they don't agree with the plan is not a sufficient reason).*
2. Does not document medical necessity or show impairment related to the substance use.

CALCULATING TIME

Face-to-Face Time: Time with the consumer, in person. If the session or service was provided by telephone, there would be no face-to-face time. For groups, the total time spent in the group must be divided between the number of group attendees (e.g., the group was 90 minutes and there were 10 participants, the progress notes for each of the 10 participants would have 9 minutes of face-to-face time. Each progress note will then be allowed documentation time that can be billed in addition to the face- to-face time to calculate total service time).

Non-Face-to-Face Time: Billable or non-billable time spent on a service activity that does not include interaction with the consumer.
Example: Analyzing information to determine risk rating levels for the dimensions of the ASAM Criteria outside of the session with consumer. This time spent working on this is billable.

Service Time
Total billable time for the service (face-to-face and/or non-face-to-face, travel, and documentation).

Documentation Time
Time it took to complete the progress note. This should never exceed the length of the session and should correspond to what is a reasonable in comparison to the interventions provided. Working on any other documents besides the progress note is not considered documentation time.

Travel Time
Time it takes to travel from one location to another to meet with consumer or provide a service. Transporting a consumer does not count for this. If solely transporting a consumer from point A to point B, this time is non-billable (Medi-Cal will not reimburse for us being a taxi service). If, during the course of transporting the consumer from point A to point B, some billable service is provided (such as discussing recent response to triggers and use of coping skills), this is considered Service Time because you provided a service.

New Units and Subunits Effective 1/1/2019

Provider 2401		BHRS The Center	
Unit	**Sub Unit**	**Program Name**	**CalOMS Required**
38	3800	The Center - 1.0 OP Adult	Yes
	3801	The Center- 1.0 OP Adult Perinatal	Yes
	3802	The Center- 2.1 IOP Adult	Yes
	3803	The Center- 2.1 IOP Adult Perinatal	Yes
	3804	The Center- Residential Placement	No
	3805	The Center- Recovery Services	Yes
	3806	The Center- CalWORKs ODS	Yes
	3808	The Center- Prop 64 Adult	No
	3809	The Center WM-1	No
	3810	The Center- Adult Education	No
Provider 2404		**BHRS – Recovery Assistance for Teens (RAFT)**	
Unit	**Sub Unit**	**Program Name**	**CalOMS Required**
38	3811	RAFT- 1.0 OP Youth	Yes
	3812	RAFT-2.1 IOP Youth	Yes
	3813	RAFT- Residential Placement	No
	3814	RAFT- Recovery Services	Yes

	3815	RAFT- Education	No
	3816	RAFT- Prop 64 Education	No
Provider 2417		**Los Banos Alcohol and Drug Counseling**	
Unit	**Sub Unit**	**Program Name**	**CalOMS Required**
38	3817	LB ODS- 1.0 OP Adult	Yes
	3818	LB ODS- 1.0 OP Adult Perinatal	Yes
	3819	LB ODS-2.1 IOP Adult	Yes
	3820	LB ODS-2.1 IOP Adult Perinatal	Yes
	3821	LB ODS- Residential Placement	No
	3822	LB ODS- Recovery Services	Yes
	3823	LB ODS- 1.0 OP Youth	Yes
	3824	LB ODS-2.1 IOP Youth	Yes
	3825	LB ODS- Youth Education	No
	3826	LB ODS- Prop 64 Education	No
	3827	LB ODS- CalWORKs	Yes
Provider 2408		**Northside Counseling Center**	
Unit	**Sub Unit**	**Program Name**	**CalOMS Required**
38	3830	LIV ODS-1.0 OP Adult	Yes
	3831	LIV ODS-1.0 OP Adult Perinatal	Yes
	3832	LIV ODS-2.1 IOP Adult	Yes
	3833	LIV ODS-2.1 IOP Adult Perinatal	Yes
	3834	LIV ODS- Residential Placement	No
	3835	LIV ODS- Recovery Services	Yes
	3836	LIV ODS- 1.0 OP Youth	Yes
	3837	LIV ODS-2.1 IOP Youth	Yes
	3838	LIV ODS- Youth Education	No
	3839	LIV ODS- Prop 64 Education	No
	3840	LIV ODS- CalWORKs	Yes

Provider 2401		Not Active at This Time	
Unit	**Sub Unit**	**Program Name**	**CalOMS Required**
38	3850	Recovery Residence (SLE)	No
Provider 2412		**Aegis Treatment Center**	
Unit	**Sub Unit**	**Program Name**	**CalOMS Required**
83	8390	Aegis- Maintenance	Yes
	8391	Aegis- Detox	Yes
	8392	Aegis- Bup	Yes
Provider 2402 / 24SN		**Hobie House**	
Unit	**Sub Unit**	**Program Name**	**CalOMS Required**
81	8190	Hobie House- Non DMC	Yes
	8191	Hobie House- 3.1 Res	Yes
Provider 2403		**Tranquility Village**	
Unit	**Sub Unit**	**Program Name**	**CalOMS Required**
82	8290	Tranquility Village- Non DMC	Yes
	8291	Tranquility Village- 3.1 Peri-Res	Yes
	8292	Tranquility Village-3.1 Non Peri-Res	Yes

New Service Codes Effective 1/1/2019

Non Billable Service Codes for OP		
Service Code	**Name**	**Comments**
74	Aftercare Individual	SABG Grant. Until Recovery Services are billable
75	Aftercare Group	SABG Grant. Until Recovery Services are billable
80	Alcohol/Drug Testing	SABG Grant
84	HIV Education	SABG Grant
90	Court Appearance	SABG Grant
91	Court Report	SABG Grant
92	Court Report Prep	SABG Grant

94	DDP2 Individual	SAMSHA Grant
95	DDP2 Group	SAMSHA Grant
309	Assessment	SABG Grant
New Service Codes for ASAM 1.0 Outpatient and 2.1 Intensive Outpatient Effective 1/1/2019		
Service Code	**Name**	**Comments**
300	Collateral Services	
301	Individual Counseling	
302	Group	
303	Treatment Plan	
305	Discharge Planning	
306	Crisis Intervention	
307	Case Management	
308	Intake	
310	Physician Consultation	
311	Ambulatory 1-WM	
312	Ambulatory 2-WM	
319	Recovery Services- Recovery Monitoring /SAA	
New Service Codes for Res 3.1 Effective 1/1/19		
Service Code	**Name**	**Comments**
340	3.1 Residential	This code to bill at new DMC-ODS Rate
350	Residential Non-DMC	This code to bill at SABG Rate $ 50.00
New Service Codes for Res 3.2 WM Effective Date: TBD		
Service Code	**Name**	**Comments**
360	3.2 Residential Withdrawal Management	
New Service Codes for Res 3.3 Effective Date: TBD		
Service Code	**Name**	**Comments**
380	3.3 Residential	
New Service Codes for Res 3.5 Effective Date TBD		
Service Code	**Name**	**Comments**
390	3.5 Residential	

PRACTICE GUIDELINES

Practice Guidelines are based on valid and reliable clinical evidence or consensus of providers in a particular field, consider the needs of the consumers, as adopted in consultation with contracting health care providers and reviewed and updated periodically as appropriate.

The goals of Substance Use Disorder Services (SUDS) treatment include the reduction of, and ultimately abstinence from, alcohol and other drug use, as well as improvement and stability in significant life domains such as housing, employment/self-sufficiency, family relationships, and resolution of legal matters. The adoption of evidence-based practices (EBPs) to achieve these goals has become the accepted standard in the SUDS treatment community, as well as in health care, social services and the criminal justice system.

1. **Welcoming Environment:** Programs will provide for a consumer's physical and emotional safety and create an engaging and predictable environment

a) The environment should be designed to reverse the effects of exposure to situations that promote substance abuse and other self-defeating behaviors. Attention to creating an environment that minimizes re-traumatization from past experiences will be a priority. The environment will be protective, respectful, and sensitive to a consumer's needs.
b) The physical environment will be clean, secure, welcoming, and accessible. Attention will be given to furniture, lighting, and décor. Welcoming materials appropriate to gender, language, culture and an individual's complex needs will be visible and available.
c) The therapeutic environment will promote a recovery-based lifestyle through supportive relationships and productive activities.

2. **Engagement & Retention:** Programs will utilize strategies specific for engagement and retention of consumers and their families.

a) There is an importance of the consumer/counselor relationship in engaging and retaining consumers in treatment. Engagement, empathy, consumer empowerment, motivational enhancement, inspiring hope, and consumer centered treatment planning are key elements.
b) Welcoming is a fundamental agency-wide commitment to encourage and support each consumer's right, as well as the importance of affirming their decisions, to seek treatment. This commitment includes the implementation of policies, practices and procedures that will support each consumer's recovery and wellness.
c) In order to ensure optimal placement, an ASAM screening of substance use and mental health symptoms will occur at the first visit. Parents/Guardians may be part of the initial assessment. Consumers will be welcomed into treatment if their needs can best be met at that provider's site; in some cases, linkage to providers with other areas of expertise may be necessary. Individuals who may require or benefit from other services will be assisted in connecting and engaging with such services.

3. **Client-Centered Care:** Programs will provide individually tailored and consumer-driven treatment, while balancing the health, safety, and integrity of the program.

a) Providers will utilize a multi-disciplinary treatment team, including the consumer and their family, to determine/create treatment plans for each program participant, based on the consumer's stated recovery goals. Effective, comprehensive, and multiple treatment techniques may be utilized to match appropriate interventions to each individual's stage of change and to meet identified needs. Individualized treatment will include clinical flexibility and a strong therapeutic alliance between staff and consumer.
b) Individualized treatment recognizes that each individual's needs are different and referrals or transfers to ancillary agencies will likely be required. Programs will work in partnership with other agencies to provide support and resources for vocational, mental health, medical, educational, AIDS/HIV, legal, financial, housing/transportation, family, and child care services, among others.
c) Comprehensive, strength-based case management and collaboration between agencies is necessary to provide a seamless, concurrent, integrated continuum of care.

4. **Culturally Competent Care:** Providers are responsible to be culturally fluent and responsive to the historical and cultural experiences and needs of each consumer.

a) Culturally competent treatment includes treating consumers in the context of their language, culture, ethnicity, geographic area, socioeconomic status, level of education, gender, age, sexual orientation, religion, spirituality, and any physical or cognitive disabilities.
b) Programs are responsible to explore and learn about a consumer's culture, ethnic background and culturally appropriate pathways to healing, and to obtain knowledge regarding how these might affect the consumer's issues, treatment goals, interventions and etiology of any conditions.
c) Developing a sound knowledge of diversity is crucial to fully understanding consumers. Knowledge should be gained from professional and scientific literature, resource persons from other cultures, and findings from research studies concerning communication between cultures.
d) Programs must insure that their policies, procedures, and practices are consistent with the principles outlined above and are embedded in the organizational structure, as well as being upheld in day to day operations. Program staff and board membership should, to the extent feasible, reflect the composition of target populations, including linguistic ability.
e) Programs, including educational and process groups, will incorporate the unique pathways to addiction, consequences of use, and barriers to treatment within the context of the cultural experiences of their consumers.

5. **Co-occurring Capable Care:** Programs will be engaged in continuously improving their co-occurring capability. Policies, procedures and programming and staff competencies are designed to meet the anticipated needs of individuals with co-occurring disorders.

a) BHRS and the ODS providers recognizes that individuals and families seeking treatment present with complex problems that must be addressed concurrently with the primary treatment phase. Programs will work toward implementing co-occurring services and utilize evidence-based practices specific to individuals with co-occurring disorders.

b) Programs will engage in a continuous quality improvement process to improve co-occurring capability. Suggested resources include the **NIDA's Principles of Effective Drug Addiction Treatment**, and **SAMHSA's TIP 42** to ensure comprehensive care for the complex needs of consumers and their families.

6. ASAM Treatment Planning: Treatment Plans must consider each domain of the ASAM for each consumer, areas that are identified within each domain should be included within the treatment plan.

a) The initial treatment plan should follow the ASAM Assessment of each consumer. The treatment plan will be conducted by the AOD Counselor and/or LPHA. The treatment plan should be consumer-centered and use treatment strategies that are acceptable to the consumer.
b) The treatment plan should include a set of comprehensive treatment interventions that are matched to individual needs, readiness, preferences and consumer goals for each problem.
c) The treatment plan must be adjusted as ongoing assessment occurs and relevant new information is integrated.
d) Further assessment may include motivation for treatment, stage of change, trauma, mental health diagnosis, and substance abuse.

7. **Effective Treatment based on Evidence-based Practices:** SUD providers will offer effective treatment for consumers with SUD problems. Evidence-based practices (EBPs) and promising practices will be utilized during all phases of treatment.

I. There is a growing body of research demonstrating that specific treatment approaches and components may improve treatment outcomes. Linking biological, psychological, and social (biopsychosocial) interventions has generally been found to be most efficacious. BHRS ODS providers will provide at least two of the following evidenced based practices.

Merced County approved ODS Evidenced Based Practices:

a) Motivational Interviewing
b) Cognitive-Behavioral Therapy
c) Relapse Prevention
d) Trauma-Informed Treatment

II. All ODS providers are required to ensure that staff are trained in the evidenced based practices and that the documentation within the consumer file reflects the evidenced base practice interventions utilized and how the interventions are assisting with the consumers recovery.

III. The approaches may be used to supplement, enhance, and/or replace existing treatment components. As new evidence-based practices are developed and researched, they may be added to the menu of options. Information on identified evidence-based practices as well as interventions that are under review can be found at the National Registry of Evidence-based Programs and Practices at http://www.nrepp.samhsa.gov.

8. **Medication Related Services:** Programs will ensure that consumers' needs for medication, both psychotropic and otherwise (including narcotic replacement therapy), are assessed and attended to and that consumers are not discriminated against due to their use of prescribed medication.

a) Programs will have procedures for assessment and linkage/integration to adjunctive services for program participants requiring medication treatment. It is expected that program staff will regularly communicate with physicians of consumers who are prescribed medications.

9. Recovery-Oriented Care: Recovery services are introduced and integrated as part of the primary treatment phase, and as part of continuing care planning for each consumer.

a) All services are provided in the spirit of working in an empowered partnership with consumers and families. Due to the nature of addiction as a chronic, progressive, relapsing condition the service continuum should shift away from single episodes of care to a long term recovery-management approach. Successful outcomes are connected to length of engagement in services.
b) Along with continuous recovery management, identifying and activating critical community supports for consumers are essential components of successful recovery.
c) Service coordination or case management should assist the consumer in linkage to continuing care and community support services.
d) These may include, but are not limited to: emotional and social supports, including self-help groups such as AA/NA, dual recovery peer supports, recovery maintenance or exit planning, relapse prevention and continued program involvement

10. **Federal, State and Local Regulations:** Programs will ensure compliance with all federal, state, and local laws and regulations when providing substance use disorder services which include the following:

Federal

- 42 Code of Federal Regulation (CFR) Part 2 of Substance Use Disorder Consumer Records
- 42 CFR Part 428 Managed Care
- Health Insurance Portability and Accountability Act (HIPAA)
- Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
- Title IX of the Education Amendments of 1972 (Regarding education programs and activities).
- Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
- The Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6601-6107), which prohibits discrimination on the basis of age.
- Age Discrimination in Employment Act (29 CFR Part 1625).
- Title I of the Americans with Disabilities Act (29 CFR Part 1630).

- Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
- Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
- The Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
- Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
- Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
- The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
- The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.
- The Americans with Disabilities Act of 1990 as amended.
- Section 1557 of the Consumer Protection and Affordable Care Act.
- Record keeping requirements for providers are to retain, as applicable, the following information: consumer grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR§§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.
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State

- California Code of Regulations (CCR) Title 9 Counselor Certification
- Title 9, Division 4, Chapter 8, commencing with Section 10800.
- CCR Title 22 Drug Medi-Cal
- Sobky v. Smoley (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994),
- Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).
- California non-discrimination act. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135**.**

State Agency – DHCS

- Drug Medi-Cal Special Terms and Conditions Intergovernmental Agreement
- DHCS Perinatal Services Network Guidelines, 2016
- DHCS Youth Treatment Guidelines, 2002
- DHCS Alcohol and/or Other Drug Program Certification Standards, 2017
- Trafficking Victims Protection Act of 2000
- ADP Bulletin 09-05 Accessibility
- CLAS Standards

County

- Merced County ODS Implementation Plan
- Individual Provider Agreements with the County

RESOURCES

BIRP PROGRESS NOTE CHECKLIST

B Behavior **Counselor observation, client statements**	**Check if addressed**
1. Subjective data about the client—what are the clients observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
I Intervention **Counselor's methods used to address goals and objectives, observations, client statements**	
1. What goals and objectives were addressed this session?	
2. Was homework reviewed?	
R Response **Client's response to the intervention, progress made toward Tx Plan goals and objectives**	
1. What is the client's current response to the clinician's intervention in the session?	
2. Client's progress attending to goals and objectives outside of the session?	
P Plan **Document what is going to happen next**	
1. What in the Tx Plan needs revision?	
2. What is the clinician going to do next?	
3. What is the next session date?	

PROGRESS NOTE GENERAL CHECKLIST

General Checklist	**Check if addressed**
1. Does the note connect to the client's individualized treatment plan?	
2. Are client strengths/limitations in achieving goals noted and considered?	
3. Is the note dated, signed and legible?	
4. Is the client name and/or identifier included on each page?	

5. Has referral and collateral information been documented?	
6. Does the note reflect changes in client status (eg. GAF, measures of functioning)?	
7. Are all abbreviations standardized and consistent?	
8. Did counselor/supervisor sign note?	
9. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
10. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	

Assessment Considerations for Each Dimension of the ASAM Criteria

Dimension	Description	Assessment Considerations Include:
1	Acute Intoxication and/or Withdrawal Potential Exploring an individual's past and current experiences of substance use and withdrawal	• What risk is associated with the client's current level of acute intoxication? • Are intoxication management services needed to address acute intoxication (e.g., preventing drunk driving by holding a person's car keys until he or she is abstinent or in safety with family members; managing acute alcohol poisoning in an adolescent experimenting with rapid intake)? • Is there significant risk of severe withdrawal symptoms, seizures, or other medical complications based on the client's previous withdrawal history, as well as the amount, frequency, chronicity and recency of discontinuation of (or significant reduction in) alcohol or other drug use? • Are there current signs of withdrawal? • What scores are derived from use of standardized withdrawal rating scales? • What are the client's vital signs? • Does that client have sufficient supports to assist in ambulatory withdrawal management, if medically safe to consider?
2	Biomedical Conditions and Complications Exploring an individual's health history and current physical condition	• Are there current physical illnesses, other than withdrawal, that need to be addressed due to their risk or potential for treatment complications? • Are there chronic conditions that need stabilization or ongoing disease management (e.g., chronic pain needing pain management)? • Is there a communicable disease present that

Dimension	Description	Assessment Considerations Include:
		could impact the wellbeing of other clients or staff? • For females, is the client pregnant? What is her pregnancy history, especially if she has an opioid use disorder?
3	<u>Emotional, Behavioral, or Cognitive Conditions and Complications</u> Exploring an individual's thoughts, emotions, and mental health issues	• Are there current psychiatric illnesses or psychological, behavioral, emotional, or cognitive conditions that need to be addressed because they create risk or complicate treatment? • Are there chronic conditions that need stabilization or ongoing treatment (e.g., bipolar disorder or chronic anxiety)? • Do any emotional, behavioral, or cognitive signs or symptoms appear to be an expected part of the addictive disorder, or do they appear to be autonomous? • Even if connected to the addiction and subdiagnositic, are any emotional, behavioral, or cognitive signs or symptoms severe enough to warrant specific mental health treatment (e.g., suicidal ideation and depression from "cocaine crash")? • Is the client able to manage the activities of daily living? • Can he or she cope with any emotional, behavioral, or cognitive conditions? • Assessment of risk (dangerousness/lethality, if MH issues interfere with SUD recovery efforts, impairments in social functioning, etc.)
4	<u>Readiness to Change</u> Exploring an individual's readiness and interest in changing	• How aware is the client of the relationship between his or her substance use or behaviors involved in the pathological pursuit of reward or relief and his or her negative life consequences? • How ready, willing, or able does the client feel to make changes to his or her substance using or addictive behaviors? • How much does the client feel in control of his or her treatment service?
5	<u>Relapse, Continued Use, or Continued Problem Potential</u> Exploring an individual's unique relationship with relapse or continued use or problems	• Is the client in immediate danger of continued severe mental health distress and/or substance use? • Does the client have any recognition or understanding of, or skills in coping with, his or her addictive or co-occurring mental health disorder in order to prevent relapse, continued

Dimension	Description	Assessment Considerations Include:
		use, or continued problems such as suicidal behavior? • Have addiction and/or psychotropic medications assisted in recovery before? • What are the person's skills in coping with protracted withdrawal, cravings, or impulses? • How well can the client cope with negative affects, peer pressure, and stress without recurrence of addictive thinking and behavior? • How severe are the problems and further distress that may continue or reappear if the client is not successfully engaged in treatment and continues to use or have mental health difficulties? • How aware is the client of relapse triggers and skills to control addiction impulses or impulses to harm self or others?
6	Recovery/Living Environment Exploring an individual's recovery or living situation, and the surrounding people, places and things	• Do any family members, significant others, living situations, or school or work situations pose a threat to the person's safety or engagement in treatment? • Does the individual have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful recovery? • Are there legal, vocational, regulatory (e.g., professional licensure), social service agency, or criminal justice mandates that may enhance the person's motivation for engagement in treatment if indicated? • Are there transportation, child care, housing, or employment issues that need to be clarified and addressed?

BHRS OUTPATIENT SERVICES DOCUMENTAION CHECKLIST

Front Desk Packets

☐ Demographic Form Pages 1 and 2
☐ Financials/Payment Agreement
☐ CASS Questions and TB Screening Form (2 Sided)
☐ AOD Medical Information Survey
☐ Income Verification and Title 22 Client Fair Hearing Form (2 Sided)

☐ HIPAA- Chart Copy with signature of client and staff
☐ HIPAA – Client Copy
☐ Explanation of Confidentiality- Client Copy and ☐ Client Rights- Client Copy (2 Sided)
☐ Admissions Agreement
☐ List of Community Resources

Counselor Packets

☐ Client Summary Sheet
☐ Anasazi Diagnosis Form
☐ Anasazi Assignment Form
☐ Level of Care Contract
☐ Universal Release of Information
☐ Additional Releases (ie: group release)
☐ CalOMS Admission (Only for Treatment)
☐ Control Sheet
☐ Group Assignments
☐ Support Group Attendance and Meeting Schedule
☐ Client Satisfaction Survey
☐ ASAM Assessment

Intake Process Checklist

Tasks for OA's / Front Desk staff
☐ Copy of Income Verification
☐ DMC Financial Statement completed
☐ Copy of Medi-Cal Card & Verification of Eligibility
☐ Copy of referral source and/or minute order
☐ Verify client's true and correct legal name
☐ Copy of proof of income (for private pay)
☐ Read / Review CASS, TB, HIPAA and Payment forms and sign where staff signature indicates
☐ Control Sheet
☐ Client Summary Sheet
☐ Put all documents together in a blank file for staff
☐ Give client another appointment with primary counselor (Within 2 days for Urgent or 10 days for Non- Urgent)

Counselor Check List for 1st Appointment – 2 Hours

☐ Fill Out Client Summary Sheet
☐ Fill out Control Sheet
☐ Diagnostic Review: Send to LPHA for signature
☐ Tx Session and Assignments Form- Listing the Units/Subunits and Primary Server

☐ Review / Medical Information Survey: Send to LPHA for signature
(MRT enters data when opening chart, counselor to sign AFTER the LPHA)
☐ Review / Sign Fair Hearing
☐ Level of Care Contract
☐ Universal Release of Information (group, referral source/s, and any other that is needed)
☐ CalOMS (OPEN)
☐ ASAM Full Assessment
☐ Initial Treatment Plan- Include # of hours that reflect appropriate LOC. Send to LPHA
☐ Group Assignments Form- Assign clients to group/s based on clients' needs and LOC.
Give client a copy of their group assignments
☐ Acceptance or Non-Acceptance Letters / Court Report – Use Universal Progress Report
☐ Conduct Drug Test and Document the Results in the Intake Progress Note
☐ Intake Progress Note
☐ Client Satisfaction Survey
☐ Exit Plan
☐ AOD Counselor to have a face to face with LPHA to review the client assessment
☐ LPHA to document the basis for the diagnosis in Diagnosis Assessment within the EHR, Sign the Treatment Plan and the Medical Information Survey.
☐ Once Completed the Physical Exam will need to be sent to the Medical Director for review and signature

Counselor Check List for 2nd Appointment- 1 Hour

☐ Modify Treatment Plan- Individualize if needed from first session.
☐ Follow up with any program specific paperwork (Court Contracts/CalWorks documents)
☐ Follow up with any referrals that were made at first appointment.
☐ Acceptance or Non-Acceptance Letters / Court Report – Use Universal Progress Report
☐ Progress Note as to what occurred during this session using the BIRP format

Checklist for Residential Process

If Opened to SUD Outpatient Services Prior to Residential Referral

☐ Complete an Initial ASAM Screening checking the box "Transitional Placement"
☐ Complete a Residential Referral and staff with LPHA or PM for approval
☐ Fax or Turn in the Referral to Maria Azevedo **and** place a copy in the consumers file
☐ Complete a CalOMS Discharge with the DC Reason 5 Left Before Completion with Unsatisfactory Progress Standard so all questions should be asked.
☐ Send email to MRT to close treatment assignment and open the client to the appropriate subunit per your location called " Residential Placement"
☐ Update the treatment plan to include Case Management and document that the client was sent to a higher level of care in both the treatment plan and in a progress note.
☐ Complete a Case management referral so client is linked with Case Management services that can assist with care coordination.
☐ Remove the client from all current assigned groups
☐ Complete a Discharge Plan

☐ Code as Discharge Planning 305

Residential Placement at POE / Intake
Complete all Front Desk Paperwork Plus the Following:

☐ Fill Out Client Summary Sheet
☐ Fill out Control Sheet
☐ Diagnostic Review: Send to LPHA for signature
☐ Tx Session and Assignments Form- Listing Appropriate Subunit based on location
☐ Review / Enter Medical Information Survey: Send to LPHA
☐ Review / Sign Fair Hearing
☐ Universal Release of Information (group, referral source/s, and any other that is needed)
☐ ASAM Assessment- Info should justify that level of care/medical necessity
☐ Send email to MRT to close treatment assignment and open the client to the appropriate subunit per your location called " Residential Placement"
☐ Complete a Case management referral so client is linked with Case Management services that can assist with care coordination.
☐ Initial Treatment Plan- with only Addiction and Physician Exam Requirements. Include Case Management
☐ Complete a Case Management Form and Document in the intake progress
☐ Conduct Drug Test and Log the Test Results in the Intake Summary Note
☐ Intake Progress Note
☐ Client Satisfaction Survey
☐ Exit Plan
☐ Change the appointment Service Code from 308-Intake to 309-Assessment so that this does not bill Drug Medical or the client.
☐ Completed a Residential referral Form
☐ Staff with Program Manager and have LPHA sign the approval
☐ Give the Residential Referral to BHRS Staff Service Analyst
☐ Place a copy of the referral in the chart
☐ Code as an Assessment 309

<u>Residential Placement from the Court</u>

☐ Complete demographics
☐ Complete an Initial ASAM Screening checking the box "Initial Screening and Placement"
☐ When returning from Court enter Initial Screening into the EHR
☐ Initial Treatment Plan- with only Addiction and Physician Exam Requirements. Include Case Management Complete a Residential Referral and staff with LPHA or PM for approval
☐ Complete Diagnosis Form- LPHA to document the basis for diagnosis
☐ Complete MIS and send to the LPHA to review and signature
☐ Meet face to face with LPHA to review the case
☐ Complete Release of Information
☐ Complete a Case management referral so client is linked with Case Management services that can assist with care coordination.

☐ Send email to MRT to open the client to the appropriate subunit per your location called " " Residential Placement
☐ Complete Residential Referral and staff with Program Manager and/or LPHA
☐ Give the Residential Referral to BHRS Staff Service Analyst
☐ Code as 309 Assessment

Opening Charts- MRT's (Charts should be opened no later than 24 hours)

☐ Ensure everything matches and is fully completed. If not send back to staff for full completion.
☐ Enter Demographics
☐ Enter Diagnosis Form. Counselor info listed as hard copy and Dx form is sent to LPHA for signature.
☐ Enter Assignment Form indicating unit and subunit and primary counselor
☐ Enter Financial and update Medi-Cal info if needed
☐ Enter Group Assignments based on the listed start date
☐ Enter Admissions CalOMS and final approve
☐ Enter Medical Survey is sent to counselor and LPHA. The counselor is to final approve once the LPHA has completed

Closing Charts- MRT's
☐ Look at the treatment plan and close it out/ modify the dates to the last service
☐ Close assignment and treatment episode
☐ *Anasazi assignment discharge is the last* ***entry of service***
☐ Enter the discharge CalOMS and Final Approve
☐ *CalOMS discharge is the date of the last* ***face to face***
☐ *Ensure that the type of discharge matches the CalOMS rules of how to discharge*
☐ Close out ISL if they just came in for an open/close (rare but it happens)

Entering and Maintaining Groups

☐ Front desk enters clients into the assigned groups at intake
☐ Counselors maintain the group logs by adding and deleting clients as needed
☐ Group Logs- Counselors print for each group, list the days topic of the group on the top, add the start and stop time to the group log, sign and date the log. Group participants are to sign the group log as proof of attendance in ink, NOT pencil.
☐ Counselor then places the Group log in the group log file cabinet behind the day the group was provided.
☐ At the end of the month the MRT takes the group logs for each day ensures they are in numerical order for that month and then places them in the month file folder.
☐ At the end of the year the MRT will collect all months that are arranged by month and day and place in manila folders labeling them Group Logs / Month / Year.

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