COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara
DMC-ODS
Substance Use Treatment Services
Companion Guide to the
CalMHSA CalAIM
Documentation Manuals

Version 4/19/2023

Note: This guide was developed on the information received from the Department of Health Care Services as of 4/19/2023. This guide may be updated as we receive more information moving forward.

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Introduction to This Companion Guide

This Companion Guide is to support the documentation of all those who are serving the needs of the County of Santa Clara Substance Use Treatment beneficiaries, both contracted providers, and our internal county clinics. This manual aligns with the current transformation of our California Medi-Cal system under the California Advancing and Innovating Medi-Cal (CalAIM) initiatives.

This Companion Guide is meant to be combined with California Mental Health Services Authority (CalMHSA) Documentation Guides that are posted on their website and updated regularly[1]. There are multiple additional manuals and websites targeted toward different disciplines in the mental health and substance use fields in the table below.

Key Links:

Please ensure all staff are also familiar with specific websites in association with their job duties:

Alcohol and Other Drugs Program Certification Standards	Alcohol and/or Other Drug Program Certification Standards
American Society for Addiction Medicine ASAM	ASAM
CalMHSA CalAim Documentation Guides	California Mental Health Services Authority | Documentation Guides (calmhsa.org)
CalMHSA Training Directions	https://www.calmhsa.org/wp-content/uploads/CalMHSA-LMS-Instructions-5.24.22.pdf
County of Santa Clara available trainings and certifications	This Month's Trainings - Behavioral Health Services - County of Santa Clara (sccgov.org)
County of Santa Clara Beneficiary Handbook	https://bhsd.sccgov.org/information-resources/behavioral-health-services-beneficiary-handbooks
County of Santa Clara SUTS Provider website	Substance Use Treatment Services (SUTS) Provider Information - Behavioral Health Services - County of Santa Clara (sccgov.org)
DHCS Adolescent Substance Use Disorder Best Practice Guide 2020[2]	Adolescent Best Practices Guide OCTOBER 2020 (ca.gov)
DHCS Billing Guide	D M C Provider Billing Manual (ca.gov)
DHCS CALAIM Homepage	https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx
DHCS CALOHMS Treatment Data Collection Guide	https://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

[1] California Mental Health Services Authority | Documentation Guides (calmhsa.org)

[2] Adolescent Best Practices Guide OCTOBER 2020 (ca.gov)

DHCS CALOHMS Treatment Data Compliance Standards	https://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Data_Cmpliance%20Standards%202014.pdf
DHCS Frequently Asked Questions	https://www.dhcs.ca.gov/Pages/CalAIM-Behavioral-Health-Initiative-Frequently-Asked-Questions.aspx
DHCS Information Notices	Behavioral Health Information Notice (ca.gov)
DHCS Perinatal Best Practices	Perinatal Services (ca.gov)
Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026	https://www.dhcs.ca.gov/Documents/BHIN-23-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf
Narcotic Treatment Program Title 9	Browse - California Code of Regulations (westlaw.com)
SAMHSA: Federal Guidelines for Opioid Treatment Programs	https://store.samhsa.gov/sites/default/files/d7/priv/pep15-fedguideotp.pdf
Substance Use Disorder Licensing and Certification Toolkit	https://www.dhcs.ca.gov/provgovpart/Documents/SUD-Toolkit.pdf
The DHCS and County of Santa Clara Inter Agency Agreement	Agreement-DHCS-DMC-ODS-FY23-FY27.pdf (sccgov.org)

This guide is intended to provide as much clarity as possible based on the information available and will be updated as needed. Please also note that Substance Use Treatment Services (SUTS) and substance use disorder (SUD) are both used in this manual when reviewing various County of Santa Clara (CSC) Behavioral Health Services Department (BHSD) Drug Medi-Cal Organized Delivery System (DMC-ODS Services) programs.

Medi-Cal Programs

In California, the Department of Health Care Services (DCHS) is the state agency responsible for the administration of the state's Medicaid program. In California, we refer to Medicaid as "Medi-Cal." The Medi-Cal program is a mix of federal and state regulations serving over 13 million people, or 1/3 of all Californians. Medi-Cal covers 40% of children and youth and 43% of individuals with disabilities in California. Medi-Cal behavioral health services are "carved out," meaning that they are delivered through separate managed care delivery systems, each of which is responsible for delivering different sets of services to individuals depending on their care needs. In Santa Clara, under our Behavioral Health Services Department, we have our Mental Health Plans (MHP), Drug Medi-Cal Plan-Organized Delivery System (DMC-ODS) and two Managed Care Plans (MCP) Santa Clara Family Health Plan and Anthem Blue Cross Partnership[3].

[3] Health plan materials | Medi-Cal Managed Care Health Care Options

DMC-ODS

Drug Medi-Cal – Organized Delivery System (DMC-ODS), is a program for the organized delivery of Substance Use Treatment Services (SUTS) across a continuum of care to Medi-Cal-eligible individuals with a substance use disorder (SUD) residing in the County of Santa Clara. The County of Santa Clara is a DMC-ODS program and does provide residents insured by Medi-Cal with a range of evidence-based SUD treatment services. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care. To receive services through the DMC-ODS, a person must be enrolled in Medi-Cal or receive support to enroll in Medi-Cal Services, reside in a participating county, and meet the criteria for DMC-ODS services.

California Outcomes Measurement System (CalOMS):

The data domains gathered in CalOMS include admission information, beneficiary identifiers, substance use, employment status, legal status, medical status, mental health status, and social connections. CalOMS is also used to monitor treatment with the goals of improving treatment, being responsive to the service recipients, their families, and communities. With CalAIM nothing has changed regarding the requirements for CalOMS. Please refer to DHCS requirements for CalOMS: https://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx

Medical Necessity:

As of January 1, 2022, DHCS has revised the definition of Medical Necessity[4] and Access criteria, based upon the age of the beneficiary as follows:

Covered Substance Use Disorder (SUD) Medi-Cal Services

Are reimbursable even when:

1) Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS criteria are met. (Only for outpatient services, excluding Narcotic Treatment Services (NTP/OTP)/Opioid Treatment Program (OTP). This is up to 30 days for

[4] Reference DHCS IN 21-075

adults and 60 days for youth (or adults if they are documented as experiencing homelessness).

2) The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan (Per BHIN 22-013: *"ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP)."(except for in residential)*; or

3) The beneficiary has a co-occurring mental health condition.

DMC-ODS programs and providers are required to use appropriate ICD-10 diagnosis code(s)[5] to submit claims to receive reimbursement of Federal Financial Participation (FFP). California Welfare & Institutions Code § 14184.402, subd. (f) provides that coverage for, or reimbursement of, a clinically appropriate and covered mental health or substance use disorder prevention, screening, assessment, treatment, or recovery service shall not be denied on the sole basis that services were provided or rendered prior to: (1) the completion of an assessment; and/or (2) the determination of a diagnosis. In other words, appropriate claims for services provided prior to the completion of an assessment or the determination of a diagnosis are allowed for outpatient services except NTP/OTP.

Residential Adult and Youth Beneficiaries:

Are reimbursable when:

1. *The claim includes an ICD-10-CM code that indicates a SUD diagnosis or an ICD-10-CM code that indicates the reason for the service encounter that is related to the SUD condition. Guidance on the* use of ICD-10-CM diagnosis code/reason for encounter[6]: 2022 ICD-10-CM | CMS

Medical Necessity - Criteria for Adult Beneficiaries (21 years and older) to Access the Substance Use Treatment Services:

1. Have at least one diagnosis from DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders OR have had the DSM Diagnosis (Dx) prior to being incarcerated or during incarceration, determined by substance use history.

[5] D M C Provider Billing Manual
[6] BHIN 22-013 (ca.gov)

2. Medical necessity for the DMC-ODS service(s) shall be determined by an LPHA based upon an assessment of the beneficiary[7].

Please note:

- Within non-residential treatment settings (Except NTP/OTP), DMC-ODS services are reimbursable for up to 30 days following the first visit with a Licensed Professional of the Healing Arts (LPHA) or registered/certified counselor, whether or not a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if a provider documents that the beneficiary is experiencing homelessness and therefore requires additional time to complete the assessment.
- For residential placement DSM and ASAM Criteria are needed to ensure that the beneficiary meets the requirements for appropriate level of care.[8]

Medical Necessity - Criteria for Beneficiaries under Age 21 to Access Substance Use Treatment Services:

1. Require appropriate and medically necessary services needed to correct or ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.

2. Beneficiaries under age 21 are eligible for DMC-ODS services without a diagnosis from the DSM for Substance-Related and Addictive Disorders (outpatient services).

3. Medical necessity for the DMC-ODS service(s) shall be determined by an LPHA based upon an assessment of the beneficiary.

4. Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)[9] services need not be curative or completely restorative to ameliorate substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable are considers ameliorating the condition (Youth).

5. The American Society of Addiction Medicine (ASAM)[10] Criteria shall be used to determine placement into the appropriate level of care for all beneficiaries and is separate and distinct from determining medical necessity.

[7] BHIN 23-001
[8] Reference DHCS IN 21-075
[9] https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/epsdt.pdf
[10] https://www.asam.org/asam-criteria/about-the-asam-criteria

6. For residential placement DSM and ASAM Criteria are needed to ensure that the beneficiary meets the requirements for appropriate level of care.

Access to Services and Screening Tools:

Per our network, a new beneficiary referral can access services through the Behavioral Health Call Center (1.800.704.0900[11]), via walk-in, direct referral, screening sites, or through pre-authorization [12](Required for residential services). A new beneficiary is screened using the Integrated Screening Tool (IST). The IST is valid for 30 days (e.g., beneficiary requests to reschedule the intake). A new IST is required if the beneficiary has not been reached or admitted within 30 days. A new IST is required for every new episode of treatment.

Providers cannot refuse to admit a beneficiary based on a blanket restriction of an admission type or previous history with the placement. When an opening is available for placement, each referral shall be deemed as a new referral, and the beneficiary will need to be assessed to see if there have been changes to their clinical needs.

Access to medically necessary services, including all Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder, cannot be denied to persons in care if they meet criteria for substance use services as per the ASAM criteria. DHCS has also alerted counties that individuals seeking substance use treatment cannot be placed on wait lists.

Services are to be provided to beneficiaries in their preferred language. Language interpretation or translation services should be utilized as necessary. Beneficiary informational materials are to be made available in alternate forms for beneficiaries with a visual impairment (e.g., large print, audio format). These should be available at no cost to the beneficiary.

In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905(r) of the Social Security Act all beneficiaries under age 21 can obtain a full comprehensive screening, diagnostic, treatment, and preventive health care services.

Withdrawal Management (WM) Services do not require initial contact with our Behavioral Health Call Center. Providers and beneficiaries may contact our WM programs directly 24 hours a day. Once a beneficiary enters WM services, the WM provider has up to 24 hours to contact the Call Center for a screening, using the IST, to open the treatment episode.

[11] https://www.dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx
[12] DHCS Interagency Agreement, DMC-ODS FY23-FY27, page 93. 3. iv.

Type of DMC-ODS Service	Days from Request to Appointment
NTP/OTP requires medical authorization.	Within 3 business days from request to appointment
Outpatient SUD Services, prior authorization is not required	Within 10 business days from request to appointment
Residential Placement, prior authorization is required.	Within 10 business days from request to appointment
Withdrawal Management (adults only), no prior authorization is required.	Withdrawal Management Services shall be available to individuals within 24-72 hours

For existing beneficiaries care coordination will be coordinated by the current provider for changes in level of care (LOC) as needed. For residential, the provider will work with the Utilization Management (UM) Team. Residential pre-authorizations are required when initiating residential care, transitioning from a lower to a higher level of residential care (e.g., ASAM LOC 3.1 to 3.5), or when transitioning from nonresidential to residential levels of care (e.g., OP to 3.1 LOC).

County of Santa Clara uses the Authorization for Level of Care (ALOC) for determining the level of care needs. The ALOC is a brief assessment utilizing the ASAM guidelines. The ALOC is utilized to determine medical necessity for LOC. It is also required at intake, transitions of care and at discharge. The ALOC is valid for 30 days. An ALOC is required for every new opening of an episode in SUTS and when the beneficiary has significant changes in status. Assessments are an ongoing process. Upon completion of the assessment with the beneficiary, if it is determined the beneficiary does not meet the LOC provided, the provider shall support the beneficiary with linkage to the appropriate LOC.

Transition Age Youth (TAY):

Young adults who are 18-21 years old may be eligible for either the Adult or Youth systems of care dependent upon the ALOC assessment determination regarding the most developmentally appropriate placement. When appropriate, TAY beneficiaries will be referred to Adult Withdrawal Management, Residential, or Recovery Residence. TAY beneficiaries may be referred to youth or adult outpatient programs.

Adult Residential Placements (18 years old and above):

Referrals for SUTS Residential Treatment may be received in different ways. When the County of Santa Clara receives a referral for SUTS Residential, the referral will be sent to the appropriate placement. Beneficiaries who are not already in treatment may receive a referral to residential treatment from the Behavioral Health Call Center or from a Screening site. The beneficiary will be screened using an IST (Initial Screening Tool) and referred to residential placement by the Utilization Management Team (UM). These beneficiaries will be pre-authorized for up to three (3) days for 3.1 ASAM level of care. The provider, after intake, will complete an Authorization for Level of Care (ALOC) and submit it to the Utilization Management Team (UM)/CSC BHSD (County of Santa Clara Behavioral Health Services Department) within 24 hours of the beneficiary being placed with the provider. The beneficiary will then be authorized for up to 30 days from the date of admission.

When an existing beneficiary is open to a LOC other than residential, the provider submits the ALOC for authorization of residential treatment to the Utilization Management (UM) Team for review. If Withdrawal Management (WM) is also needed for the beneficiary, the provider will call WM as soon possible and work to get the beneficiary into the WM program. In addition, they will indicate on the ALOC that they have referred the beneficiary to both WM services and residential treatment.

When a beneficiary is coming from any LOC and is experiencing acute medical/mental health symptoms, the current provider will care coordinate with medical/mental health providers to ensure the beneficiary is able to participate in residential treatment. Some examples include when the beneficiary is actively suicidal, severely psychotic, or has high potential for seizures. The SUTS provider will not close the beneficiary to services until it is confirmed the beneficiary has successfully entered residential treatment and or withdrawal management.

Once the ALOC is submitted, the Utilization Management (UM) team has 24 business hours to review & respond to the residential ALOC request from the date the ALOC is received. The UM Team will either authorize/approve, reject, or deny the request based on the information provided in all six dimensions to justify medical necessity for residential LOC care (for either 3.1, 3.3, or 3.5). If the request is not approved, the UM team will inform the provider (perhaps additional information or care coordination is needed, or the beneficiary does not meet medical necessity for residential LOC). Once the beneficiary enters residential treatment, if it is determined the beneficiary needs a higher or lower level of care (e.g., 3.1 to 3.5) this would be documented in a new ALOC by the residential provider. The new ALOC needs to be submitted to the UM Team with documentation to justify medical necessity if there is a change in LOC. If justified, the UM Team/CSC will increase the placement authorization to the appropriate level of care. ALOC requests for residential treatment are submitted to UM utilizing an encrypted email

sutsauthorization@hhs.sccgov.org. Included in the email will be the beneficiary's first and last name, date of birth and Avatar ID #.

The average length of stay for residential treatment is thirty (30) days. If the beneficiary requires more than 30 days of residential treatment, the residential provider will complete and submit a new ALOC justifying medical necessity for additional days of treatment. Requests for additional authorization for residential treatment will be given based on clinical need. A request needs to be submitted to the UM team at least three (3) business days prior to the initial authorization end date.

When a beneficiary is residing in a facility (e.g., a hospital, Skilled Nursing Facility (SNF), Crisis Residential etc.), a medical consultation with the residential providers' medical/clinical staff is required prior to placement. The CSC is informed of this request via Behavioral Health Call Center or through Valley Medical Center (VMC), Emergency Department (ED) or Emergency Psychiatric Services (EPS). Once the CSC is informed, care coordination is initiated between the facility and the residential provider by CSC. The CSC will present the case to the residential providers' medical director & clinical team, who will complete an MD-to-MD consultation. If the beneficiary is cleared for residential placement, CSC will pre-authorize the beneficiary for residential treatment & place the beneficiary utilizing the IST. For "same day access" requests from VMC, ED or EPS, the beneficiary may not have an IST. Thus, if the beneficiary is cleared, upon placement the residential provider has up to 24 business hours to contact the BH Call Center to ensure an IST is completed. If the beneficiary is already open to services with a SUTS provider, that provider would be notified to help with care coordination by submitting an ALOC to the UM team for review. If for some reason, the existing provider cannot submit the ALOC in time, then treatment should not be delayed for the beneficiary and the SUTS residential provider may submit the ALOC upon admit.

Youth Residential Treatment:

Currently, The Behavioral Health Call Center refers youth to outpatient (OP) services and any SUTS OP provider can refer a youth to SUTS residential treatment. The OP provider submits an ALOC to the UM Team providing justification for medical necessity for residential LOC. If the youth is residing in juvenile hall, the Guadalupe BH staff will complete an IST and submit the ALOC, Adolescent Residential Demographics (ARDs), & signed ROI to the UM Team for review[13]. If the UM team approves the residential authorization, the youth will be authorized for residential treatment for up to 30 days. If additional days are needed beyond 30 days, a new ALOC would be submitted to request additional days of treatment. The request would need to justify medical necessity & be submitted to the UM Team three days prior to the initial authorization expiration date.

[13] .pp-7710-reisdential-placement-and-authorization-blank-ard-form-attachment-a-9-25-19.pdf (sccgov.org)
pp-10000-attachment-authorization-form-for-use-of-phi-01-01-17.pdf (sccgov.org)

Perinatal Residential Treatment (pregnant & parenting beneficiaries with children 0-5):

Beneficiaries may be referred to residential treatment directly from Social Services Administration (SSA), the BH Call Center, their SUTS provider, a screening site or facility. Beneficiaries currently receiving a lower LOC other than residential will be referred by the existing provider utilizing the ALOC, which is submitted to the UM Team for review. Beneficiaries without a current provider will be placed & pre-authorized for up to three (3) days for 3.1 ASAM level of care. The residential provider, after intake, will complete and submit the ALOC to the UM Team within 24 hours of the beneficiary being placed. Pregnant and parenting beneficiaries (with children ages 0-5) will be authorized for up to 60 days from the date of admission. If additional days are needed beyond 60 days, a new ALOC request would be submitted justifying medical necessity. The ALOC request needs to be submitted to the UM Team three days prior to the initial authorization expiration date.

County of Santa Clara Referral source	Process for Residential Authorization
Behavioral Health Call Center & Screening Sites	1). Initial Screening Tool (IST) completed and sent to Utilization Management Team (UM). 2). UM team sends placement to residential provider. 3). Placement is then pre-authorized for up to 3 days, initially, for ASAM 3.1 LOC. 4). Residential provider submits ALOC to UM Team within 24 business hours of admission. 5). UM Team responds within 24 business hours from date ALOC was received. 6). Authorization is given for up to 30 days from date of admission.
Current SUTS Provider	1). ALOC completed. 2). ALOC submitted to UM Team. 3). UM Team responds within 24 business hours from date ALOC was received. 4). UM team sends placement to the residential provider upon authorization. 5). Authorization is given for up to 30 days from date of admission. 6). Referring SUTS provider keeps beneficiary open to services until it is confirmed the beneficiary has entered residential treatment.

Facility requests (e.g., hospital, crisis residential, SNIFF etc.)	1). IST completed and sent to UM Team. 2). CSC initiates care coordination between facility & residential provider. 3). MD to MD consult. 4). When cleared, placement sent by UM Team to the residential provider. 5). ALOC submitted to UM Team by the residential provider or existing SUTS provider within 24 hours of admission (or submitted by pre-existing outpatient provider). 6). UM Team responds within 24 business hours from date ALOC was received. 7). Authorization is given for up to 30 days from date of admission.
Same Day Access requests (e.g., VMC, ED, EPS)	1). CSC informed of request. 2). CSC initiates care coordination between facility & residential provider. 3). MD to MD consult. 4). When cleared, placement sent by UM Team to the residential provider. 5). Residential provider supports beneficiary with contacting BH Call Center to complete IST within 24 hours of admission. 6). ALOC is submitted by residential provider for authorization. 7). UM Team responds within 24 business hours from date ALOC was received. 8). Authorization is given for up to 30 days from date of admission.

New CSC BHSD Beneficiaries:

Once a person is screened into the CSC BHSD system of care, there may be additional intake paperwork that needs to be completed. These generally come from regulations about providing all beneficiaries with information about their services. Initial paperwork would include, but may not be limited to:

- Consent to treatment, signed and dated by the beneficiary.
- Admission Agreement, signed and dated by the beneficiary.
- Beneficiary's Rights, signed and dated by the beneficiary.
- Evidence that Beneficiary Handbook has been provided to beneficiary.
- Financial Agreement form.
- Follow-Up Post Discharge Consent, signed and dated by the beneficiary.
- Fair Hearing Rights information acknowledgement
- Notice of Privacy Practices

- HIPAA Confidentiality
- Releases of Information compliant with 42 Code of Federal Regulations (CFR)
- For some providers, an HSQ or additional intake documents are required and are specific to their regulations, such as NTP/OTP and Perinatal Services.

It is required to maintain documentation in the chart of Medi-Cal eligibility status for each month in treatment.

Treatment and Service Components:

Outpatient Treatment Services

Early Intervention Services for Youth and Young Adults (ASAM Level 0.5)

Early Intervention services are covered DMC services under EPSDT[14] (ASAM 0.5) and are appropriate for youth (ages 12-17) and young adults (ages 18-20) who have been screened and determined to be at risk of developing an SUD (i.e., but who do not meet DSM criteria for a SUD), and would benefit from psychoeducation (using the Healthy Youth Early Intervention Curriculum) and any other services covered under the outpatient LOC as early intervention services, and in accordance with the EPSDT benefit to correct or ameliorate a substance use condition. This includes services that sustain, support, improve or make more tolerable an existing substance misuse or a SUD condition. The Early Intervention services benefit includes receipt of any DMC reimbursable service available in outpatient settings.

Early Intervention services are provided in an outpatient modality and must be available as needed based on individual clinical needs, even if the beneficiary is not participating in the full array of outpatient treatment services. A full assessment utilizing the ASAM criteria is not required for a DMC beneficiary to receive Early Intervention services. To establish medical necessity for Early Intervention services, providers must screen youth and/or young adults using the "ASAM Screener for Youth and Young Adults."

Outpatient services are provided to beneficiaries up to nine hours per week for adults, and less than six hours per week for adolescents.

Outpatient Drug Free or ODF are provided to beneficiaries as medically necessary.
Outpatient Services ASAM Level 1 include the following components:

1. Assessment
2. Care Coordination
3. Counseling (Individual and Group)
4. Family Therapy

[14] https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/epsdt.pdf

5. Medication Services
6. MAT for Opioid Use Disorder (OUD)
7. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
8. Patient Education
9. Recovery Services
10. SUD Crisis Intervention Services

Narcotic Treatment Program/Opioid Treatment Program

Narcotic Treatment Program (NTP) Services, also described in the ASAM criteria as an Opioid Treatment Program (OTP), is an outpatient program that provides FDA (Federal Drug Administration) drugs approved to treat SUDs when ordered by a physician as medically necessary. NTP/OTP are required to offer and prescribe medications including Methadone, Buprenorphine (transmucosal and long-acting injectable), Naltrexone (oral and long-acting injectable), Disulfiram, and Naloxone. The NTP/OTP shall offer the beneficiary a minimum of fifty (50) minutes of counseling services per calendar month. NTP/OTP shall offer adequate counseling services to each beneficiary as clinically necessary.

Once a program becomes an accredited and certified Opioid Treatment Program[15] they use a combination of medication assisted treatment (MAT) and counseling treatment services to alleviate the symptoms of withdrawal Management and provide whole person care. NTP/OTP programs adhere to federal regulations and are not required to utilize the problem list.

NTP/OTP includes the following components:

1. Assessment
2. Individual Counseling
3. Group Counseling
4. Patient Education
5. Medical Psychotherapy
6. Medication Services
7. MAT for OUD
8. SUD Crisis Intervention Services
9. Naltrexone Treatment
10. Care Coordination

NTP/OTP Specific Requirements (Methadone)

Consent for Methadone: Federal Consent must be signed at admission and re-signed within 30 days.

[15] https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program

Intake:

- Must conduct laboratory test and certify fitness for treatment.
- Includes Physical exam.
- Beneficiary receives Narcan (Naloxone), education and completes receipt.
- Treatment start date is the first day beneficiary receives medication.

Treatment Plan:

- Initial Treatment Plan must be written within 28 days of admission to the program.
- Must be signed by MD within 14 days of completion of the Initial treatment plan and subsequent completed treatment plans.
- Subsequent treatment Plans are required every 90 days from the date of admission.

Discharge

- Discharge date is the last day of medication dosing.
- Beneficiaries must be discharged after missing 14 days of dosing while in Methadone Maintenance Treatment (MMT).

Frequency of Counseling

- Beneficiaries must receive a minimum of 50 minutes of counseling per calendar month except when the MD adjusts or waives services, must include rationale for adjusting or waiving of counseling services. The minimum reimbursable is 200 minutes per calendar month unless justified by MD documented in beneficiary record.
- Progress notes are documented in 10-minute intervals.

Progress Notes: NTP/OTP Methadone: Title 9 & 10345

Duration of sessions are in 10-minute units. Counselors must also include beneficiary's response to positive drug screening results.

NTP/OTP (Opioid Treatment Program Services) ASAM Level 1

- NTP/OTP refers to daily dosing of Suboxone and Methadone. Services include Intake, Individual Counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention, treatment planning and discharge services. This includes NTP/OTP Perinatal. Unit of services for NTP/OTP treatment are in 10-minute increments.
- These services are rolled up under one of four (4) counseling categories: 1. Intake, 2. Individual Treatment NTP/OTP, 3. Group Treatment NTP/OTP, 4. Case Management SUTS

- Additional medical services provided by an MD and/or Nurse can include dosing, Suboxone, medication visit MD-SUTS only, medical visit MD- SUTS only, MD physical exam- SUTS Only.

Note*: NTP/OTP services may be provided concurrently at the residential WM & Residential Treatment sites.

Medication Assisted Treatment (MAT)[16][17]

All Providers MUST offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services. Providing a referral number is not considered sufficient or an effective way to connect a beneficiary with MAT services.[18]MAT includes all FDA-approved medications and biological products to treat AUD, OUD, and any SUD. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed in this "Covered DMC-ODS Services" section. MAT may be provided with the following service components:

1. Assessment
2. Care Coordination
3. Counseling (individual and group)
4. Family Therapy
5. Medication Services
6. Patient Education
7. Recovery Services
8. SUD Crisis Intervention Services
9. Withdrawal Management Services

All providers are required to discuss and inform patients about MAT as a treatment option for all beneficiaries being treated for an alcohol, opioid, and/or tobacco use disorder so that they understand that MAT is an evidence-based treatment option for their condition. MAT is required to be offered as a concurrent treatment option for patients with these conditions at all levels of care and settings across the County of Santa Clara Substance Use Treatment. The passive or active discouragement of the use of MAT is contrary to the guidance and the science of effective SUD treatment.[19] Acceptance or refusal of MAT must be documented in clinical record.
MAT is available to Medi-Cal beneficiaries through the Medi-Cal pharmacy benefit without prior authorization.

[16] https://www.dhcs.ca.gov/Documents/BHIN-21-024-DMC-ODS-Expanding-Access-to-Medications-for-Addiction-Treatment-MAT.pdf
[17] http://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006
[18] BHIN-23-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf
[19] Resource Center | SAMHSA

Beneficiaries needing or utilizing MAT must be served by providers and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in treatment.

Providers offering MAT shall not deny access to medication or administratively discharge a patient who declines counseling services. Providers will attempt to utilize various evidence-based[20] practices, different staff, and/or different services to continue to treat the beneficiary.

MAT includes obtaining informed consent, ordering, prescribing, administering, and monitoring of all medications. When MAT is provided to patients, licensed prescribers operating within their scope of practice should assist the patient to collaborate in clinical decision-making, assuring that the patient is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT, taking into consideration the benefits, side effects, alternatives, cost, availability, and potential for diversion, among other factors.

Intensive Outpatient Treatment, ASAM Level 2.1

Services are provided to beneficiaries when medically necessary in a structured programming environment (offering a minimum of nine (9) hours with a maximum of 19 hours a week for adults, and a minimum of six (6) hours with a maximum of 19 hours a week for adolescents)[21]. Services may exceed the maximum based on individual medical necessity. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving intensive outpatient treatment services if not provided on-site). Providing a beneficiary, the contact information for a treatment program is insufficient.

Intensive Outpatient Treatment includes the following components:

1. Assessment
2. Care Coordination
3. Counseling (individual and group)
4. Family Therapy
5. Medication Services
6. MAT for OUD
7. MAT for AUD and other non-opioid SUDs
8. Patient Education
9. Recovery Services
10. SUD Crisis Intervention Services

[20] https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4671.pdf
[21] D M C Provider Billing Manual (ca.gov)

Residential Treatment (ASAM Levels 3.1-3.5)

Residential Treatment Services are delivered to beneficiaries when medically necessary in a short-term residential program.

1. Level 3.1 – Clinically Managed Low Intensity Residential Services
2. Level 3.3 – Clinically Managed Population – Specific High Intensity Residential Services
3. Level 3.5 – Clinically Managed High Intensity Residential Services

Residential Treatment Services includes the following components[22]:

1. Assessment
2. Care Coordination
3. Counseling (individual and group)
4. Family Therapy
5. Medication Services
6. MAT for OUD
7. MAT for AUD and other non-opioid SUDs
8. Patient Education
9. Recovery Services
10. SUD Crisis Intervention Services

Health screening questionnaire Form 5103 (HSQ) or a comparable form and/or physical exam are required for both residential and withdrawal management services. Residential requires a minimum of 20 hours per week and must include preparation to step down into less intense levels of treatment. Residential services are pre-authorized, and re-authorized based on medical necessity (withdrawal management services do not require authorization). All residential services should be provided primarily in person. Telehealth and telephone services, when provided, shall supplement, not replace the in-person service.

Withdrawal Management Services:

Withdrawal Management Services are provided to beneficiaries experiencing withdrawal in outpatient or residential settings. In the County of Santa Clara Behavioral Health Department, we provide withdrawal management ASAM Level 3.2 within residential settings for adults. For youth we work with the pediatric unit of Valley Medical Center (VMC) to manage the withdrawal and start them on Medication Assisted Treatment.

1. Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision).
2. Level 2-WM: Ambulatory withdrawal management with extended on-site.

[22] BHIN-23-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf

monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting)
3. Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting. (Currently Provided by multiple residential facilities in CSC BHSD)
4. Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits)
5. Level 4-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

Withdrawal Management Services includes the following components[23]:

1. Assessment
2. Care Coordination
3. Medication Services
4. MAT for OUD
5. MAT for AUD and other non-opioid SUDs
6. Observation
7. Recovery Services

The three essential functions of withdrawal management are assessing the beneficiary's needs, stabilization, and facilitation of follow-up, including readiness for and entry into SUTS treatment.

Withdrawal Management (WM), also known as detoxification, is a set of treatment interventions aimed at medical and clinical management of acute intoxication and withdrawal from alcohol and other substances. The rationale for WM is to provide the appropriate level of medical and clinical support to allow patient safety during the withdrawal period, which then allows the patient and treatment team to work together to determine the optimal ongoing treatment strategy. Withdrawal Management Services may be provided in an outpatient, residential, or inpatient setting. If a beneficiary is receiving WM in a residential setting, each beneficiary shall reside in the facility. Inpatient treatment services will primarily be provided in-person. Telehealth and telephone services, when provided, shall supplement, not replace the in-person service.

Health screening questionnaire Form 5103 (HSQ) or containing the same information and/or physical exam are required.

In instances where youth (under the age of 18) require withdrawal management, please work with the providers medical director to determine what is clinically indicated. If needed, please consult with the Utilization Management Team. Please note, this will be on a case-by-case basis & provided in connection with VMC.

[23] BHIN-23-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf

Perinatal Practice[24]:

Per DHCS, "Counties and Providers receiving Substance Abuse Prevention and Treatment Block Grant (SABG) funding are required to follow the Perinatal Practice Guidelines (PPG). The PPG outlines the SABG requirements for SUD services for pregnant and parenting women."

The target population for the PPG is pregnant and parenting beneficiaries. In accordance with SABG requirements, all SUD perinatal treatment providers must treat the family as a unit and admit both the beneficiary and their children into treatment services, if appropriate.

Per PPG, it is essential for SUD providers to perform initial and ongoing assessments to ensure pregnant and parenting beneficiaries are placed in the level of care that meets their needs. It is important to develop an individual treatment plan for each pregnant and parenting beneficiary with a SUD. This helps to ensure that pregnant and parenting beneficiaries are receiving the most effective care for their SUD.

In addition, providers offering perinatal services shall address treatment issues specific to the pregnant beneficiary. Perinatal-specific services shall include the following: i. Pregnant beneficiary/child habilitative and rehabilitative services, such as parenting skills and training in child development; ii. Access to services, such as arrangement for transportation; iii. Education to reduce harmful effects of alcohol and drugs on the pregnant beneficiary and fetus or the pregnant beneficiary and infant; and iv. Coordination of ancillary services, such as medical/dental, education, social services, and community services.

SUD providers delivering perinatal residential services should attempt to obtain physical examinations for beneficiaries prior to or during admission. In addition, providers must obtain medical documentation that substantiates the beneficiary's pregnancy. Perinatal Guidelines for NTP/OTP beneficiaries have additional regulations as noted in Title 9.

Perinatal Residential Substance Use Disorder Treatment is a non-institutional, non- medical, residential program which provides rehabilitation services to pregnant and postpartum beneficiaries with a substance use disorder diagnosis. Each beneficiary shall live on the premises and shall be supported in their efforts to restore and apply interpersonal and independent living skills and access community support systems. Perinatal Residential Substance Use Disorder Treatment programs shall provide a range of activities and services for pregnant and postpartum beneficiaries. Supervision shall be available day and night, seven (7) days a week. Medically necessary rehabilitative services are provided in accordance with individualized beneficiary needs. The cost of room and board is not reimbursable under the Medi-Cal program. Facilities shall store and safeguard all residents' medications, and facility staff members may assist with resident's self-administration of medication. NTP/OTP (medication) services will be provided for opioid abusing pregnant beneficiaries (as well as opioid abusing beneficiaries with and without children) in

[24] https://www.dhcs.ca.gov/individuals/Pages/Perinatal-Services.aspx

residential settings. NTP/OTP medications and NTP/OTP beneficiaries will not be discriminated against by any residential staff, including paraprofessionals, as well as medical and other licensed staff.

Perinatal Residential Substance Use Disorder Treatment include the following components:

1. Assessment
2. Individual Counseling
3. Group Counseling
4. MAT for Opioid Use Disorder (OUD)
5. Patient Education
6. SUD Crisis Intervention Services

Outpatient Perinatal Specific Treatment Requirements

Admission Criteria:

1. Beneficiaries must be pregnant or with children 5 years and under.
2. For pregnant and post-partum beneficiaries: Medical documentation substantiating the beneficiary's pregnancy and last day of pregnancy is required.
3. Beneficiaries must complete a standard Lab test, Vitals, UAs and TB test.
4. Admit date is the first date the beneficiary meets with counselor.

Treatment: Treatment may include Individual and group counseling, but must include parenting classes, pregnancy education, health and nutrition counseling, coordination of care with OBGYN, smoking cessation program, and childcare. Transportation and Case Management services are also offered.

Treatment Plan: Must reference Prenatal or post-partum issues.

Urine Testing: UAs are done randomly for all PSAP beneficiaries and weekly for pregnant women.

Transportation Assistance[25]:

Non-medical transportation (NMT) and non-emergency medical transportation (NEMT) services may be covered by the beneficiary's Medi-Cal managed care plan for the following situations[26]:

1. Transportation to medical, dental, or behavioral health appointments for all Medi-Cal services (available to beneficiaries receiving outpatient, inpatient, or residential services).

2. Transportation for transfer from general acute care hospitals or emergency departments to psychiatric facilities, including psychiatric hospitals, skilled nursing facilities and mental health rehabilitation centers.

[25] BHIN 22-031 and All Plan Letter (APL) 22-008

[26] https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx

3. Transportation after discharge.

Youth

Providers shall provide beneficiaries with linkage to transportation for the purpose of receiving substance use treatment services. Substance use treatment programs should have policies and procedures for how youth will be provided transportation and by whom. Youth residential programs should have written procedures for signing adolescents in and out of program sites. Providers should consider the unique challenges frontier, rural, suburban, and urban locations face with respect to transportation. Transportation assistance may be accomplished in a variety of ways, such as provisions of public transportation passes, identification of and access to other community transportation resources. When transportation is not practical, services may be delivered through e-therapy, telemedicine, or electronic means.[27]

Adult

- Find out if they have Medi-Cal Managed Care through Santa Clara Family Health Plan (SCFHP) or Anthem Blue Cross Partnership.
- The handbooks can each be found at: Health Plan Materials | Medi-Cal Managed Care Health Care Options.
- There is both Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) that can be provided, the description below is for NMT.
- The request needs to be through the Doctor. NMT includes Car, Bus, Train, or Taxi to and from a covered Medi-Cal appointment.
- Once the doctor has put in the request, five days prior to an appointment or as soon as they can, seven days if a new rider, they can call with their ID number, name and address of the doctor, date, and time of appointment.
- For SCFHP 1-800-260-2055 (TTY 711)
- For Anthem BlueCross 1-877-931-4755 (TTY 711)

New CSC BHSD Beneficiaries:

Once a person is screened into the CSC BHSD system of care, there may be additional intake paperwork that needs to be completed. These generally come from regulations about providing all beneficiaries with information about their services.

It is required to maintain documentation in the chart of Medi-Cal eligibility status for each month in treatment.

[27] Adolescent Best Practices Guide OCTOBER 2020 (ca.gov)

There are specific state and federal required confidentiality laws for all clinical records that contain protected health information (PHI). The 42 CFR Part 2 regulations (Part 2) serve to protect patient records created by federally assisted programs for the treatment of substance use disorders (SUD). Part 2 has been revised to further facilitate better coordination of care in response to the opioid epidemic while maintaining its confidentiality protections against unauthorized disclosure and use.[28] All providers are expected to follow the regulations.

Consents 42 CFR, Part 438

Counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS)[29] are considered Prepaid Inpatient Health Plans (PIHP) and therefore subject to applicable Medi-Cal Managed Care laws and regulations governed by the Centers for Medicare and Medicaid Services (CMS)[30]. The regulations include many requirements designed to ensure beneficiaries receive high quality services without barriers to access. As a component of becoming a managed care entity, ACBH and its SUD network must abide by the 42 Code of Federal Regulations (CFR), Part 438[31] managed care requirements (with exceptions noted in the DMC-ODS-IA Section II.A).

In general, one of the primary aims of 42 CFR, Part 438 is to achieve delivery system and payment reforms by focusing on the following priorities:

1. Quality of care
2. Network adequacy and access to care standards (e.g., timeliness of services, distance standards)
3. Client/consumer protections

Any verbal, written, recorded or electronic information that identifies or can identify a client is considered Protected Health Information (PHI). All counselors must complete the mandated training that covers Health Insurance Portability and Accountability Act (HIPAA)[32] and 42 Code of Federal Regulations (CFR) Part 2[33] regulations, and the Health Information Technology for Economic and Clinical Health (HITECH)[34] upon employment and every year thereafter.

[28] Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule | SAMHSA
[29] https://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx
[30] https://www.cms.gov/
[31] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438
[32] https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html
[33] https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2
[34] https://hipaasurvivalguide.com/hitech-regulations.php

Informed Consent

When providing information about mental health services, make sure to provide all necessary information per your licensure and ethical requirements. For example, MFTs, whether licensed or not (LMFTs and AMFTs) must provide information about the limits of confidentiality (duty to report suspected child, elder, or dependent adult abuse or neglect and duty to warn under Tarasoff). If unlicensed, an AMFT must provide information that they are currently working under the license of their supervisor, who is licensed.

Informed consent also often includes letting people know that sometimes when starting treatment, things may get worse before they get better, as discussing symptoms may trigger trauma response or starting medication may not be successful with the first attempt or dosage. If the beneficiary is closed from a program and then later reopened, a new consent must be completed.

Youth Consent:

"A minor who is 12 years of age or older may consent to outpatient medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem." (Cal. Family Code §6929(b)).[35] State law requires that the parents or guardians of a minor receiving services for drug or alcohol related problems be contacted and encouraged to participate in the treatment. The parents or guardian may not be contacted if the health care professional treating the minor believes it would not be advantageous to the minor to have parents or guardian involved. The professional person providing medical care or counseling to a minor shall state in the minor's treatment record whether and when the professional person attempted to contact the minor's parent or guardian, and whether the attempt to contact the parent or guardian was successful or unsuccessful; or the reason why, in the opinion of the professional person, it would not be appropriate to contact the minor's parent or guardian.[36]

Parental or guardian's consent to receive narcotic treatment services (NTP/OTP) is required. Any parental involvement for minor seeking treatment, must involve a written Release of Authorization per 42 CFR.

Below are some resources and links related to minor consent for SUD treatment. This is not an exhaustive list and is provided for informational purposes only.

1. 22 CCR § 51473.2 - Social Security regulation authorizing minors to consent to treatment.

[35] www.teenhealthlaw.org
[36] 4V-MinorConsent-12-16-21 (ca.gov)

2. CA Family Code § 6929 allows for minors aged 12 – 17 to consent for services related to the treatment of a drug or alcohol related disorder.

3. Medication services and other types of treatment services that pose a higher client risk are typically not allowed without parental/guardian consent.

4. Children under 12 years old are NOT eligible for minor consent related to drug or alcohol abuse, a sexually transmitted disease, or for outpatient mental health care.

5. 42 CFR § 8.12.d - Source federal regulation for minor consent of SUD services.

6. https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/minor.pdf

7. DHCS Behavioral Health Information Notice 14-002

8. DHCS Behavioral Health Information Notice 18-061

9. California Health & Safety Code § 124260

10. http://teenhealthlaw.org/consent/

Telehealth Consent:

If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally (until signature can be obtained), at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary[37], as well as document the information below.

1. An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit.
2. An explanation that uses of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future.
3. An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted.
4. The potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

[37] https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf

5. The provider must document in the beneficiaries record the provision of this information and the beneficiaries verbal or written acknowledgment that the information was received. [38]
6. A Telehealth Consent Form shall either be signed or indicate verbal consent and work towards obtaining a signature. The form shall be in the chart, not just noted in the chart progress notes.
7. In addition, each session they must document that they have confirmed that the beneficiary is in a confidential location for treatment session.

Telehealth Regulations

These are just a few of the many telehealth links available.

- California Legislative Information
- California Board of Behavioral Sciences
- California Board Of Psychology
- California Board of Registered Nurses
- Medical Board of California
- Medi-Cal & DHCS

Documentation:

Please refer to the billing manual for detailed information. The billing manual specifies who can bill, for what service, and how they can bill. For instance, page 38 of the DMC Billing Manual – Jan 2023 states:[39]

Travel Time:

Travel time and documentation time is billable for DMC-ODS Outpatient Services. Travel time is used for community-based services where the counselor drives from the clinic setting to the location where the service is provided. This includes return travel to the clinic. To bill for transportation, the counselor must document the date and start and end time for each portion (to and from) of travel time.

Documentation time is specific to the beneficiary and the time it takes for the counselor to write a progress note for an individual counseling session, or each beneficiary that

[38] Reference DHCS IN 21-47 and DHCS IN 22-019
[39] D M C Provider Billing Manual (ca.gov)

participated in a group counseling session. If there is more than one counselor providing the group counseling, each practitioner must complete a separate progress note for each beneficiary. Documentation time should also include the date, start and end time for each progress note.

Travel time is no longer separately billed. The time spent on activities that include travel are now included in the code's rates. The time spent providing those services is still required to be accurately documented in the progress note.

Group Counseling:

For group counseling, one or more LPHA/counselors treat two or more beneficiaries at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service. Counties should calculate the minutes/units to submit on a claim using the following formula:

Number of minutes for the group + travel time / Number of beneficiaries in the group = Total minutes per beneficiary + documentation time.

For example: 90 minute group + transportation to the site, 15 minutes + transportation back to the provider site, 15 minutes = 120 minutes / number of beneficiaries in the group, 12, + documentation time, 5 minutes for a specific beneficiary = 15 minutes or 1 unit of service

For every group counseling session, the following are included:

1. Name and signature of counselor(s)
2. The date of the counseling session
3. The topic of the counseling session
4. The start and end time of the counseling session
5. A list of the participants/group sign-in sheet

Care Coordination

Care Coordination, formally referred to as Case Management, is a collaborative and coordinated approach to the delivery of health and social services that links patients with appropriate services to address specific needs and achieve treatment goals. Care Coordination is a patient-centered service that is intended to complement clinical services, such as individual and group counseling, to address areas in an individual's life that may negatively impact treatment success and overall quality of life. Care Coordination offers support services to patients to increase self-efficacy, self-

advocacy, basic life skills, coping strategies, self-management of biopsychosocial needs, benefits and resources, and reintegration into the community.

Guiding principles for Care Coordination are the following:

- Patient-centered and should be primarily focused on meeting the varied needs of patients.
- Provides a point of contact between health and social services.
- Provides advocacy by acting in the patient's best interests.
- Helps patient navigate and obtain community resources and integrate into the community after discharge from inpatient or residential services.
- Culturally sensitive.
- Flexible.
- Anticipatory and understands that SUDs may be chronic and relapsing.

Care Coordination is available to all patients who enter the SUD treatment system. This service is available throughout the treatment episode and may be continued during Recovery Services. Care Coordination services may be provided face-to-face, by telephone or by telehealth, with the patient.

The Care Coordination plan should include tracking key components of service, including Care Coordination needs, Connection/Coordination/Communication activities, and advocacy efforts. Regular Miscellaneous Notes clearly documenting Care Coordination activities are critical to demonstrating the rationale and details of the activities performed. Care coordinators are responsible for working with beneficiaries to implement a Care Coordination plan that addresses the problems listed on the Problem List (non-NTP/OTP settings) or Treatment Plan (NTP/OTP settings) and monitor the beneficiary's progress. Care Coordination should be documented within the clinical notes in the medical record and should include a description of the beneficiary's relevant resources and prioritized service needs, a quantifiable statement of the beneficiary's short-term and long-term goals, planned activities, desired outcomes, and target completion dates. When appropriate, the clinical notes should describe barriers, contingencies for anticipated complications, or alternative plans to achieve stated objectives on which the care coordinator should focus.

ASAM CRITERIA

Providers of DMC-ODS services are required to use the American Society of Addiction Medicine (ASAM) Criteria®, formerly known as the ASAM patient placement criteria, for all service types. The ASAM Criteria® is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcomes-oriented and results-based care in the treatment of substance use disorders (SUDs). The ASAM Criteria® relies on a comprehensive set of guidelines for level of care placement, continued stay, and transfer/discharge of patients with addiction, including those with

co-occurring conditions. The ASAM Criteria® uses a multidimensional patient assessment to direct medical management and the structure, safety, security, and intensity of treatment services. Detailed information about The ASAM Criteria® is available on the ASAM website.

Initial Assessment and Services Provided During the Assessment Process (DMC-ODS)

1. Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA), registered/certified counselor, **or Peer Support Specialist** whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the beneficiary is experiencing homelessness and therefore requires additional time to complete the assessment.
2. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.
3. The initial assessment shall be performed face-to-face, by telehealth ("telehealth" throughout this document is defined as synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home for many of the DMC-ODS services.
4. If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis.
5. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing or by telephone.
6. Residential Treatment Services include assessment.[40]

Evidenced Based Practice

All programs in the DMC-ODS are required to implement at least two of the five Evidence Based Practices (EBPs) in the DMC-ODS. These EBPs currently include motivational interviewing, cognitive behavioral therapy, relapse prevention, trauma-informed treatment (Seeking Safety), psycho-education for groups, and other contract-specific EBPs. SUD programs must be prepared to show evidence of annual EBP training participation by providing documentation of EBP training attendance in staff personnel files. The requirement for EBP training pertains to all direct service LPHAs, and SUD counselors. It also extends to clinical supervisory staff.

[40] DHCS Interagency Agreement, DMC-ODS FY23-FY27, page 111. 7. vii.

The Problem List

The problem list shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any. Problem List and progress notes should reflect the codes, including Z codes, submitted on the claims for service and include diagnostic specifiers from the DSM if applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the person in care and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Providers shall add to or remove problems from the problem list when there is a relevant change to a person's condition.

DHCS does not require the problem list to be updated within a specific time frame or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice. The problem list shall be updated on an ongoing basis to reflect the current needs of the person in care.

Accuracy of the diagnoses and problem list are necessary for appropriate treatment services to a person, and to support claiming for services. Inconsistencies in either can lead to poor coordination of care across teams and treatment as well as inadequate documentation of the medical necessity of services, which can lead to rejected claims.

Treatment Plan

A Treatment Plan is required for SUTS Narcotic Treatment Programs (NTP/OTP), mandated to be updated a minimum of every 90 days. Please see additional requirements for NTP/OTP programs in NTP/OTP Documentation.

Peer support services must also have an approved care plan. The care plan shall be documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services. All treatment plans shall be reviewed periodically and updated to accurately reflect the beneficiary's progress or lack of progress in treatment.

Client Status Report Form (CSR)[41]:

Many beneficiaries are referred to the System by outside agencies, such as: Criminal Court Department of Corrections; Pre-Trial, Probation, and Parole Agencies; the Social Services Agency; Family Court, Recovery Residence, and the Juvenile Dependency Court. The Client Status Report (CSR) Form is the standard tool for this communication process for treatment providers. CSC BHSD does not permit other types of status reporting, such as personalized letters written by counselors.

All Email Communication with PHI (Protected Health Information) requires use of Encrypted Email Services.

Health Screening Questionnaire (HSQ)[42] and Physical Exam Requirements:

- Required in Youth and Adult Residential Treatment, Withdrawal Management (WM) and NTP, and Perinatal programs.
- Required for AOD Licensed facilities at this time.
- Completed at intake.
- Signed by beneficiary and provider.
- In WM, the HSQ shall be reviewed and signed by the MD within 24 hours of admit date.
- In NTP/OTP, the beneficiary may have a Physical Exam upon admission.
- In NTP/OTP, the MD also provides the determination of medical eligibility for treatment services.
- Youth entering Residential treatment are required to complete a physical exam by the 30th day of treatment. (Community Care Licensing standard).
- All providers support beneficiaries in obtaining a physical exam within a twelve-month period to support their overall health and document this in Dimension two of the ASAM Assessment.

Service	Requirement for HSQ	Days to MD or Designee Signature
Outpatient Services (except NTP/OTP, Perinatal)	Not required	Not required

[41] CSR-Form-v2.docx (live.com)

[42] CLIENT HEALTH QUESTIONNAIRE AND INITIAL SCREENING QUESTIONS (ca.gov)

Residential Treatment (Youth and Adult)	Within 24 hours from admission (Youth are required to have physical exam by 30th day of treatment.)	Within 10 business days from admission.
NTP	At admission (Form is more comprehensive)	At admission
WM	Within 24 hours of admission	Within 24 Hours

Progress Notes

A. Providers shall create progress notes for the provision of all DMC-ODS services. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description. Each service activity should have a corresponding progress note to substantiate the service being provided. The progress notes will support what has occurred in the beneficiary's treatment, their progress, their stages of change and the planning made throughout for their discharge.

B. Progress notes shall include:

- The type of service rendered.
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
- The date that the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time.
- Location of the beneficiary at the time of receiving the service.
- A typed or legibly printed name, signature of the service provider, license/credential, and date of signature.
- Evidence Based Practices have been utilized (At a minimum ensure Motivation Interviewing and Cognitive Behavior Therapy and an option for a referral to MAT must have been documented in the notes within the duration of treatment).
- Reference strengths and efforts made to help the individual and/or risk factors that have been identified.
- Progress made in treatment based on the individual or group sessions, including noting clinical observations.
- If necessary ongoing risk assessment.
- For valid Medi-Cal claims, appropriate ICD-10 and HCPCS/CPT codes must appear in the clinical record, associated with each encounter and consistent with the description in the progress note. This can be done at billing and may not need to be a part of the progress note.

- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

C. Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

D. Providers shall complete a daily progress note for services that are billed daily, such as residential and withdrawal management services. Weekly summaries will no longer be required for residential treatment.

E. When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider for each beneficiary note. Each progress note shall document the interventions and the amount of time of the group activities. Notes will be individualized per the beneficiary. All other progress notes requirements listed above shall also be met.

The Clinical Record

Does the clinical record substantiate the beneficiary's need for Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS) services as appropriate to their age and in alignment with Behavioral Health Information Notice (BHIN) 23-001.

Missed Appointments

All missed appointments should be documented for tracking and reporting purposes; however, should not be documented in a billable note for the particular scheduled and missed service.

Care Transitions

Care transitions occur between systems of care but also *within* our system of care. Beneficiaries can start in any LOC and they can move up and down the continuum of care as needed to meet their needs. Some of our programs are more intensive to address more severe problems. Once stabilized, these beneficiaries are transitioned to a less intensive program. Additionally, some beneficiaries may need a higher LOC and thus can be transition to a more intensive program. Beneficiaries may also request to be transferred to another provider within the same LOC to meet their needs. Programs should coordinate care when transitioning and supervisors should ensure continuity of care. When a beneficiary moves from one CSC BHSD

program to another, the ALOC and Discharge Summary are completed to denote this transition, including any referrals made to ensure continuum of care.

Standalone Services

As part of the CalAIM changes to DMC-ODS, Care Coordination, MAT, Recovery Services, and Peer Support Services may be provided either concurrently with other SUD services or as a standalone service. If a beneficiary requests a standalone SUD service, the provider shall complete the admission process as usual and provide the standalone service in the LOC as identified by the ASAM assessment. For all DMC-ODS services, including standalone services, medical necessity, access criteria for DMC-ODS, level of care determination, and ASAM assessment activities must be completed by staff with the scope of practice to do so. Standalone services are only available at non-OTP outpatient programs.

Discharge Planning

1. Planning for discharge is part of the clinical process that begins at intake.
2. If a beneficiary is not continuing to attend the program, providers will show they attempted to contact the person. If the person does not continue the program, the discharge summary can be completed over the phone, or based on information from previous sessions. All beneficiaries should have a discharge summary and if possible a discharge plan.
    a. A discharge summary is required for all beneficiaries even when contact has been lost, and the purpose is to provide a brief summary of treatment and the circumstances of the discharge. Should the beneficiary return, the discharge summary from the previous episode should be reviewed to reorient the program to the beneficiaries' needs and assist with reacclimating to services.
3. The Discharge Plan is completed with the beneficiary and addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for **ongoing care** and **resources**. If the beneficiary cannot be reached to complete the discharge plan, this is noted in the progress note.
4. The written clinical discharge summary shall be included in the note, and address the treatment episode, including duration of treatment, reason for discharge, whether voluntary or involuntary and discharge prognosis.
5. Complete CalOMS Discharge Questionnaire.
6. Utilize the CalOMS Administrative Discharge if the beneficiary has left treatment and cannot be interviewed via telehealth/phone.
7. Upon completion of services, a discharge ALOC will be completed.
8. All documentation is required within 48 hours of date of service, thus when a beneficiary successfully completes treatment, the completion of the discharge should also be done at

that time. The 30-day timeline is appropriately used for beneficiaries who stop attending treatment and it is unclear whether they are returning. DHCS allows for 30 days.

Peer Specialist Roles

The County of Santa Clara is employing Peer Support Specialists (PSS) who must be certified by the State and whose services must be provided under the direction of a behavioral health professional who is qualified by the State. Regarding Peer Support Services, on May 2, 2022, DHCS received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 22-0024, with an effective date of July 1, 2022 to broaden the definition of a Peer Support Specialist as someone who must be in recovery themselves or have lived experience with the process of recovery as a parent, caregiver, or family member. Prior to this update, Peer Support Specialists were defined solely as individuals in recovery, which excluded parents, caregivers, or family members from becoming certified as Peer Support Specialists. This update aligns with the definition of a Peer Support Specialist with the Medi-Cal Peer Support Specialist Certification Program requirements. BHSD has officially opted-in to Peer Support Services for Specialty Mental Health Services (SMHS) and DMC-ODS effective July 1, 2022. It will still be awhile before CSC is ready to bill DHCS for Peer Support Services. At this time, we are working through the Peer Support Certification grandparenting process. Further details are in process.

Peer Support Services are provided by Peer Support Specialists. A Peer Support Specialist is an individual with a current State-approved certification by the Medi-Cal Peer Support Specialist Certification Program, and meets all other applicable California state requirements, including ongoing education requirements. Peer Support Specialists provide services under the direction of a Behavioral Health Professional. A Behavioral Health Professional must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC, DMC-ODS, or SMHS. Although Peer Support Services must be provided under the direction of a Behavioral Health Professional, Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements.

Fraud, Waste, and Abuse[43]

Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for “fraud,” “waste,” and “abuse” can also be

[43] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

found in the Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit [44].

- Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. §1347).
- Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Appendices

Appendix I: Medi-Cal Plans by Type

Santa Clara County has two Medi-Cal managed Care Health Care Options, Santa Clara Family Health Plan and Anthem Blue Cross Partnership.[45]

Appendix II: Documentation Manual Change Log

Section	Change Description	Revision Date
Documentation	Deleted: Treatment Plans are required for SABG (Substance Abuse Block Grant) funded programs.	5/10/23

[44] Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit

[45] Health plan materials | Medi-Cal Managed Care Health Care Options