



**SUD COUNSELOR HANDBOOK  
WITH DOCUMENTATION GUIDELINES**

**VERSION 3A**

**September 2020**

**Orange County Health Care Agency  
Behavioral Health Services**

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## 1. INTRODUCTION

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### PURPOSE

The County of Orange provides Substance Use Disorder (SUD) services to adolescents and adults who have a substance use disorder.

The County of Orange has opted in to participate in the State's Drug Medi-Cal Organized Delivery System (DMC-ODS), which allows greater coordination of care for clients 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 provided to SUD clients. It is our responsibility to our clients 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 clients in our SUD programs so that we may work towards maintaining compliance with the regulations. It is intended to complement the documentation trainings provided by Authority and Quality Improvement Services (AQIS).

Please note that this manual is for educational purposes only.

#### **\*\*\*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.

## 2. MEDICAL NECESSITY

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Medical necessity is the foundation on which all treatment rests. According to the DMC-ODS standards, clients must meet the following medical necessity criteria:

1. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
2. Must meet the American Society of Addiction Medicine (ASAM) Criteria definition of medical necessity for services based on the ASAM Criteria.
3. If applicable, must meet the ASAM adolescent treatment criteria.

Clients who do not meet the full diagnostic criteria for a substance use disorder, cannot be admitted into treatment. They may, however, qualify for the 0.5 ASAM Level of Care (Early Intervention). Adolescents who may be "at risk" of developing a substance use disorder can be

referred to receive Prevention & Early Intervention or other appropriate services through the County. Adults can be referred back to the Beneficiary Access Line for resources.

### 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 clients. The ASAM Criteria offers to improve treatment outcomes by accurately assessing the client’s needs and ensuring that the services provided meet those needs. The client’s needs are assessed through each of the six (6) dimensions of the ASAM Criteria, which are as follows:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and/or Complications
3. Emotional, Behavioral, and/or Cognitive Conditions and/or Complications
4. Readiness to Change
5. Relapse and/or Continued Use Potential
6. Recovery/Living Environment

Based on how severe the client’s functioning is in each of these six (6) dimensions, clients will receive services at the corresponding levels of care. The ASAM Levels of Care 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 2.5	Partial Hospitalization Services	20 or more hours of service/week (not requiring 24-hour care)
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	Clinically Managed Population-Specific	24-hour care with trained counselors; less intense milieu for those with cognitive or other impairments

	High-Intensity Residential Services	
Level 3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors
Level 3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; 16 hours/day counselor availability
Level 4	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3; counseling available to engage client in treatment
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 2-WM	Ambulatory withdrawal management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.
Level 3.2-WM	Clinically managed residential withdrawal management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
Level 3.7-WM	Medically monitored inpatient withdrawal management	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.
Level 4-WM	Medically managed intensive inpatient withdrawal management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

## 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. Those in the above disciplines must also abide by the scope of practice guidelines set forth by the respective certifying or licensing board.

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.

Trainees of a behavioral health discipline (those in graduate programs of study who may be gaining internship or practicum hours in a SUD clinic) are not authorized to provide services in the DMC-ODS. If a trainee is also registered as an AOD Counselor, he or she may provide and bill for services in the DMC-ODS program working within the scope of a registered AOD Counselor. Providers will need to keep in mind that the service and corresponding documentation by this provider type must reflect the scope of practice of an AOD Counselor. Please ensure that trainees are fully advised of the requirements and implications of registering as an AOD Counselor. A registered AOD counselor "shall complete certification as an AOD counselor within five (5) years of the date of registration" (CCR Title 9, Chapter 8, Subchapter 3, Section 13035 (f)(1) and (2)). Additionally, please be sure to confirm with graduate training programs and administration in regards to the granting of credit for internship or practicum hours intended to fulfill the requirements of a graduate program while the individual operates under a different discipline.

The link below is a helpful grid provided by the State Department of Health Care Services (DHCS) 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](http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/ODS_Staffing_Grid_Revised_031518_Final.pdf)

DMC-ODS also requires that counselors and clinicians receive training in ASAM Multidimensional Assessment and From Assessment to Service Planning and Level of Care, also known as ASAM A and ASAM B prior to delivering DMC-ODS covered services. Training in two (2) Evidence-Based Practices (EBP) is also required. In order to bill for services under DMC-ODS, providers must complete all required training as shown on the DMC-ODS Training requirements Policy and Procedure (P&P). This and all other BHS P&P can be found by visiting [www.ochealthinfo.com/bhs/pnp](http://www.ochealthinfo.com/bhs/pnp).

LPHA must obtain a minimum of five (5) hours of continuing education related to addiction medicine each year.

Physicians must obtain a minimum of five (5) hours of continuing medical education related to addiction medicine each year.

### 3. INITIAL ASSESSMENT

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For SUD services, the initial assessment that is completed upon the client'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 client and, if applicable, with information from significant others that may be involved with the client's treatment or referral for treatment. The assessment must include information about the following aspects of the client'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, the County's SUD Assessment form incorporates the six (6) dimensions of the ASAM Criteria. All of the above information that must be incorporated into a standard assessment, is intended to be addressed in the County's SUD Assessment form through each of the dimensions. When using the County's SUD Assessment form, make sure that there is documentation for each of the ten (10) elements listed above. It does not matter where the information is placed or in which specific dimension, as long as it is included. For suggestions on where to place the required assessment information in the County's SUD Assessment, see the table beginning on page 10. It is important to ensure all elements are included because missing information will result in disallowance of services.

As we get to know our clients during the assessment period, we should always keep the following in mind:

“How does this relate to the substance use?”

This is because we need to demonstrate how the problems in the client's life is a result of the substance use. These are the problems that we will be addressing in the client'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 client's life. It is a purposeful gathering of information, directed at identifying how the substance use has affected the client.

With the information gathered, we must first determine whether the client 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 client 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. For a quick guide to the DSM-5 criteria for a substance use disorder, refer to [Appendix A](#) (Page 48). Please remember that the non-LPHA cannot diagnose the client. What the non-LPHA will be doing is gathering the necessary information so that the LPHA can determine the most appropriate diagnosis. Therefore, the County’s SUD Assessment form has two parts: pages 1-10 (Dimensions 1-6 and the Placement Summary), which can be completed by either a non-LPHA or LPHA; pages 11-12 (Diagnosis and Case Formulation), which can only be completed by the LPHA.

**Diagnosis Required for Billing**

Since the State requires a diagnosis for billing, this can present challenges for those situations where the non-LPHA has conducted assessment sessions with the client and is going to bill for those services. In such cases, the non-LPHA and an LPHA would need to consult so that the LPHA can determine a diagnosis to be used for the purposes of billing. (This consultation is different than the non-LPHA and LPHA consult for the creation of the Case Formulation or establishment of medical necessity by the LPHA. For more information on the consultation needed for the Case Formulation, see page 15 under “Important Reminders about the SUD Assessment Form.”) The consultation for determining a preliminary diagnosis will need to take place within the first three (3) days from the client’s admission to treatment or before the next service, whichever comes first. Best practice would be to complete this consultation the same day as the client’s admission. The consultation should be documented in the client’s chart to demonstrate that it was the LPHA who provided the temporary diagnosis and not the non-LPHA. This consultation is a billable Case Management activity and both the non-LPHA and the LPHA can bill. The start and end time of the consultation needs to match for each of the progress notes completed. If both parties are not going to bill, at minimum, the LPHA must document so there is evidence of the LPHA determining the initial diagnosis for billing.

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

ASAM Criteria Dimensions:	Required Assessment Information:	DSM-5 Criteria for SUD Diagnosis:
Dimension 1 – Acute Intoxication and/or Withdrawal Potential	<ul style="list-style-type: none"> <li>• Drug and/or alcohol use history;</li> <li>• Previous SUD treatment history</li> </ul>	<ul style="list-style-type: none"> <li>• Tolerance</li> <li>• Needing to use more to get the same effect</li> <li>• Using the same amount but not getting the same effect</li> </ul>

		<ul style="list-style-type: none"> <li>• Using more or for longer than anticipated</li> <li>• Withdrawal</li> </ul>
Dimension 2 – Biomedical Conditions and/or Complications	<ul style="list-style-type: none"> <li>• Medical history</li> </ul>	<ul style="list-style-type: none"> <li>• Keep using even when it is physically dangerous to do so</li> <li>• Keep using even though the client knows that there are physical problems caused by or made worse by the use</li> </ul>
Dimension 3 – Emotional, Behavioral, and/or Cognitive Conditions and/or Complications	<ul style="list-style-type: none"> <li>• Psychiatric/psychological history</li> </ul>	<ul style="list-style-type: none"> <li>• Keep using even when it is psychiatrically dangerous to do so</li> <li>• Keep using even though the client knows that there are psychological problems caused by or made worse by the use</li> </ul>
Dimension 4 – Readiness to Change	<ul style="list-style-type: none"> <li>• Previous SUD treatment history (as it relates to motivation and willingness for treatment);</li> <li>• Family history; Social/recreational history; Financial status/history; Educational history; Employment history; and/or Criminal history, legal status (as it relates to severity of problems impacting desire to change)</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing use impacting work, school, home; interpersonal problems</li> <li>• Keep using despite knowing it is causing problems</li> <li>• Desire to discontinue, but unable to</li> </ul>
Dimension 5 – Relapse and/or Continued Use Potential	<ul style="list-style-type: none"> <li>• Previous SUD treatment history (as it relates to occurrences of relapse)</li> </ul>	<ul style="list-style-type: none"> <li>• Desire to discontinue, but unable to</li> <li>• Keep using despite knowing it is causing</li> </ul>

		<p>problems or is a danger</p> <ul style="list-style-type: none"> <li>• Inability to tolerate withdrawal (using to avoid withdrawals)</li> </ul>
<p>Dimension 6 – Recovery/Living Environment</p>	<ul style="list-style-type: none"> <li>• Family history;</li> <li>• Social/recreational history;</li> <li>• Financial status/history;</li> <li>• Educational history;</li> <li>• Employment history;</li> <li>• Criminal history, legal status</li> </ul>	<ul style="list-style-type: none"> <li>• School, work, home situation that has suffered as a result of use</li> <li>• Not following through or taking care of responsibilities at home, school, or work because of use</li> <li>• A lot of time and energy going towards trying to get, use, or recover from the use</li> </ul>

The SUD Assessment form or similar psychosocial assessment is required for every intake at a new provider.

For a tool that can be used to identify client-specific information for each of the dimensions of the ASAM Criteria, refer to [Appendix B](#) (Page 49).

**Transitions in level of care within the same provider**

For those clients who may transition from one level of care to another within the same provider, the SUD Re-Assessment form completed at the former level of care (which substantiates the need for a different level of care) can also act as the initial assessment for the new level of care that the client is going into. In such cases, the SUD Re-Assessment form must fulfill the requirements of an initial assessment. This means that the required assessment elements need to be addressed (Drug and/or alcohol use history; Medical history; Family history; Psychiatric/psychological history; Social/recreational history; Financial status/history; Educational history; Employment history; Criminal history, legal status; and Previous SUD treatment history. See page 9 for more on the required assessment elements.). You may reference the Initial SUD Assessment, if the relevant information has been captured at that time and it has not changed. You will still want to include updates to any information because changes in functioning must also be considered for determining the client’s current risk in each dimension. For example, information in Dimension 1 might read, “See client’s past drug/alcohol use history in SUD Assessment dated 1/5/2020. Client has been able to abstain from alcohol use (weekly negative drug testing) throughout time in ODF and has been sober for a total of 4 months. Client does not exhibit or endorse any intoxication or withdrawal symptoms.”

For information that has not changed and is not impacting the client's severity in functioning in a particular dimension, this should be noted. For example, if there have been no changes to the client's highest level of education from the time of the initial assessment in ODF to admission in Recovery Services, it may be documented as "No changes in client's education since admission to treatment. See client's educational history in SUD Assessment dated 1/5/2020."

Example: The Santa Ana Clinic has Intensive Outpatient Treatment (IOT), Outpatient Drug Free (ODF), and Recovery Services. Client X currently attends ODF at Santa Ana Clinic. The counselor completes the SUD Re-Assessment for client X, which indicates the client is ready for a lower level of care. Client X may transition to Recovery Services at Santa Ana Clinic and the same SUD Re-Assessment (from ODF) can be used as the assessment that substantiates the need for Client X to receive services at the Recovery Services level. A new treatment plan should be created based on the information captured in the SUD Re-Assessment form.

Note that the State does not consider a transition from IOT to ODF within the same provider as a discharge. Therefore, an initial assessment or the use of an SUD Re-Assessment that documents the client's readiness for discharge from IOT and the need for ODF does not need to be used as the initial assessment for ODF, since it is not considered a new admission. However, since it is a change in level of care and the needs of the client have changed, there still needs to be documentation of medical necessity and it is advised that an SUD Re-Assessment be used to document this. This ensures that the provider has done due diligence in applying the ASAM Criteria to confirm that the client is ready to be transitioned. It is also advised that the provider use this opportunity to check to make sure that the required assessment information has been captured in the initial SUD Assessment or subsequent Re-Assessments. If the information was lacking or insufficient, it should be captured in a Re-Assessment to demonstrate that all of the client's psychosocial history was considered.

Note that for the County Integrated Records Information System (IRIS) billing system, the IOT and ODF levels of care are considered two separate episodes of care (EOC). This requires an administrative step to end one EOC and start the other.

### **Transitions in level of care across different providers**

The State allows for using the same assessment document when a client transitions from one provider to another. This means that the SUD Re-Assessment completed to justify the client's appropriateness for discharge from Provider A's program can be used as the initial assessment for substantiating the client's admission to Provider B's program. The assessment document that is being carried over will need to contain all of the elements of an initial assessment in order to be used for that purpose. These include: Drug and/or alcohol use history; Medical history; Family history; Psychiatric/psychological history; Social/recreational history; Financial status/history; Educational history; Employment history; Criminal history, legal status; and Previous SUD treatment history - See page 9 for more on the required assessment elements. It will be the responsibility of the receiving provider to thoroughly review the assessment document that is received from the client's previous provider. In addition to the required elements of an assessment, the receiving provider will also need to make sure that the assessment

document sufficiently establishes the client’s medical necessity for services at the new program. The LPHA will need to make this determination based on the information contained within the assessment document. Upon review, if the assessment document received does not contain the necessary information, it is advised that a full assessment or SUD Assessment form be completed to ensure that the requirements of an initial assessment are fully satisfied and to avoid disallowances. Relevant information from the previous provider’s assessment document can be referenced as appropriate.

The time spent by the receiving LPHA reviewing the information on the assessment document that is received from the previous provider is a billable activity coded as Case Management. In order to justify billing for the time, the LPHA needs to clearly describe what he or she did (review the client’s previous provider’s SUD Re-Assessment), what the purpose for doing so was (to determine the client’s appropriateness for the receiving provider’s program), and what the results of this review are (what clinical determination was made based on the review).

For a quick guide on billing associated with review of documents, see [Appendix E](#) (page 53).

### **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 client’s \_\_\_\_\_ (symptoms of SUD), client \_\_\_\_\_ (behaviors) resulting in \_\_\_\_\_ (impairment).”

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 client meets medical necessity and is most helpful to use in the Rationale sections of each dimension on the SUD Assessment form and the Case Formulation section. If the above formula is utilized, please remember to tailor it with details specific to each client so it is not the same template from client to client. Using the same template information has the potential to be scrutinized as fraudulent and susceptible to recoupment. For additional help on documenting how the substance use is related to the impairments, refer to [Appendix C](#) (Page 50) for a quick guide. For a helpful guide on how to write the Case Formulation, see [Appendix D](#) (Page 51). For further assistance in completing the County’s SUD Assessment form, please refer to the Accompanying Guide.

### **Important Reminders about the SUD Assessment Form**

1. For Residential Treatment, it is to be completed and signed within three (3) calendar days of the client's admission.
2. For Intensive Outpatient and Outpatient Drug Free, it is to be completed and signed within thirty (30) calendar days of the client's admission.
3. The Immediate Needs, Dimensions 1-6, and the Placement Summary may be completed by the non-LPHA counselor. The Case Formulation and Diagnosis must be completed by an LPHA.
4. If the assessment is completed by a non-LPHA counselor, there must be a consultation (by face-to-face, telehealth, or telephone) between the non-LPHA counselor and the LPHA who will review the assessment. This interaction needs to be documented to show evidence that this consultation took place. It can best be captured using a progress note. Both the non-LPHA counselor and the LPHA can account for the time spent in the consultation through a billable Case Management note. This means that if the consultation took 23 minutes, both the non-LPHA and the LPHA can claim 23 minutes on each of their progress notes. Please remember that this interaction must be a separate activity from clinical supervision. Clinical supervision is not billable to DMC. Caution: The start and end times for the consultation on each note must match! The LPHA must then complete the Case Formulation and the Diagnosis section of the SUD Assessment form. The LPHA must complete and sign this within thirty (30) calendar days of the client's admission. It is permissible for the LPHA to document that the consultation took place within the Case Formulation in lieu of completing a progress note. However, if there is no separate progress note documenting the consultation, this means that the time spent in that consultation cannot be billed. For a guide on billing for Assessment and Re-Assessment activities, see [Appendix E](#) (page 53).
5. If the LPHA is the one who is completing the entire assessment document (no non-LPHA involvement), the LPHA does not need to complete the Counselor Recommendation section of the assessment. The LPHA can indicate "N/A" or "See case formulation." It is advised that the LPHA sign the page that includes the counselor's recommendation since it will make it clear to an auditor who completed dimensions 1-6 and the placement summary.
6. If the SUD Assessment form cannot be completed within the timeframe specified above, the reason(s) should be documented in the progress notes. If the assessment is not completed by the end of the required timeframe, all additional services after this point must be coded as non-compliant (services cannot be billed without a valid assessment and treatment plan in place beyond the timeframe). Once the assessment and treatment plan are completed, billing can resume.
7. If the SUD 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 documented on the progress note where it is indicated that it was worked on. This is to show that what was stated as completed in the progress note was actually completed on that date.
8. 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.

**\*\*\*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.

#### 4. TREATMENT PLAN

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Once the SUD Assessment form has been completed, you now have the basis for building the client's treatment plan. The treatment plan is the client's roadmap for his or her time in the current treatment episode or level of care. The risk ratings that are indicated for each dimension of the SUD Assessment form will help you to identify and prioritize the areas that need to be addressed in treatment. It is expected that all problems identified in the assessment are reflected on the treatment plan. However, not all need to be addressed at once. We must take into account what will be feasible for the client as well as what the priorities are for the client. In order to develop a meaningful treatment plan, it must be a collaborative process that includes the input of the client. In the progress note for the session in which you collaborated with the client on the treatment planning process, it can be documented as to why a particular problem will or will not be addressed on the treatment plan. Such problems or goals can be "deferred" for a later date.

##### **Treatment plans completed before the assessment**

Since the treatment plan must be completed based on the information on the assessment, any treatment plans developed and signed prior to the assessment being completed, will not be valid. This is true regardless of whether or not the non-LPHA or LPHA completes the assessment with the client. The information needs to be documented in sequence. The client's diagnoses are required to be on the treatment plan, which means that the formal diagnoses need to be confirmed by the LPHA and medical necessity established. The LPHA will need to complete the Diagnosis and Case Formulation sections of the SUD Assessment *PRIOR* to the development of the treatment plan! Please note that dates of signatures on the treatment plan before the completion of the assessment will result in recoupment. Services provided based on a treatment plan signed before the completion date of the assessment would be non-compliant and will be recouped if found to be using a billable CPT code. In this circumstance, an updated treatment plan would need to be completed and signed reflecting a date of service that is on or after the date on which the assessment was completed. Services on and subsequent to this date could then be compliant and be billed using compliant CPT codes.

The following are the four (4) required components of a treatment plan:

1. Statement of the Problem

2. Statement of the Goal
3. Action Steps
4. Target Dates

### Statement of the Problem

These are based on the dimensions where impairments were identified and areas that need to have a corresponding goal on the treatment plan. Since treatment planning is a collaborative process with the client, it is important to explore with the client what problems he or she would like to resolve or what he or she is looking to achieve. Although broad, it should not be a category such as “addiction” or “medical.” Be more descriptive to identify what the problems within those categories are. What the client 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 client on breaking it down to what corresponds with what have been identified as the key problems in the assessment process.

### 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 Criteria within the SUD Assessment form, we will want to determine “what do we need to work on first to get you to where you want to be?” Goals must be measurable and or quantifiable. Therefore, it is recommended that goals be written in the SMART format:

1. S – Specific
  - a. Targets an observable behavior
    - i. Example: Using coping skills to manage triggers; completing tasks for acquiring employment (ties back to what was in the assessment)
2. M – Measurable
  - a. Quantifiable with a baseline and target (how often is it happening now and where do we want it to be?)
    - i. Example: ...from 0x/day to 3x/day; ...from 4x/month to 1x/month
3. A – Achievable
  - a. Is the client willing? Is the client able? Set them up for success
4. R – Realistic
  - a. Results-focused, does it fulfill the desired reason for having that goal; applicable; worthwhile
5. T – Time-bound
  - a. Setting a period of time, specific to the client, when the goal will be worked on and progress can be tracked, which helps both the counselor and the client stay on course.

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), client will \_\_\_\_\_ (behavior change desired) from \_\_\_\_\_ to \_\_\_\_\_ (baseline and target) in order to \_\_\_\_\_ (how it addresses the problem).”

For a reference on treatment planning, see [Appendix F](#) (Page 55).

For a quick guide on SMART goals, see [Appendix F](#) (Page 57).

Remember to check to see if the client needs a goal for obtaining a physical exam. All clients who have not had a physical exam within the twelve (12) months prior to admission to treatment must have a goal on the treatment plan to address this. This is required for ALL levels of care, including Withdrawal Management and Recovery Services.

Likewise, if there are any medical or health concerns or conditions that necessitate coordination of care, there must be a goal on the treatment plan to address this.

Regardless of whether it is a perinatal program or not, if the client is pregnant or postpartum, the treatment plan must address the requirements for covered services under the Perinatal Treatment Guidelines (i.e., addressing treatment and recovery services specific to pregnant and postpartum women like relationships, sexual and physical abuse, and development of parenting skills; mother/child habilitative and rehabilitative services; education to reduce harmful effects of alcohol and drugs on the mother and child/fetus; coordination of ancillary services).

### Action Steps

Action Steps are what the counselor and/or the client will do to work towards achieving the identified goal. They need 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 for billing. It also needs to include the frequency of the service or how often it will be provided. Action steps must be clinical and within the scope of practice of the individual who will be providing the stated action. They 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 client manage cravings” is pretty vague. It begs the question, “*How* will you help the client 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 clients with a substance use disorder. A better intervention would be, “The counselor will provide individual counseling 1x/week to educate client on the physiological and psychological effects of addiction,” or “The counselor will provide individual counseling 2x/month to help the client identify changes in thoughts, feelings, and behaviors associated with the experience of cravings.”

A formula for writing an action step such as the one below can be used as an option to guide you:

“(WHO – counselor, staff, therapist, etc.) will provide (TYPE OF SERVICE – individual counseling, case management, etc.) (FREQUENCY – 1x/week, 2x/month, etc.) in order to (example of the TYPE OF INTERVENTION that will likely be used for this type of service).”

## Target Dates

The target date is the anticipated date of completion for the particular action step. If there are multiple action steps to a goal on the treatment plan, there needs to be a target date associated with each one. However, the target dates for all action steps may be the same date. The date should be determined based on the particular action step and be specific to the needs of the client. Therefore, we should be moving away from designating a target that corresponds to the length of a program or how long we expect the client to stay in treatment. Some action steps will be able to be achieved in a few weeks whereas some action steps may take several months.

## Important Reminders about the Treatment Plan

1. For Residential Treatment, it is to be completed, signed, and dated by the primary counselor (or creator of the treatment plan) within ten (10) calendar days of the client's admission.
2. For Intensive Outpatient and Outpatient Drug Free, it is to be completed, signed, and dated by the primary counselor (or creator of the treatment plan) within thirty (30) calendar days of the client's admission.
3. For Residential Treatment, the client must review, sign, and date the treatment plan within ten (10) calendar days of the client's admission.
4. For Intensive Outpatient and Outpatient Drug Free, the client must review, sign, and date the treatment plan within thirty (30) calendar days of the client's admission.
5. If the client refuses to sign the treatment plan, it should be documented in the progress note along with a plan for how to engage the client to participate in treatment. The treatment plan can be valid with the counselor and LPHA's signature alone, only if there is documentation of the reason for the missing signature of the client.
6. If the treatment plan is completed by a non-LPHA counselor, the LPHA must review, sign, and date this within fifteen (15) calendar days from the date of the counselor's signature. This applies for Residential, Intensive Outpatient, and Outpatient Drug Free levels of care.
7. If the counselor completing and signing the treatment plan is not the assigned primary counselor, the primary counselor's name must be indicated on the treatment plan.
8. If the treatment plan cannot be completed within the timeframe specified above, the reason(s) should be documented in the progress notes.
9. After day ten (10) (for Residential) and day thirty (30) (for Intensive Outpatient and Outpatient Drug Free), if there is no valid treatment plan completed, services are non-compliant until the treatment plan is completed. Once the treatment plan is complete, services can be billed going forward from the date of completion.
10. In the cases where the treatment plan is created by a non-LPHA, if the LPHA does not sign the treatment plan within fifteen (15) calendar days from the counselor's signature, **services are non-compliant between day fifteen (15) and the date of the LPHA's signature.**
11. The client's diagnosis or diagnoses must be on the treatment plan and must match what was indicated on the diagnosis section of the SUD Assessment form. The ICD-10 code is only necessary for billing purposes, therefore, it is not required to have the ICD-10 code

on the clinical documents. The DSM-5 descriptor is sufficient. If both the ICD-10 code and the DSM-5 descriptor are written, it is important to ensure that the two match. If they do not match, this is a potential deficiency that can result in recoupment for services.

**\*\*\*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.

For a treatment plan checklist, see [Appendix G](#) (Page 58).

To see a sample treatment plan, see [Appendix H](#) (Page 59).

## 5. CONTINUING SERVICES JUSTIFICATION & TREATMENT PLAN REVIEW

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As we know, treatment does not happen in a bubble. Life still happens and circumstances change. All while the client 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. re-assess) the client for changes in need. This too is a part of individualizing services to the clients. For Residential Treatment, Intensive Outpatient Treatment, and Outpatient Drug Free levels of care, the way that this can be documented is through the County's SUD Re-Assessment form. Although we are looking at the client's progress in treatment on a regular basis, we need to have documentation that the client is being re-assessed using the ASAM Criteria. WHY? It is a quality check to make sure that we are addressing the client'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 client is doing and what the client needs. Is it clinically appropriate for the client 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 client? A re-assessment of a client can happen at any point in time as clinically necessary. The State specifically refers to this type of documentation for ongoing medical necessity of services as a Continuing Services Justification.

**WHEN DOES IT NEED TO BE DONE?** For Intensive Outpatient and Outpatient Drug Free, a Continuing Services Justification (CSJ) is required to be completed no sooner than five (5) months and no later than six (6) months from the client's admission to treatment. The County's SUD Re-Assessment form can be used as it will have a place to indicate whether the form is a CSJ or a Re-Assessment. The CSJ is required every six (6) months from the date of admission. If there is no CSJ completed between the fifth (5<sup>th</sup>) and sixth (6<sup>th</sup>) month of treatment, services will be disallowed and result in recoupment.

For Residential Treatment, there is no requirement for a CSJ. However, the County requires a re-assessment every thirty (30) calendar days from the date of admission. Thus, the first SUD Re-

Assessment form will need to be completed thirty (30) calendar days from the date of the client's admission to treatment and every thirty (30) calendar days thereafter. If the County SUD Re-Assessment form is used, the "Re-Assessment" box can be checked. If there is no change in diagnosis or change in level of care, the Case Formulation does not need to be completed. The LPHA can simply co-sign to demonstrate that the information has been reviewed and that the LPHA is in agreement with the outcome of no change in diagnosis or level of care.

It is recommended that the LPHA drop a billable Case Management note for review of the Treatment Plan and Re-Assessment completed by the non-LPHA, particularly noting if there were no diagnosis and/or level of care change.

**\*\*\*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 CSJ is required for the Intensive Outpatient and Outpatient Drug Free levels of care. The following are the required elements for justifying continuing services for a client:

- Consideration of the client's personal, medical, and substance use history. (If the required assessment elements were not clearly documented in the initial assessment, be sure to include it in the CSJ. See page 9 and 12 for more information on the required assessment elements.)
- Whether the client has received a physical exam. If so, state that/if there is a copy in the chart.
- Taking into account the client's progress on treatment plan goals based on progress note documentation.
- Consideration of the LPHA or counselor's recommendations.
- Statement about the client's prognosis.

If the SUD Re-Assessment form (for fulfilling the CSJ between the fifth [5<sup>th</sup>] and sixth [6<sup>th</sup>] month), 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 client meets medical necessity for the level of care indicated. No consultation is required for the Re-Assessment or Continuing Services Justification. The non-LPHA and LPHA may have a consultation at their discretion and would be able to bill for the time spent as Case Management if they choose to do so. If, upon review of the SUD Re-Assessment, the LPHA finds that the client does not meet medical necessity, the client will need to be discharged and arrangements made for alternative care or resources. Or the situation may be that the client does not meet criteria for the current level of care, in which case, arrangements will need to be made to transfer or refer the client to the appropriate level of care. The Case Formulation for the CSJ will need to include information on how the client continues to meet the diagnostic criteria for the substance use related diagnosis based on DSM-5. The documentation of impairments should focus on reflecting the severity of the impairments related to the SUD diagnosis that warrants the need for the level of care being indicated for the client.

If the client is appropriate for a different level of care and needs to be transitioned, a short period of transition is permitted, as long as the documentation demonstrates the need for the services provided during the transition period. For example, if case management is needed to coordinate the transition, this can be billed even though the CSJ has indicated that the client is not appropriate for the current level of care. We would want to make sure that the documentation clearly shows the purpose of the case management and why it was necessary.

For those clients whose CSJ or SUD Re-Assessment may have indicated that there is no other need for treatment at the current level of care (such as clients who have completed all treatment goals for this level of care) it is not required that the client be immediately discharged upon completion of the CSJ or SUD Re-Assessment. It would be permissible, for quality of care, to provide clients with a few transition/termination services. Again, the services that are provided once it is determined that the client is ready for discharge, should be documented with information to support the need for that particular service and indicate that it is for the purpose of successfully preparing the client for discharge and/or access to recovery services.

To see a sample Continuing Services Justification form, see [Appendix I](#) (page 62).

**IS A TREATMENT PLAN UPDATE REQUIRED?** Yes. There will need to be an updated treatment plan every ninety (90) calendar days from the date of admission. The primary counselor and the client 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/or the target date re-set. Or it may be more appropriate to create a brand new goal that will better serve the client. In order to adequately update a client's treatment plan, there inevitably will be more involved in the discussion than just whether the client is or is not making progress. In addition to changes to the existing goals, there also needs to be consideration for what is currently happening in the client's life. It is an informal assessment of the client's current functioning so that we may take into consideration any new issues or areas of concern that should be incorporated into the client's treatment going forward. This helps to ensure that we are providing a tailored treatment that addresses the client's needs appropriately. This should be clearly documented in your session progress note. New signatures will need to be obtained to show that this was discussed and collaborated on with the client. Once the counselor and the client establish an updated treatment plan, it will need to be signed by the client within thirty (30) calendar days from the counselor's signature. If the client 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 client and get the signature in the future.

For Residential Treatment, the SUD Re-Assessment form is to be completed thirty (30) calendar days from the client's admission to treatment date and every thirty (30) calendar days thereafter, but the treatment plan update is only needed ninety (90) calendar days from the client's admission to treatment date and every ninety (90) calendar days thereafter.

Regardless of the level of care, 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 fifteen (15) calendar days of the counselor’s signature.

**WHAT IF THERE ARE MULTIPLE TREATMENT PLAN UPDATES WITH NO CHANGES?** It is possible that your client may have made little or no progress towards goals, but we need to demonstrate that we have done our professional duty to consider what we may need to do differently. It may be that the goal just needs minor adjustments like striving to implement the use of two coping skills instead of five. Perhaps it is the same goal, but we need to modify the action step for individual counseling to focus on addressing the strain in the client’s relationship with their family of origin that is at the root of their substance use rather than general education about healthy relationships in recovery. Or maybe we need to increase the frequency of one-on-one sessions because there is now an additional stressor of having moved to a new sober living, causing greater anxiety and ambivalence.

**\*\*\*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 minimum requirements.

## 6. PROGRESS NOTES

Progress notes are required for services claimed. At the Residential Treatment level of care, a weekly progress note can be completed to capture all claimed services for the week.

The GIRP format for progress note documentation is shown below. Please consult with your county administrator for documentation styles indicated for your facility.

G	Goal	<ul style="list-style-type: none"> <li>• Topic or purpose of the session</li> <li>• Goal(s) from the treatment plan that will be addressed in this session</li> </ul>
I	Intervention	<ul style="list-style-type: none"> <li>• Description of what the counselor did to help the client towards the goal of the session and goal(s) on the treatment plan</li> <li>• Clinical, within the scope of practice of the individual providing it</li> <li>• Related to the SUD</li> <li>• Incorporate relevant Evidence-Based Practices</li> </ul>
R	Response	<ul style="list-style-type: none"> <li>• Description of how the client responded to the counselor’s interventions</li> <li>• Stay objective and state the facts</li> </ul>
P	Plan	<ul style="list-style-type: none"> <li>• Description of what will be addressed in the next session</li> </ul>

		<ul style="list-style-type: none"> <li>• 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</li> </ul>
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Using the GIRP 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 (for session and documentation)
3. A description of the client’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 client’s confidentiality was protected in that setting

It is important that the start and end time of the session is to the minute. It should accurately reflect the actual start and end time of the session. In addition to the start and end time for the session, the start and end time of the documentation for the progress note also needs to be indicated in the note. For example, the session with the client present may have been from 2:13pm to 3:02pm, while the documentation for the progress note may have been completed from 5:06pm to 5:15pm. The start and end times for documentation time can be indicated in the body of the progress note. The State places a great emphasis on start and end times because of the history of fraud that has occurred throughout the state. Regulators will be referring to the time to confirm that staff are not providing multiple services at the same time.

For weekly progress notes at the Residential Treatment level of care, the start and end time for each group or service provided in the week must be included in the note.

See [Appendix J](#) (Page 67) for a helpful checklist on progress note requirements.

**TEMPLATED CONTENT: IS COPY AND PASTE OK?** No. Please be careful not to “copy and paste” information from one progress note to another, meaning that one progress note looks like a carbon copy of another progress note intended for a different day or different client. This type of documentation is considered fraudulent and will result in recoupment and/or compliance investigations. There may be times when you may do the same intervention with a client over several sessions, but there should be an explanation as to the purpose and intent of doing so. It is expected that each individual session progress note is specific to the service and to the client. You may use the same intervention but in different ways or focusing on different components depending on the client and his or her needs. Therefore, your documentation would need to demonstrate this. It is acceptable to have a general outline of how you would like to structure your progress notes, however, the information needs to be made specific to that client and session.

**MY GROUPS ARE ALWAYS 90 MINUTES AND SCHEDULED FROM 10:00AM – 11:30AM, DO I STILL HAVE TO PUT THE EXACT START AND END TIME?** Yes.

Even if all groups are scheduled for a specific length of time, the reality is that groups often do not start on time or end on time. It is important to capture these variances as billing with the same exact number of minutes for every group is going to be flagged by the State as needing review. Just as auditors do not like to see content that appears to be a template for progress notes, they do not like the times to be a template.

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

No. We want to protect the client'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 client 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 seven (7) calendar days of the session. The date of the session counts as day one (1) and anything written after the seventh (7<sup>th</sup>) day cannot be billed to Medi-Cal. If a note is written and signed beyond the seven (7) days, the note will need to be made non-compliant.

For Residential programs, clinical services must be documented within seven (7) calendar days of the service in order for it to count towards the required number of clinical hours for the week. \*The required number of clinical service hours in the week for Residential levels of care are five (5) hours. These include medically necessary individual and group counseling sessions (groups cannot exceed twelve [12] participants).

### **OTHER COMPONENTS OF A PROGRESS NOTE:**

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

**Non-Face-to-Face Minutes** is billable time spent on a service activity that does not include interaction with the client. Time spent providing a service via telephone would also be considered Non-Face-to-Face time. Sessions with other individuals involved in the client's treatment and do not include the client, such as Family Therapy without the client present, would be Non-Face-to-Face time.

Example: Analyzing information to determine risk rating levels for the dimensions of the ASAM Criteria outside of the session with the client. The time spent working on this is billable.

**Service Minutes** is the billable face-to-face and/or non-face-to-face time.

Example: 45 minutes of face-to-face time with the client 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 client, working on conceptualizing the level of risk for dimension

6 of the ASAM Assessment. The service time would be 90 minutes, and the note would reflect 45 minutes of face-to-face time and 45 minutes of non-face-to-face time.

**Documentation Minutes** 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 Minutes** is the time it takes to travel from one location to another to meet with the client to provide a billable service. Transporting a client does not count for this. If solely transporting a client from point A to point B, this time is non-billable (Medi-Cal will not reimburse for us to simply drive a client places). However, if during the course of transporting the client 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 Minutes because a service was provided. It may be helpful to think of travel time as time in the car without a client and transportation time as time in the car with a client when there is no service being provided. This does not mean that if 5 minutes of counseling was provided during a 30 minute drive, we can bill all 30 minutes! Only the time spent providing an actual service can be billed.

- *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 client (e.g., picking up a client to take to a doctor appointment).

For a guide on these other elements of a progress note, see [Appendix K](#) (page 68).

For a reference sheet on documentation language, refer to [Appendix L](#) (Page 69).

## 7. CODES & SERVICES

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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 clients 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 client's needs, there will be times when services need to be provided to the client before his or her treatment plan is created (or during the thirty [30] calendar 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 client's SUD and impairments. This is only during the timeframe that the State allows for treatment plan development. For Residential Treatment, since the treatment plan is due within ten (10) calendar days of the client's admission, if medical necessity is demonstrated, services prior to the ten (10) calendar days can be billed without a

valid treatment plan. However, if there is no valid treatment plan after the ten (10) calendar days, services must be coded as non-compliant until the treatment plan is complete. Once the treatment plan is complete, services can be billed going forward. This will also apply for Intensive Outpatient and Outpatient Drug Free, where the treatment plan is due within thirty (30) calendar days of the client’s admission. If there is no valid treatment plan in place, services billed after day thirty (30) must be made non-compliant until there is a valid treatment plan in place. Once there is a valid treatment, services going forward can be billed.

### Withdrawal Management (WM)

#### Billing Codes

<b>Withdrawal Management (WM)</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
WM Residential 3.2	99499-779

### Medication Assisted Treatment (MAT)

#### Billing Codes

<b>Medication Assisted Treatment (MAT)</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
IOT MAT	99499-506
ODF MAT	99499-500
IOT MAT Vivitrol Administration (per dose)	90899-713
ODF MAT Vivitrol Administration (per dose)	90899-707

\*\*All other billing within MAT falls under IOT/ODF services

### Narcotic Treatment Programs/Opioid Treatment Programs (NTP/OTP)

#### Billing Codes

<b>NTP/OTP</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
OTP/NTP Methadone Dosing	90899-632
OTP/NTP Individual Counseling	90899-620

### Recovery Services

#### Billing Codes

<b>Recovery Services</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
Residential 3.5 Recovery Monitoring	90899-689

Residential 3.5 Perinatal Services Recovery Monitoring	90899-776
Residential 3.1 Recovery Monitoring	90899-653
Residential 3.1 Perinatal Services Recovery Monitoring	90899-671
IOT Perinatal Services Recovery Monitoring	90899-605
ODF Recovery Monitoring	90899-524
ODF Perinatal Services Recovery Monitoring	90899-551

**Individual Counseling**

**Billing Codes**

<b>Residential (billed by the day – includes individual/group counseling)</b>	
<i>Level of Care/Type of Service:</i>	<i>CDM/CPT Code:</i>
Residential Services 3.5	90899-674
Residential Services 3.1	90899-638
<b>Intensive Outpatient</b>	
<i>Level of Care/Type of Service:</i>	<i>CDM/CPT Code:</i>
IOT Individual Intake	90899-554
IOT Individual Counseling	90899-560
IOT Perinatal Services Individual Intake	90899-581
IOT Perinatal Services Individual Counseling	90899-587
IOT Perinatal Recovery Services Individual Counseling	50899-596
<b>Outpatient Drug Free</b>	
<i>Level of Care/Type of Service:</i>	<i>CDM/CPT Code:</i>
ODF Individual Intake	90899-500
ODF Individual Counseling	90899-506
ODF Recovery Services Individual Counseling	90899-515
ODF Perinatal Services Individual Intake	90899-530
ODF Perinatal Services Individual Counseling	90899-533
ODF Perinatal Recovery Services Individual Counseling	90899-542

The Individual Counseling category is very broad and captures several different types of activities or sub-categories:

1. Assessment
2. Crisis Intervention
3. Treatment Planning
4. Collateral
5. Family Therapy
6. Individual Counseling
7. Discharge Planning

Individual Counseling services can be provided in-person, by telephone, or by telehealth (except in the case of assessment, which must be completed in-person or by telehealth).

### Assessment

The following are billable assessment activities:

- Gathering psychosocial information for the SUD Assessment
- Interviewing the client about his or her substance use and its impact on functioning
- Formulating a DSM-5 diagnosis
- Determining the appropriate level of care
- Applicable for SUD Re-Assessment and Continuing Services Justification

**I HAVE TO WRITE A LOT FOR THE ASSESSMENT, CAN I BILL FOR THAT?** We cannot bill for simply “completing the SUD 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 SUD 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.

This assessment formulation can be documented as non-face-to-face time (with zero face-to-face minutes if client was not present) on a billable Individual Counseling progress note. If this happens in conjunction with a session with the client, the time can be included in the session note. For example, if 45 minutes was spent in a session with the client and then the counselor spends 60 minutes working on determining the severity ratings and rationale for the client’s impairments in each of the ASAM Criteria dimensions, this can be billed as one Individual Counseling note with face-to-face time of 45 minutes and non-face-to-face time of 60 minutes.

For Residential levels of care, assessment activities that do not include the presence of the client also fall under Individual Counseling. Since Individual Counseling is part of the daily bundled rate for a residential program, it is included as part of what is offered by the program. This means that it cannot be billed as an additional service for a residential program. Any non-face-to-face time spent completing assessment activities should not be counted towards the required

number of clinical hours for the week. Only activities that directly involve the client should be counted.

**MY CLIENT HAS A LOT OF PAPERWORK FROM OTHER AGENCIES THAT I NEED TO REVIEW. CAN I BILL FOR MY TIME?** If the activity is relevant to the client's treatment, it may be billable. Reviewing another document (i.e., discharge paperwork, psychological evaluation, previous assessment, etc.) to help inform the assessment or treatment plan would be billable as Case Management. Be sure to clearly document how the activity was medically necessary.

The time spent by the LPHA to review the SUD Assessment completed by the non-LPHA as part of determining the client's diagnosis and medical necessity for services is billable as Case Management. It can also be included in the time spent in the consultation with the non-LPHA (if provided on the same day).

This is also applicable for the physician who may be reviewing physical exams. The time spent reviewing can be billed as Case Management. It can also be included in the time the physician spent providing consultation to staff about recommendations for follow up based on review of the physical exams (if provided on the same day).

**I WORKED ON THE ASSESSMENT OVER MULTIPLE SESSIONS. HOW DO I DOCUMENT IT?** Time spent working on analyzing and developing parts of the Assessment form are billable. Here is where the initials and date on each page of the County's SUD 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 synthesized information to complete Dimensions 1 and 2 (pages 2-4) on the SUD Assessment..." If the initials/date indicate those pages were done on 11/11/17, then the corresponding progress note for 11/11/17 should document the counselor's work on this part of the assessment. Be sure to print out those completed pages to place in the chart in the event that the chart is audited before the whole assessment is completed. This is to help corroborate what the counselor is claiming to bill for the activity and what is actually done. If the Assessment form is going to be completed in sections, over a period of time, make sure that there is one clean copy placed in the chart once completed. This is to help the auditor to be able to read through the assessment with ease and to ensure all sections are in place. If the information was gathered over various sessions, the final copy should be encompassing of all the information gathered up until the point of completion (in which case all initials at the bottom of each page on that final copy will be dated the same date).

**WHAT IF I HAVE NEW INFORMATION THAT THE CLIENT HAS GIVEN SINCE THE INITIAL ASSESSMENT SESSION THAT I WANT TO ADD TO THE ASSESSMENT FORM?**

If those sections of the form were printed out to be placed in the chart (to demonstrate that the time billed corresponds with what was worked on), the counselor should document this in the session progress note to indicate that the assessment form will include updated information. The counselor may then choose to manually add the information to the printed out pages (with

initials/date of addition) or wait to include the new information or changes in the final, clean copy of the Assessment form.

**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 client 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. Once your assessment is completed, follow your agency's protocol for addressing risks related to DTS, DTO, or GD.

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

Assessment services can be provided in-person or by telehealth.

Note: For the initial assessment session where intake paperwork is provided, reviewed, and signatures are obtained in order to enroll or admit the client into the program and the assessment process is started, the CDM/CPT Code used will be for that labelled as "Intake." This code is to be used one time during the client's episode of care. All other assessment sessions or activities should be coded as "Individual Counseling."

**WHAT IS TELEHEALTH?** A telehealth session means office or outpatient visits via interactive audio and video telecommunication systems. Please refer to your program administrator for the specific platform that is used for the interactive audio and video telecommunication system at your site. We must have the client's consent to receive services by telehealth. Please be sure that there is documentation of the client's consent. When using telehealth to provide services, best practice is to make sure that the documentation includes information about how the client's confidentiality was ensured.

The ability to utilize telephone and telehealth as a means of providing services to our clients is helpful for ensuring that clients stay connected and have access to the services that are needed. Although services can be provided from anywhere in the community, both the client and the provider must be in the state of California at the time the service is rendered. Those clients who may need to temporarily be out of state for personal business cannot continue to receive telephone and/or telehealth services while away. If clients are going to be out of state for over thirty (30) calendar days, this does require that we discharge the client. The documentation should clearly indicate that you have confirmed that the client is in California. The documentation also should clearly show that the provider is in California as well.

**DO WE NEED TO DO AN INTAKE NOTE?** Yes, for all levels of care, there should be a progress note completed for the intake session. For Intensive Outpatient Treatment and Outpatient Drug Free levels of care, the "Intake" code should be utilized for billing this service. This code is intended to be used one time for that initial session. For Residential levels of care, there should be documentation of an intake session, even though there is no separate billing. The

time spent with the client for the intake session can count towards the weekly clinical hours required at Residential programs. Regardless of the level of care, the content for an intake note should include information about how legal intake paperwork (i.e., informed consent, notice of privacy practices, limits of confidentiality, etc.) was explained and reviewed with the client. It should also include some assessment of the client's appropriateness for treatment services (i.e., substance use history, referral source and reason, etc.). There should be enough assessment information gathered to justify a working or provisional diagnosis until the full psychosocial assessment or the SUD Assessment form can be completed.

**Non-LPHA completing the intake service...**Don't forget that if the intake service is conducted by a non-LPHA, there needs to be a consultation between the non-LPHA and LPHA so that a working or preliminary diagnosis can be established for the purposes of billing (see page 9 for more information on a diagnosis being required for billing).

### Crisis Intervention

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 client's emergency situation. The above example of a client 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 client is at imminent threat of relapse. If the counselor were to receive a phone call from the client 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 client to prevent relapse. Another type of situation may be where the counselor is called out to the client's place of residence because the client has relapsed. The activities involved with obtaining information necessary to arrange for potential medical attention and prevent ongoing use would be considered crisis intervention activities.

### **DURING OUR SESSION, MY CLIENT 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 client 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. If this is unrelated to substance use or a potential relapse (perhaps more mental health related), the service would be non-billable. It does not mean that we cannot address the issue; however, it will need to be coded accordingly.

## **I WENT TO THE CLIENT'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 client, travel to the client'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 client, 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 client 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). This can all be documented in one note, as long as it falls under the same code. In the example above, it is a crisis (which falls under Individual Counseling) until determined to no longer be a crisis, at which point family counseling was provided (which also falls under Individual Counseling). Therefore, it can be written in one note.

Crisis intervention does not need to be a service that is specifically authorized on the treatment plan. However, we cannot bill for crisis (which is coded as Individual Counseling) without a valid treatment plan in place once a signed treatment plan is already required to provide any services. Instead, a non-compliant note should be written to document the crisis event and the interventions provided as well as plans for completing/creating/updating a valid treatment plan.

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

## **Treatment Planning**

The following are billable treatment planning activities:

- Collaborating with the client 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 client 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.

As mentioned earlier in the Treatment Plan section, the collaboration with the client is an important aspect. Therefore, it is important that there be documentation of a discussion with the client about his or her treatment plan. Treatment planning sessions may be billed as Individual

Counseling. (Please see page 16 for more information on completing treatment plans before the assessment).

For Residential levels of care: treatment planning services fall under Individual Counseling, which is part of the daily bundled rate. Time spent with the client working on treatment plan development can be counted towards the required number of clinical hours needed each week. In order for the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

### Collateral

The following is a billable collateral activity:

- Sessions with significant people in the client's life

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

This is an activity that can be provided by AOD certified or registered counselors for any psychoeducation or information gathered from significant people in the client's life.

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

Collateral services can be provided with or without the presence of the client.

Billed as Individual Counseling with clear documentation of all parties involved in the service or session.

For Residential levels of care: Collateral falls under Individual Counseling, which is part of the daily bundled rate. Time spent providing Collateral services that includes the client can be counted towards the required number of clinical hours needed each week. In order for the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

### Family Therapy

Although family therapy falls under the Individual Counseling category and gets billed as Individual Counseling, we have separate CDM/CPT Codes internally to help distinguish this documentation.

### Billing Codes

<b>MAT/Intensive Outpatient</b>	
<i>Level of Care/Type of Service:</i>	<i>CDM/CPT Code:</i>
IOT Family Therapy	90899-758
IOT Perinatal Services Family Therapy	90899-764
IOT Perinatal Recovery Services Family Therapy	90899-767
<b>MAT/Outpatient Drug Free</b>	

ODF Family Therapy	90899-746
ODF Recovery Services Family Therapy	90899-749
ODF Perinatal Services Family Therapy	90899-752
ODF Perinatal Recovery Services Family Therapy	90899-755

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 client.

Billed using the Family Therapy codes (which are billed to the State as Individual Counseling).

For Residential levels of care, Family Therapy falls under Individual Counseling and is part of the daily bundled rate. However, time spent providing Family Therapy services that include the client can count towards the required number of clinical hours needed each week. In order for the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

**WHAT IS THE DIFFERENCE BETWEEN COLLATERAL SESSIONS AND FAMILY THERAPY?** Collateral sessions involves counselors meeting with a client’s family or significant others that can support their treatment needs. This service focuses on the treatment needs of the client, and how loved ones can support the client 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 client’s recovery.

### Individual Counseling

The following are billable individual counseling activities:

- Working with the client on skill-building for the purposes of maintaining sobriety and relapse prevention
- Educating the client on issues related to substance use, such as concepts of withdrawal, recovery, an alcohol and drug-free lifestyle

- Increasing the client’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 client’s treatment goals in order to individualize the treatment to the needs of the client.

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

They are billed as Individual Counseling for the respective level of care that the client is receiving.

For Residential levels of care, Individual Counseling services are part of the daily bundled rates, but can count towards the required number of clinical hours needed each week. In order for the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

### Discharge Planning

The following are billable discharge planning activities:

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

Discharge planning services do not need to be specified on the treatment plan.

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

The session with the client where the discharge plan is collaborated on needs to be documented to provide evidence that this occurred. This session is billable as an Individual Counseling service.

For Residential levels of care: discharge planning falls under Individual Counseling and are part of the daily bundled rates, but can count towards the required number of clinical hours needed each week. In order for the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

If the service with the client involves discussing potential resources or referrals that are needed upon discharge, this would be considered case management.

### *Discharge Plan*

Except for those clients whose contact is lost, all clients will have a discharge plan.

The discharge plan can be completed by a non-LPHA or LPHA counselor. At minimum, it must be completed within thirty (30) days prior to the scheduled date of the last face-to-face session with the client. The discharge plan is a document that is to be worked on collaboratively with the client. Again, if a counselor loses contact with the client (e.g., client being discharged due to

client not showing up for sessions and being unable to be reached by phone, etc.), there is no expectation that a discharge plan be completed.

The discharge plan must include, at minimum, the following information:

1. A description of the client’s relapse triggers
2. A plan to assist the client to avoid relapse when confronted with each trigger
3. A support plan (including referrals)

During the counselor’s last face-to-face session with the client, the counselor and the client will need to sign and date the discharge plan. A copy must be provided to the client and the original should be placed in the client’s chart.

**DISCHARGE PLANNING STARTS AT ADMISSION!** No matter the level of care the client is at, the eventual goal is to help the client 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 client’s functioning enough to prepare the client for the transition to a less restrictive setting. Therefore, as soon as the client enters treatment, we should be looking at how we are going to help them transition out of treatment. Working collaboratively with the client on this mentality will also serve to help the client 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 client will be. The client 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 client can reference is a great tool for them.

For a sample discharge plan, see [Appendix M](#), (page 70).

**WHAT IS CONSIDERED A “LAST FACE-TO-FACE?”** This must be a service that can be entered into the County’s electronic health record and billing system (IRIS). Therefore, it must be an activity that can be provided by a non-LPHA counselor or LPHA. This does not include activities by Community Health Workers or front office staff. It also does not include drug testing, regardless of who performs it. The service must be provided in-person.

## Case Management

### Billing Codes

<b>NTP</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
OTP/NTP Case Management	90899-611
<b>WM</b>	
WM 3.2 Case Management	90899-782
<b>Residential</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
Residential 3.5 Case Management	90899-677

Residential 3.5 Recovery Services Case Management	90899-686
Residential 3.5 Perinatal Services Case Management	90899-695
Residential 3.5 Perinatal Recovery Services Case Management	90899-704
Residential 3.1 Case Management	90899-641
Residential 3.1 Recovery Services Case Management	90899-650
Residential 3.1 Perinatal Services Case Management	90899-659
Residential 3.1 Perinatal Recovery Services Case Management	90899-668
<b>MAT/Intensive Outpatient</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
IOT Case Management	90899-569
IOT Perinatal Services Case Management	90899-593
IOT Perinatal Recovery Services Case Management	90899-602
<b>MAT/Outpatient Drug Free</b>	
ODF Case Management	90899-509
ODF Recovery Services Case Management	90899-521
ODF Perinatal Services Case Management	90899-539
ODF Perinatal Recovery Services Case Management	90899-548

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 client’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 clients 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 services can be provided with or without the client present.

### **Transitioning clients from one level of care to another**

Case management services should be provided to assist with the transition to the next level of care, while the client is still receiving treatment at the current level of care. We should not wait to begin these case management activities until just prior to the client's transition or until the client is ready to move on. As a result, we are allowed a short transition period from the time the client leaves the current level of care, for the purposes of continuity of care, to provide and bill for case management. This period of transition should last no more than seven (7) calendar days and corresponding documentation needs to justify each of the case management services provided.

For the Residential levels of care, clients will be able to stay for forty-eight (48) hours after no longer meeting medical necessity for that level of care, as long as it is for the purpose of transitioning the person to the next level of care. There must be corresponding documentation that explains the need for these extra days, and the client should continue to participate in programming and case management services during the additional days.

### **Review of Documents**

Case management can be billed by any level of care for time spent reviewing documents that are pertinent to the client's treatment. Please keep in mind that the amount of time claimed must be supported by the documentation or explanation in the note. The explanation needs to include what was reviewed and the purpose as well as its relevancy to the client's overall treatment. If the review of the document leads to a particular change or influences the course of treatment for the client, this should also be captured in the documentation (see page 29 for more information).

### **Consultations**

In addition to being able to bill for the consultation between a non-LPHA and LPHA for the purposes of establishing a preliminary diagnosis or for completing the assessment process so the LPHA can formalize the Case Formulation, there are other consultations that can be billed. Peer-to-peer consultations within your agency may be a billable consultation. Oftentimes, there is a need to coordinate the client's care by discussing the client's functioning and his or her needs with others on your team. Most commonly this occurs for a primary counselor and a group

facilitator to relay information about a possible change in behavior or need. In such instances, if the consultation is a necessary activity that is relevant to the client’s treatment, it can be billed as Case Management. As with other consultations discussed earlier, it can be billed by both parties involved, as long as the start and end times match. In the documentation, it will be important to clearly write the purpose of the consultation, who was involved, and how the exchange is related to the client’s treatment. If the consultation or discussion leads to a change in course of treatment or any actions that need to be taken to assist the client, this should also be noted. Please be mindful that consultations that appear as appropriate for clinical supervision are not billable.

**Completing a Discharge Summary for Unplanned discharges**

See page 44.

**Group Counseling**

**Billing Codes**

<b>Residential</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
3.1 Recovery Services Group Counseling	90899-647
3.5 Recovery Services Group Counseling	90899-683
<b>MAT/Intensive Outpatient</b>	
<i>Level of Care/Service Type:</i>	<i>CDM/CPT Code:</i>
IOT Group Counseling	90899-563
IOT Perinatal Services Group Counseling	90899-590
IOT Perinatal Recovery Services Group Counseling	90899-599
<b>MAT/Outpatient Drug Free</b>	
ODF Group Counseling	90899-512
ODF Recovery Services Group Counseling	90899-518
ODF Perinatal Services Group Counseling	90899-536
ODF Perinatal Recovery Services Group Counseling	90899-545

Group counseling services must be provided face-to-face with a minimum of two (2) and a maximum of twelve (12) clients present in the group. One of those clients 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 clients allowed in the group or overall group billing amount.

Groups will be limited to twelve (12) participants only. If it ever happens that a person is overbooked and there are more than twelve (12) people present (even 1 extra), then it is recommended that the program pull other staff and split up the group into 2 groups. Alternatively, one client can 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 twelve (12) clients present. As usual, any non-Medi-Cal participants in the group will still count toward the twelve (12) maximum and at least one (1) Medi-Cal client needs to be present. If this was found to be a deficiency during reviews, the entire group would be disallowed and marked non-compliant.

Patient Education Groups are those groups that provide research based education on addiction, treatment, recovery and associated health risks. Typically, these are conducted in lecture-style formats. For the county clinics, an example of such a group is the HIV Education group offered by a Registered Nurse at the Intensive Outpatient and Outpatient Drug Free levels of care. For all levels of care, except Residential, Patient Education Groups cannot exceed twelve (12) people in order to bill. If the Patient Education Group code is being used, please be sure that it is billable only when there are two (2) to twelve (12) participants. At Residential levels of care, the Patient Education Groups can exceed twelve (12) and will be counted as part of the structured hours for the daily bundled rate.

For group sign-in sheets, please utilize one (1) sign-in sheet for all attendees in the group (regardless of funding source). This is to demonstrate that the group size did not exceed the maximum of twelve (12) allowed by DMC-ODS for billing. Clients should already be informed during the intake process about confidentiality within the group setting. Please follow up with your respective administrators for confirmation that this has been made explicit in the intake paperwork. Some providers may choose to also include information on the actual sign-in sheets to remind clients about this. It may also be helpful to review this with clients in the group setting from time to time to ensure understanding.

Group counseling services do need to be identified as a specific service on the treatment plan.

Group services must be provided in-person.

For Residential levels of care: groups are part of the daily bundled rate. However, clinical groups in a residential program can count towards the required number of clinical hours needed each week.

**WHAT NEEDS TO BE ON THE GROUP SIGN-IN SHEET?** The printed name of the LPHA or counselor conducting the group session must be on the group sign-in sheet. Next to the printed name, the LPHA or counselor must provide his or her signature and date. The date of signature should be the same as the date of the session. The LPHA or counselor is signing to document that the information on the group sign-in sheet is accurate. The topic of the group, date and start and end time of the group session must also be indicated on the group sign-in sheet. Each participant will need to provide a signature with his or her full name printed on the group sign-in sheet. If there is no corresponding group sign-in sheet to go along with the group service documentation or progress note, the service cannot be billed.

**ARE ALL TYPES OF GROUPS BILLABLE?** This depends 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 client 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 clients 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 as long as it is clear on the documentation that such activities are intended to build skills and not simply to occupy the client. It is helpful to focus on what the intention of the activity is and ask ourselves, “how is this relevant to the client’s substance use treatment?” and “how might this be beneficial for the client’s recovery?” and “what is the result or benefit of the client participating in this activity?”

### **GROUP NOTE DOCUMENTATION**

If the GIRP format is utilized for progress notes to document group services, the G (Goal) and I (Intervention) section of the note may be the same across all participants in the group. This is allowed because the group facilitator is providing the same intervention(s) to the entire group. It is advised, however, that if the facilitator happens to provide an intervention to a particular client, it should be documented on the progress note for that particular client. For example, if one of the clients demonstrated a lack of engagement and there were prompts directed specifically to that client, this can be noted in the I (Intervention) section to demonstrate how the facilitator attempted to enhance the client’s participation. The R (Response) and P (Plan) sections of the progress notes for the clients in attendance for that group will be specific to each client, making each group note individualized to the client and to the service.

Please note that this does not mean that the I (Intervention) section of group service progress notes can be the same across different groups. The interventions provided in the group setting must be specific to that particular group. It needs to correspond with the topic of the group and provide enough description of how the group topic was discussed to justify the amount of time claimed. Groups are typically 60 or 90 minutes in length, so the interventions should reflect how this time was used.

For the R (Response) section of the group service progress note, keep in mind that there should be enough information to clearly illustrate how the client presented and behaved in the group. Specifically, it is important to document the client’s reaction to the facilitator’s interventions. For example, if the group topic was on improving communication and asserting one’s needs effectively as a way to ask for help from one’s sober support network, the R (Response) section should describe how the client did with this topic and the associated interventions. It will be helpful to consider what the client may have said in the group or how he or she may have

interacted with peers. Take note of how the client's participation tells you that the client is or is not making progress in treatment overall.

## 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.

Activities considered by DMC to be services that are NOT billable can include but are not limited to the following:

1. Waiting time
2. Translating/Interpreting
3. Clerical Services:
  - a. Faxing
  - b. Scheduling appointments
  - c. Photocopying
4. Searching for a missing client
5. Checking messages
6. Leaving messages
7. Providing transportation
8. Supervision with a supervisor/service chief
9. Completion of bus pass application
10. Completion of immigration form
11. Conducting internet searches
12. Most letter writing is not billable
13. Services for the sole purposes of addressing anything other than the substance use disorder impairment. This can include solely dealing with:
  - a. Mental health and/or other excluded diagnoses
  - b. Health care
14. Any service while the client is in Jail/Juvenile Hall, Psychiatric Hospitalization, or an Institute for Mental Disease (IMD)
  - a. Exceptions to this rule:
    1. Day of admission
    2. Placement services provided during the thirty (30) calendar days immediately prior to the day of discharge for a maximum of three (3) non-consecutive periods of thirty (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 not 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 seven (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 client/conservator/legal guardian  
*(Exception: If the client refuses to sign, the treatment plan will still pass if documented appropriately. However, mere refusal to sign because they don't agree with the treatment plan is not a sufficient reason).*
2. Does not document medical necessity or show impairment related to the substance use

For a quick reference on billable vs. non-billable vs. non-compliant, see [Appendix K](#) (page 68).

### Time Reminders

- Service minutes claimed must be substantiated by the interventions provided. Does the documentation clearly reflect what took place in the session and the amount of time it took to provide the service? Are we billing a 60 minute service for an activity that, as documented, appears that it would take only a couple of minutes to do? Excessive service minutes for what is documented may result in recoupment.
- Documentation minutes claimed must be congruent with the amount of the content written. This is the only time that we are allowed to bill for an administrative function of typing or writing. It must be a reasonable amount of time, meaning that an outside observer would concur that the amount of the content would have taken the amount of time that is being billed for documentation. Excessive documentation minutes for what is documented may result in recoupment.
- As a general rule, documentation minutes should never be more than service minutes.
- Use actual minutes, not estimated time. Just as the start and end time for the service and documentation must be exact and to the minute, rather than rounding to the nearest quarter-hour or hour, the session or service times should reflect this as well. Using the same standard amount of time for sessions (i.e., 50 minute individual counseling sessions for all individual counseling sessions or 10 minute documentation for all progress notes) is going to be a red flag that will necessitate a review of all of the corresponding documentation.

## 8. DISCHARGE SUMMARY

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Best practice is that for every client that is admitted, regardless of the length of stay and reason for discharge, there will be a discharge summary completed.

However, at minimum, a discharge summary must be completed for every unplanned discharge.

The non-LPHA or LPHA counselor can complete it.

The discharge summary must be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the client.

The discharge summary must include the following:

1. The client’s length of stay in treatment (date of admission to date of discharge)
2. Reason for discharge
3. Narrative summary of the treatment episode (include current alcohol/drug use, vocational/educational achievements, transfers/referrals provided)
4. The client’s prognosis

Time spent on completing the documentation for the discharge of a client that is unplanned is a billable Case Management service.

TYPE OF DISCHARGE	TYPE OF NOTE
Unplanned discharge	Billable Case Management
Planned discharge	Non-Billable Case Management

An unplanned discharge includes discharge due to loss of contact, the client leaving prematurely against clinical advice such as “AWOL,” incarceration, abrupt move out of the area, etc. If there was no opportunity to sit with the client to complete a discharge plan, due to the client leaving the program earlier than expected, the completion of the discharge summary is a billable activity.

For transitions from one level of care to another within the same provider, the completion of the discharge summary is not billable to DMC because it is not considered a discharge (see page 13 for more on transitions within the same provider). Please use the non-billable Case Management code for completing the discharge summary and any additional discharge-related activities when documenting. This is the administrative step required to end one EOC and to start another at a different LOC.

For completing discharge summaries of unplanned discharges beyond the thirty (30) calendar days from the last face-to-face with the client, do not bill Case Management. A non-compliant code can be used for the progress note documenting the completion of the discharge summary in such cases. Discharge summaries may only be billed as long as they occur within the required thirty (30) days from that last service.

If using the County Discharge Summary form, please remember that the “Number of Minutes to Complete the Discharge Process” is equivalent to Service Minutes. This is the time it takes to research the client’s chart for information to complete the treatment summary narrative and complete any other aspects of closing a client’s case. Just as we need to justify the amount of time claimed for any progress note with Service Minutes, we must also include a brief explanation as to how the time was spent for “Number of Minutes to complete the Discharge Process.” This can be included as part of the narrative section with the client’s treatment summary. The “Documentation Minutes” will be the amount of time it takes to complete the discharge summary (since the progress note is embedded into the form). The “Documentation

Date” and the “Facility and EOC Discharge Date” should be the same since the chart will be closed as of the last date of charting.

For a sample discharge summary, see [Appendix N](#) (page 71).

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## 9. DOCUMENTATION EXAMPLES

### **Individual Counseling Progress Note:**

G: Client 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 client 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 client 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: Client 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. Client 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: Client 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. Client 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:**

G: To meet with the sober living manager in an effort to coordinate services to help client to improve relationships with other residents and prevent loss of housing that could threaten recovery efforts.

I: Spoke with sober living manager about client’s recent verbal altercation with another resident. Also inquired about his general observations of client’s behaviors and potential risks to sobriety.

R: Client was not present for this service. Sober living manager reported that client 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 conflicts between the two, but on most recent encounter, client seemed to be instigating. Sober living manager expressed frustration with client and possibility that he may not be a good fit for the house. Sober living manager shared that client seems to need help managing his anger and impulsivity, saying that he has some concern that these may prompt client to return to using.

P: Follow up with sober living manager over the next few weeks for monitoring of changes in client's behaviors and interactions with peers. Plan for next session with client 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 client make progress towards his treatment goal to reduce altercations with others that perpetuate behaviors associated with use.

**Group Counseling Service Progress Note:**

G: 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 client 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: Client was more withdrawn in this session than usual, but participated with prompting. Client was able to share that he continues to feel guilty for lying to his family during his use. Client seemed to be listening and reflecting on what his peers shared. Client 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 client to continue to engage in groups and work towards increasing self-awareness and verbalization of thoughts and feelings. Client 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.

## 10.APPENDIX

### Appendix A: Substance Use Disorder Diagnoses DSM-5 Criteria Guide

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

			CRITERIA:
			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:

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**Mild** = 2-3 of the criteria are met

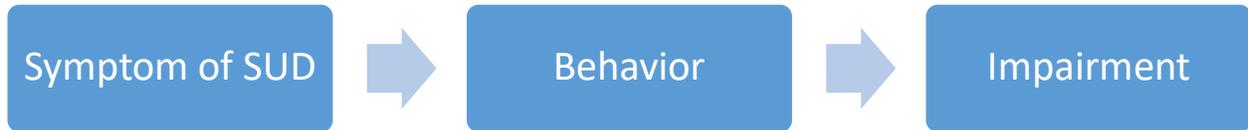
**Moderate** = 4-5 of the criteria are met

**Severe** = 6 or more of the criteria are met

Appendix B: ASAM Criteria Dimensions and Rationale Worksheet

ASAM Criteria	Justification (diagnosis)	Justification (ASAM severity based on impairments)	Severity/ Risk Rating
<b>Dimension 1: Acute Intoxication and/or Withdrawal Potential</b>			
<b>Dimension 2: Biomedical Conditions and Complications</b>			
<b>Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications</b>			
<b>Dimension 4: Readiness to Change</b>			
<b>Dimension 5: Relapse, Continued Use, or Continued Problem Potential</b>			
<b>Dimension 6: Recovery/Living Environment</b>			

## Appendix C: Documenting Impairments Related to SUD Guide



Think about what it is about the client'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.

### FORMULA:

Due to client's \_\_\_\_\_ (symptoms of SUD), client \_\_\_\_\_ (behaviors) resulting in \_\_\_\_\_ (impairment).

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

*\*NOTE: It is not required or necessary to use this formula...as long as the documentation shows how all three are connected, you can write it however you like!*

### Pro Tip:

If you know the impairment (unemployment, no housing, loss of social support, etc.), you can work backwards to get to the behavior and how it is related to a SUD.

Example: Client has been unemployed for the past 3 years.

Q: What happened 3 years ago with his/her employment?

A: He/she lost his/her job.



Q: How did he/she lose their job?

A: He/she was fired.



Q: What did he/she do that got him/her fired?

A: He/she stopped showing up for work.



Q: Why did he/she stop showing up for work?

A: He/she was drinking throughout the night and unable to get up in the morning. He/she started showing up to work later and later, eventually stopping. He/she has not been able to work since then.



Due to client's excessive drinking throughout the night, he/she was often tardy or did not show up to work because he/she was unable to get up in the morning, which resulted in him/her getting fired and being unemployed for the past 3 years.

## Appendix D: What Needs to be in The Case Formulation?

1. Basis for the DSM-5 SUD diagnosis → description of how the client meets criteria for the diagnosis
2. Impairments related to the SUD → description of life areas most severely affected by the substance use
3. Corresponding level of care → what is indicated based on 1 and severity of 2 that will meet the client's needs

### Sample Format:

**“Client 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. Client endorses \_\_\_\_\_ (criteria). (Continue with all criteria). Client has had a pattern of problematic use over/within the last \_\_\_\_\_ (duration of use).**

**Client 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 client's \_\_\_\_\_ (symptoms of SUD), client \_\_\_\_\_ (behaviors) resulting in \_\_\_\_\_ (impairment). (Continue with other dimensions with the most severe risk ratings). Client is most appropriate for \_\_\_\_\_ (level of care) and will need \_\_\_\_\_ (services that will address client's problems).”**

\*\*Any format can be used, as long as the required elements are addressed!\*\*

### Example:

Client meets criteria for (F10.10) Alcohol Use Disorder, Moderate. Severity is moderate as she meets 5 of the criteria. Client endorses daily cravings to use that have led to preoccupation with drinking and feelings of agitation and restlessness. Client states that she has stopped working out and spending time with friends and family. She spends most of her time at home drinking alone, often neglecting to take care of responsibilities like paying bills and completing household tasks. Client stopped going to her job as a waitress because she was either drinking at home or sleeping after blacking out. Client has had a pattern of problematic use over the last year, but client has been sober for about two weeks.

Client meets medical necessity based on the above diagnosis and impairment in dimensions 5 and 6 of the ASAM Criteria. Due to client's inability to tolerate cravings to continue drinking, client states she is “always planning my next drink” and has stopped participating in social activities with friends and family. Client states that she feels guilty for this and that she would like to be close with her family again and “have people that are there for me instead of being all alone because I pushed everyone away.” Due to client spending time drinking, she has not been keeping up with paying bills or completing household tasks, resulting in her being behind on payments and accumulating debt. She is no longer able to pay off the debt because she has no job. Due to her spending time drinking or recovering from the effects, client has stopped going to work resulting in job loss. Client's risk for continued use and problem potential are significant as she states that she has not made any attempts to try stopping since she began and that “I don't know how to stop.” Client was unable to verbalize any ways to manage cravings, other than by drinking, and states that “everything is a trigger.” Therefore, client does not have the skills needed to be able to abstain from drinking for prolonged periods of time. Client would benefit most from the Intensive Outpatient Treatment Services level of care to increase her understanding and awareness of the effects of drinking as well as cravings and triggers. Client needs a moderate level of support to be able to learn

healthy coping skills and relapse prevention skills in order to become self-sufficient in applying them as she improves in functioning.

## Appendix E: Billing Assessment and Re-Assessment Activities

Activity	Completing sections of the SUD Assessment form (client not present)	SAME DAY: Assessment session (FTF) + completing sections of the SUD Assessment form (NFTF)	DIFFERENT DAY: Assessment session (FTF) + completing sections of the SUD Assessment form (NFTF):	Review of documents	SAME DAY: Review/research documents for assessment information (NFTF) + completing sections of the SUD Assessment form (NFTF)	DIFFERENT DAY: Review/research documents for assessment information (NFTF) + completing sections of the SUD Assessment form (NFTF)	SAME DAY: Assessment session (FTF) + Review/research documents for assessment information (NFTF) + completing sections of the SUD Assessment form (NFTF)	DIFFERENT DAY ASSESSMENT SESSION (FTF): Review/research documents for assessment information (NFTF) + completing sections of the SUD Assessment form (NFTF) on same day
Who	Non-LPHA or LPHA	Non-LPHA or LPHA	Non-LPHA or LPHA	Non-LPHA or LPHA	Non-LPHA or LPHA	Non-LPHA or LPHA	Non-LPHA or LPHA	Non-LPHA or LPHA
Billing	Individual counseling (NFTF)	Individual counseling (FTF & NFTF)	(two notes): Individual counseling (FTF) + Individual counseling (NFTF)	Case management (NFTF)	(two notes): Case management (for review of docs NFTF) + Individual counseling (for completing SUD Assessment form NFTF)	(two notes): Case management (for review of docs NFTF) + Individual counseling (for completing SUD Assessment form NFTF)	(two notes): Individual counseling (FTF and NFTF completing Assessment) + Case management (NFTF review docs)	(three notes): Individual counseling (FTF) + Case management (NFTF review docs) + Individual counseling (NFTF completing Assessment)

Activity	Consult between non-LPHA and LPHA (NFTF)	Completing case formulation (NFTF)	SAME DAY: Consult with non-LPHA (NFTF) + completing case formulation (NFTF)	DIFFERENT DAY: Consult with non-LPHA (NFTF) + completing case formulation (NFTF)	SAME DAY: Review SUD Assessment (NFTF) + completing case formulation (NFTF)	DIFFERENT DAY: Review SUD Assessment (NFTF) + completing case formulation (NFTF)	SAME DAY: Consult with non-LPHA (NFTF) + Review SUD Assessment (NFTF) + completing case formulation (NFTF)	DIFFERENT DAY: Consult with non-LPHA (NFTF) + Review SUD Assessment (NFTF) + completing case formulation (NFTF)
Who	Non-LPHA and LPHA can both bill	LPHA	LPHA	LPHA	LPHA	LPHA	LPHA	LPHA
Billing	Case management (NFTF)	Individual counseling (NFTF)	(two notes): Case management (consult NFTF) + Individual counseling (case formulation NFTF)	(two notes): Case management (consult NFTF) + Individual counseling (case formulation NFTF)	(two notes): Case management (for review of docs NFTF) + Individual counseling (for completing case formulation NFTF)	(two notes): Case management (for review of docs NFTF) + Individual counseling (for completing case formulation NFTF)	(two notes): Case management (consult NFTF and review of docs NFTF) + Individual counseling (completing case formulation NFTF)	(three notes): Case management (consult NFTF) + Case management (review of docs NFTF) + Individual counseling (completing case formulation NFTF)

<b>INDIVIDUAL COUNSELING (ASSESSMENT ACTIVITIES):</b>	
<b>Interviewing the client</b> LPHA or non-LPHA	<p><i>IOT/ODF:</i> 1<sup>st</sup> assessment session=intake code; all subsequent assessment sessions=individual counseling code</p> <p><i>Residential:</i> part of daily rate but can count towards clinical hours</p>
<b>Completing sections of the SUD Assessment/Re-Assessment</b> LPHA or non-LPHA	<p>ASAM Dimensions including severity ratings, rationale; placement summary</p> <p><i>IOT/ODF:</i> billable individual counseling</p> <p><i>Residential:</i> part of daily rate (cannot count towards clinical hours)</p>
<b>Developing the diagnosis</b> only LPHA	<p>For the diagnosis page of the SUD Assessment/Re-Assessment</p> <p><i>IOT/ODF:</i> billable individual counseling</p> <p><i>Residential:</i> part of daily rate (cannot count towards clinical hours)</p>
<b>Compiling the case formulation</b> only LPHA	<p><i>IOT/ODF:</i> billable individual counseling</p>

<b>CASE MANAGEMENT:</b>	
<b>Reviewing documents</b> LPHA or non-LPHA	<p>In order to complete the SUD Assessment/Re-Assessment (ASAM Dimensions including severity ratings, rationale; placement summary)</p> <p><i>IOT/ODF:</i> billable case management</p> <p><i>Residential:</i> billable case management</p>
<b>Reviewing the SUD Assessment/Re-Assessment</b> only LPHA	<p>To complete the diagnosis/case formulation</p> <p><i>IOT/ODF:</i> billable case management</p> <p><i>Residential:</i> billable case management</p>
<b>Consultation to establish the diagnosis (same day or no later than 3 days from admission or prior to the next service)</b> LPHA and non-LPHA	<p>To help establish medical necessity upon admission</p> <p><i>IOT/ODF:</i> billable case management</p> <p><i>Residential:</i> billable case management</p>
<b>Face-to-Face Consultation</b> LPHA and non-LPHA	<p>For establishing medical necessity (to complete the case formulation)</p> <p><i>IOT/ODF:</i> billable case management</p>

## Appendix F: Treatment Plan Reference Sheet

### How do I know what goals to create?

1. Ask the client what he/she wants or needs the most help with!
2. Look at the dimensions of the ASAM Criteria and find the highest risk level ratings.
3. Discuss with client what he/she would like to improve in each dimension.

#### **STATEMENT OF PROBLEM:**

1. In the client's own words. Can use quotes.
2. Can be long-term.
3. May or may not be achievable during this treatment phase.
4. Should tie back to the impairments identified in the assessment (making it related to SUD).
5. OK if it does not directly relate to SUD. **\*\*If it does not relate to SUD, explore with client to break it down to what can be worked on in the short-term!\*\***

#### **STATEMENT OF GOAL:**

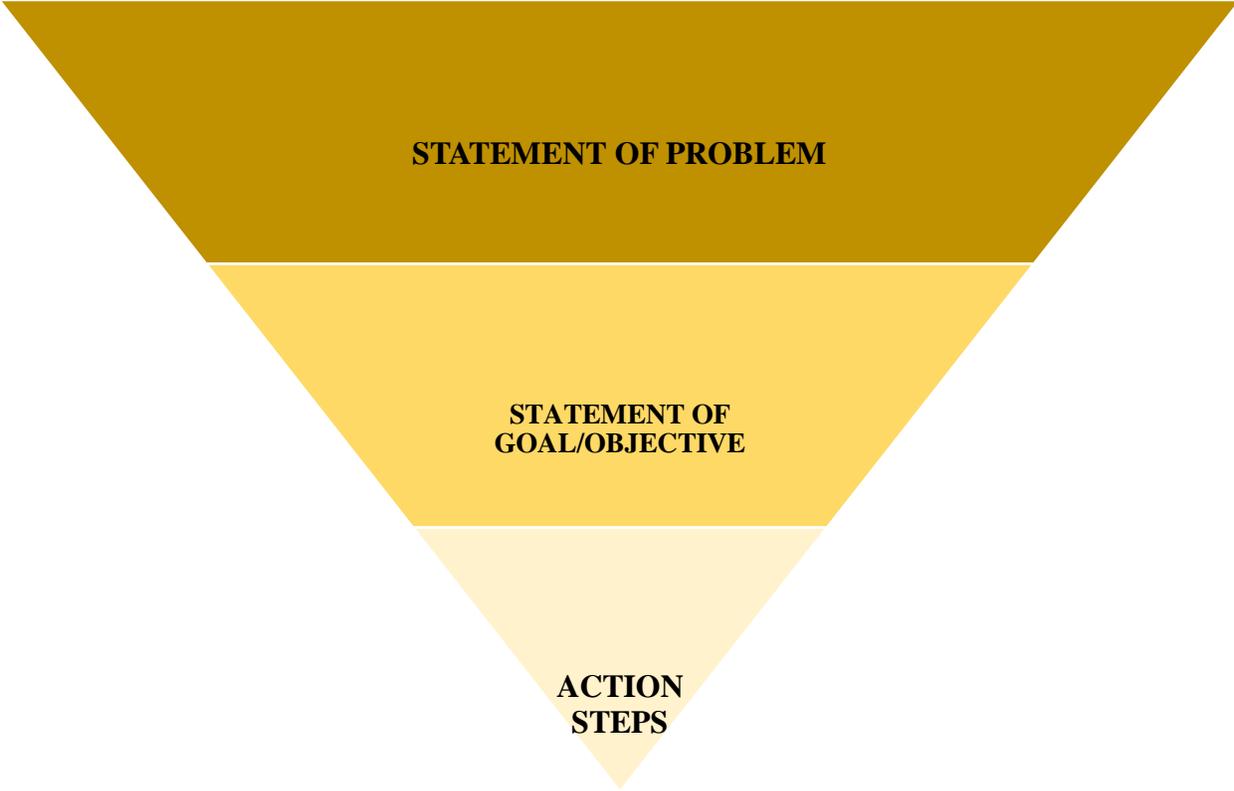
1. This is what will help the client work towards resolving the statement of the problem above.
2. Must relate to SUD.
3. Must be SMART.
  - a. Specific
  - b. Measurable
  - c. Achievable
  - d. Realistic
  - e. Time-bound
4. Duration (how long will it be worked on for? i.e., For the next 30 days, 90 days, etc.)

#### **ACTION STEPS:**

1. Describes what you as the provider will do to help the client meet his/her goal above.
2. Describes what the client will do to work towards his/her goal above.
3. Must include-
  - a. who will provide the service (i.e., counselor, provider, therapist, etc.)
  - b. type of service (i.e., individual counseling, group counseling, case management)
  - c. frequency (how often? i.e., 1x/week, 2x/month, etc.)

#### **TARGET DATE:**

1. The expected date that client will achieve his/her action steps above.
2. Not program specific (i.e. date of discharge after the 8 week program).
3. Can be before the discharge date. All action steps of a goal may have the same target date.



## Appendix F: What are SMART goals?

### ● SPECIFIC

- Related to the problem
- Clearly ties back to the SUD
- Concrete
- Action verbs

*Sample formula* – “Client will \_\_\_\_\_ (action verb)...”

*Example* – “Client will use healthy coping skills to manage triggers...”

### ● MEASURABLE

- There is a baseline and target
- Quantifiable
- Observable
- Behaviors

*Sample formula* – “from \_\_\_\_\_ (baseline) to \_\_\_\_\_ (target)...”

*Example* – “...from 0x/day to 3x/day...”

### ● ACHIEVABLE

- Can be done in this level of care
- It is appropriate for this level of care
- It is appropriate to the client’s needs and abilities

### ● REALISTIC

- Can reasonably expect that client can meet this goal
- Set up for success!

### ● TIME-BOUND

- A set timeframe for when client will be able to meet this goal
- Set amount of time for monitoring progress

*Sample formula* – “...in the next \_\_\_\_\_ (timeframe).”

*Example* – “...in the next 30 days.”

**SAMPLE FORMULA:** “In the next \_\_\_\_\_ (timeframe), client will \_\_\_\_\_ (behavior change) from \_\_\_\_\_ to \_\_\_\_\_ (baseline and target) in order to \_\_\_\_\_ (problem).”

## Appendix G: Treatment Plan Checklist

### Statement of Problems

- Can be in the client's own words
- Tied back to the ASAM dimensions

### Statement of the Goal

- Specific
  - Related to SUD
  - Ties back to the problem identified in the ASAM Dimension
- Measurable
- Achievable
- Realistic
- Time-Bound

### Action steps & Target Date

- Each indicates the type of service
- Each includes the frequency
- Written as what client or counselor will do (either or both)
- Connected to the goal/objective
- Reasonable expectation that this will help the client
- Within the scope of practice for the counselor
- Target date is indicated for each action step

### Signatures

- Signature line includes printed name and credentials
- Signed by the counselor
- Counselor signature has the date of signature
- Signed by client
- Client signature has the date of signature
- If client has refused to sign, it is documented (along with plan for how to address this) in the progress note
- Signed by the Medical Director/physician or LPHA
- Medical Director/physician or LPHA signature has the date of signature

# Appendix H: Sample Treatment Plan

CONFIDENTIAL PATIENT INFORMATION  
See CA WIC Section 5328 &  
Title 42 CFR Part 2

## Substance Use Disorder Treatment Plan



Initial plan       Updated plan

Last Name		First Name		Middle Name	DOB	MRN
Doe		John				
Admit Date	Facility Name & Location			Level of Care	Primary Counselor Name	
9/29/17	Sober Up Recovery Treatment Center			IOT	Mary Sunshine, Cadc	
Assessment Date	Diagnosis(es) in priority					P/E in Chart?
9/27/17	#1: F11.20	#2:	#3:	#4:		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Problem # 1	Dimension(s): <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input checked="" type="checkbox"/> 5 <input type="checkbox"/> 6
Statement of Problem	
"I still have problems with my back pain and it makes me want to use."	
Statement of Goal	Action Steps / Interventions
1. Client will follow through with linkages for pain management from 0x to 1x in the next 30 days in order to maintain sobriety.	<ol style="list-style-type: none"> <li>Counselor will provide Case Management services 1x/week to refer client and follow up for alternative options in managing his chronic pain issues (i.e., ABC Pain Management) that may impact his recovery. (Target date: 11/15/17)</li> <li>Counselor will provide Case Management services 1x/week to coordinate with other providers to ensure that client's biomedical needs that may impact recovery are being met. (Target date: 11/15/17)</li> </ol>
Target Date: 11/15/17	Completion Date:      Status: <input type="checkbox"/> Completed <input type="checkbox"/> Continued <input type="checkbox"/>

Problem # 2	Dimension(s): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Statement of Problem	
"Ever since the accident, I don't wanna do the things I used to do and I feel sad all the time."	
Statement of Goal	Action Steps / Interventions
1. Client will follow through with mental health linkages provided from 0x to 1x in the next 30 days to alleviate impact of mental health on recovery.	<ol style="list-style-type: none"> <li>Counselor will provide Case Management services 1x/week to link client to community mental health resources (i.e., Psychological Evaluation) to address possible mental health issues. (Target date: 11/15/17)</li> <li>Counselor will provide Case Management services 1x/week to follow up and consult with community mental health services as needed to ensure coordination of care with SUD services. (Target date: 11/15/17)</li> <li>Sober Up Recovery counselors will provide Group Counseling 3x/week to educate client on the impact of mental health issues on substance use and familiarize client to common symptoms. (Target date: 11/15/17)</li> </ol>
Target Date: 11/15/17	Completion Date:      Status: <input type="checkbox"/> Completed <input type="checkbox"/> Continued <input type="checkbox"/>

Doe, John

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Counselor initials

Problem # 3		Dimension(s): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4 <input checked="" type="checkbox"/> 5 <input type="checkbox"/> 6	
Statement of Problem			
"I don't want to go back to using."			
Statement of Goal		Action Steps / Interventions	
<p>1. Client will learn to cope with triggers and cravings to use from 1x/day to 3x/day to help prevent relapse in the next 90 days. (Target date for action steps 1a - 1c: 1/15/18)</p> <p>2. Client will continue with Buprenorphine treatment as prescribed by MAT provider 1x/month for the next 90 days to abstain from substance use. (Target date for action step 2a: 1/15/18)</p>		<p>1a. Sober Up Recovery counselors will provide Group Counseling 3x/week to help client to practice relapse prevention skills such as recognizing physiological/psychological responses to triggers, ways to manage cravings, and available resources for supporting abstinence.</p> <p>1b. Counselor will provide Individual Counseling 1x/week to teach client relaxation and grounding techniques for coping with triggers.</p> <p>1c. Client will participate in individual counseling sessions 1x/week and practice skills for coping with triggers/cravings to help prevent relapse.</p> <p>2a. This Counselor will provide Case Management services 1x/week to coordinate care with MAT provider for continuity of care.</p>	
Target Date: _____			

Problem # 4		Dimension(s): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input checked="" type="checkbox"/> 6	
Statement of Problem			
"I want to be able to go back to work."			
Statement of Goal		Action Steps / Interventions	
<p>1. Client will complete activities related to vocational achievement (i.e., completing his resume, following through with linkages, practicing time management skills) from 0x/week to 1x/week in the next 90 days to support recovery efforts.</p>		<p>1. Counselor will provide Individual Counseling 1x/week to help client to develop skills necessary in the work setting that will be conducive to his recovery (i.e., stress management, effective communication, time management). (Target date: 1/15/18)</p> <p>2. Counselor will provide Case Management services 1x/week to explore and provide referrals for vocational resources in the community (i.e., JobCorp, Good Will) in order to build a living environment conducive to recovery. (Target date: 1/15/18)</p>	
Target Date: 1/15/18		Completion Date: _____ Status: <input type="checkbox"/> Completed <input type="checkbox"/> Continued <input type="checkbox"/>	

Problems Not Currently the Focus of Treatment	
Problem	Plan

Check services authorized that are documented in the Action Steps / Interventions section of this Treatment Plan:

- Case Management     
  Group Counseling     
  Individual Counseling

\_\_\_\_\_  
*Printed Name of Counselor & Credentials*

\_\_\_\_\_  
*Signature of Counselor*

\_\_\_\_\_  
*Date*

John Doe  
 \_\_\_\_\_  
*Printed Name of Client*

\_\_\_\_\_  
*Signature of Client*

\_\_\_\_\_  
*Date*

I did contribute to the creation of my treatment plan.

\_\_\_\_\_  
*Printed Name of LPHA & Credentials*

\_\_\_\_\_  
*Signature of LPHA*

\_\_\_\_\_  
*Date*

Client refused to sign this Treatment Plan

# Appendix I: Sample SUD Re-Assessment (Continuing Services Justification)



## Substance Use Disorder (SUD) Re-Assessment

Based on the American Society of Addiction Medicine (ASAM) Criteria, 3<sup>rd</sup> Edition

- Re-Assessment
- Continuing Services Justification
- Discharge

For each ASAM Criteria dimension, consider progress note documentation, progress toward treatment goals, and include any relevant changes and/or new issues that may need to be addressed:

Select if Dimensions 1-6 were intentionally left blank

### Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential

Rationale (Include substance use history & history of previous SUD treatment):

See client's past drug/alcohol use history in SUD Assessment dated 9/27/2017. Client has been able to abstain from alcohol use (weekly negative drug testing) throughout time in IOT and has been sober for a total of 5 months. Client does not exhibit or endorse any intoxication or withdrawal symptoms.

#### Severity Rating – Dimension 1

0 None <input checked="" type="checkbox"/>	1 Mild <input type="checkbox"/>	2 Moderate <input type="checkbox"/>	3 Significant <input type="checkbox"/>	4 Severe <input type="checkbox"/>
No signs of withdrawal/intoxication present.	May be intoxicated, interferes with daily functioning. Minimal risk of severe withdrawal	Mild/moderate intoxication but responds to support. Moderate risk of severe withdrawal.	Significant intoxication and/or risk of severe but manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

### Dimension 2: Biomedical Conditions and Complications

Rationale (Include medical history, whether most recent physical exam has been completed, and copy is on file):

Client completed his physical exam in Feb. 2018 (copy filed in chart). Client has been linked with ABC Pain Management for evaluation and treatment of client's chronic back pain (see client's past medical history in SUD Assessment dated 9/27/2017). Client has been following through with keeping appointments and has recently begun trying acupuncture as an alternative method. Client reports that he is experiencing less physical discomfort, but continues to have some sleep difficulties. Client needs ongoing monitoring and support to encourage active participation in keeping up with his medical treatment to prevent it from leading to relapse.

#### Severity Rating – Dimension 2

0 None <input type="checkbox"/>	1 Mild <input checked="" type="checkbox"/>	2 Moderate <input type="checkbox"/>	3 Significant <input type="checkbox"/>	4 Severe <input type="checkbox"/>
No medical signs or symptoms present or medical conditions are stable.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, non-life-threatening problems present, or serious biomedical problems are neglected.	Serious medical problems neglected during outpatient treatment. Severe medical problems present but stable. Poor ability to cope with physical problems.	Incapacitated with severe medical problems.

### Dimension 3: Emotional, Behavioral, or Cognitive Condition and Complications

Rationale (Include psychiatric/psychological history & treatment):

Client has been linked to Living Well Psychological Group for a mental health evaluation and has started to work with a therapist to address symptoms of sadness, low self-worth, and loss of interest in activities that he previously enjoyed doing (see client's past psychiatric/psychological history in SUD Assessment dated 9/27/2017). Client says that therapy has been helpful in addressing the trauma of the accident. He continues to report some negative thinking in regards to his abilities to maintain sobriety and has periods of sadness about decline in physical capabilities since the bicycle accident. This continues to be a trigger for client. Client will need ongoing monitoring of symptoms and support for continuing with psychotherapy services to ensure it does not negatively impact his recovery.

#### Severity Rating – Dimension 3

0 None <input type="checkbox"/>	1 Mild <input checked="" type="checkbox"/>	2 Moderate <input type="checkbox"/>	3 Significant <input type="checkbox"/>	4 Severe <input type="checkbox"/>
No impulsive behaviors, good social functioning and self-care, no interference with recovery.	Suspect diagnosis of EBC, requires intervention, but does	Persistent EBC. Symptoms distract from recovery, but no immediate	Severe EBC, but does not require acute level of care. Minimal coping skills.	Severe EBC. Requires acute level of care. Exhibits severe and acute life-

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Client Name:

MRN:

## SUD Re-Assessment

### Dimension 4: Readiness for Change

Rationale (Include life areas affected by substance use & motivating factors for SUD treatment):

Client has engaged in treatment well as he attends and participates in all groups and individual sessions scheduled. He has been able to maintain a high level of motivation to continue living a sober life and has improved in his willingness to discuss his thoughts/feelings about where he is in the recovery process. Client seeks out assistance when needed and has become more open to verbalizing his needs and asking for help.

#### Severity Rating – Dimension 4

<b>0 None</b> <input checked="" type="checkbox"/>	<b>1 Mild</b> <input type="checkbox"/>	<b>2 Moderate</b> <input type="checkbox"/>	<b>3 Significant</b> <input type="checkbox"/>	<b>4 Severe</b> <input type="checkbox"/>
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

### Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Rationale (Include relapse history, triggers & management of triggers):

With the improved management of his chronic back pain, client's triggers to use have decreased. However, client continues to struggle occasional experiences of sadness and frustration related to the decline in his physical capabilities since the bicycle accident. His negative thinking in this regard continues to be a trigger for client. He has made progress in learning and applying coping skills to manage trigger (positive self-talk, calling his sponsor, reading the big book), but would benefit from ongoing monitoring to ensure that he stays connected to his supports and continue to strengthen his relapse prevention skills.

#### Severity Rating – Dimension 5

<b>0 None</b> <input type="checkbox"/>	<b>1 Mild</b> <input checked="" type="checkbox"/>	<b>2 Moderate</b> <input type="checkbox"/>	<b>3 Significant</b> <input type="checkbox"/>	<b>4 Severe</b> <input type="checkbox"/>
Low/no potential for relapse. Good coping & relapse prevention skills.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition of risk for relapse, poor skills to cope with relapse.	No coping skills for relapse/addiction problems. Substance use/behavior, places self/others in danger.

### Dimension 6: Recovery/Living Environment

Rationale (Include employment/educational history, financial status history, legal history, & family/social history):

No changes to client's family history, criminal history, legal status, and previous SUD treatment history, see SUD Assessment dated 9/27/2017. Client has been able to build up a support network over the past 5 months with his involvement in NA and working his steps with his sponsor. He has reported meeting peers in his meetings that he has been able to reach out to for assistance in managing his triggers. Client continues to stay with a friend who regularly uses alcohol and drugs, but client has been able to demonstrate separating himself from the influence and maintain his sobriety (for client's social/recreational and housing history, see SUD Assessment dated 9/27/2017). Client has also made progress towards taking steps to gain employment that is currently part-time, with the potential for full-time employment after his probation period (refer to SUD Assessment dated 9/27/2017 for financial and employment history). No changes in client's education since admission to treatment. See client's educational history in SUD Assessment dated 9/27/2017. Client appears hopeful and obtaining this position has greatly increased his confidence. He has been working to use this positive outcome to empower himself by reminding him of the benefits of living a sober lifestyle. Client would like to continue to work on improving his relationship with family members as he still has some difficulty in communicating with them and has a tendency to avoid/isolate himself from them.

#### Severity Rating – Dimension 6

<b>0 None</b> <input type="checkbox"/>	<b>1 Mild</b> <input checked="" type="checkbox"/>	<b>2 Moderate</b> <input type="checkbox"/>	<b>3 Significant</b> <input type="checkbox"/>	<b>4 Severe</b> <input type="checkbox"/>
Environment supportive of recovery process.	Environment is supportive. May require clinical intervention.	Environment is unsupportive to recovery process but able to participate with clinical support.	Environment unsupportive to recovery process, difficulty in participating even with clinical support.	Environment toxic/hostile to recovery. Unable to participate and the environment may pose a threat to safety.

## SUD Re-Assessment

Level of Care Summary	
<b>Level of Care/Service Indicated by Assessment</b> – The following level of care offers the most appropriate treatment setting/service intensity needed to address the client’s current functioning and severity:	
Withdrawal Management: <input type="checkbox"/> 1-WM <input type="checkbox"/> 2-WM <input type="checkbox"/> 3.2-WM <input type="checkbox"/> 3.7-WM <input type="checkbox"/> 4-WM Prevention: <input type="checkbox"/> 0.5 Outpatient: <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2.1 <input type="checkbox"/> 2.5 Residential: <input type="checkbox"/> 3.1 <input type="checkbox"/> 3.3 <input type="checkbox"/> 3.5 Medical Inpatient: <input type="checkbox"/> 3.7 <input type="checkbox"/> 4 Recovery Services: <input type="checkbox"/>	<input type="checkbox"/> OTP (NTP)
<b>Level of Care/Service Accepted</b> – Enter the level of care/service intensity that is actually accepted:	
Withdrawal Management: <input type="checkbox"/> 1-WM <input type="checkbox"/> 2-WM <input type="checkbox"/> 3.2-WM <input type="checkbox"/> 3.7-WM <input type="checkbox"/> 4-WM Prevention: <input type="checkbox"/> 0.5 Outpatient: <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2.1 <input type="checkbox"/> 2.5 Residential: <input type="checkbox"/> 3.1 <input type="checkbox"/> 3.3 <input type="checkbox"/> 3.5 Medical Inpatient: <input type="checkbox"/> 3.7 <input type="checkbox"/> 4 Recovery Services: <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> OTP (NTP)
<b>Reason for Discrepancy</b> – If there is a difference between the level of care indicated by the assessment and the level of care actually provided, then select <b>one (1)</b> reason for the discrepancy:	
<input checked="" type="checkbox"/> <b>Not Applicable – no difference</b> <input type="checkbox"/> Declined Services <input type="checkbox"/> Client preference <input type="checkbox"/> Lack of insurance/payment source <input type="checkbox"/> Level of care not available <input type="checkbox"/> Clinical judgment <input type="checkbox"/> Language <input type="checkbox"/> Managed care refusal <input type="checkbox"/> Family responsibility <input type="checkbox"/> Legal issues <input type="checkbox"/> Used two residential stays in a year already <input type="checkbox"/> Geographic accessibility <input type="checkbox"/> Other: _____	
<b>Continued Treatment Determination</b> – Please select <b>one (1)</b> .	
<input type="checkbox"/> Continuous assessment/No change in level of care <input checked="" type="checkbox"/> Discharge/Change in level of care – Referred to another provider <input type="checkbox"/> Discharge-Client declined services <input type="checkbox"/> Discharge/Change in level of care – Continuing with current provider	
Counselor Recommendations	
<i>Indicate clinical recommendations for continued treatment.</i>  Upon consideration of client’s functioning in all 6 dimensions of the ASAM Criteria (severity ratings are predominately mild) and client’s progress on treatment plan goals during this treatment episode, it appears that client is ready for a transfer to a lower level of care (Outpatient Treatment Services). Client has been successfully linked to a pain management specialist and further evaluation/treatment for mental health symptoms. Client has also achieved his vocational objective by securing a part-time job. Client has been able to achieve his goal to use coping skills for his triggers and cravings 3x/day. Counselor’s recommendation is for client to be stepped down to the Outpatient Treatment Services level of care at The Stay Clean Program in Santa Ana.	

<b>Printed Counselor Name and Credentials</b>	<b>Signature</b>	<b>Date</b>
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**Client Name:** \_\_\_\_\_

**MRN:** \_\_\_\_\_

## SUD Re-Assessment

DSM-5 Diagnosis (LPHA to complete)		
<b>Primary: (must be SUD)</b>	Code: F11.21	Diagnostic Descriptor: Opioid Use Disorder, Severe, In early remission
<b>Secondary:</b>	Code:	Diagnostic Descriptor:
<b>Tertiary:</b>	Code:	Diagnostic Descriptor:
<b>Additional:</b>	Code:	Diagnostic Descriptor:
<b>Justification for change/update to diagnosis (required):</b>		
<p>Client previously met the full criteria for Opioid Use Disorder, Severe, but has met none of the criteria for the past 5 months. Therefore, he is in early remission.</p>		

**Printed LPHA Name and Credentials**

**Signature**

**Date**

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Revised: 08.18.20

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## SUD Re-Assessment

### LPHA Case Formulation

*Indicate the client's prognosis and medical necessity for continued services to justify the level of care.*

Client's prognosis is good. Client meets criteria for Opioid Use Disorder, Severe, In early remission as he has been sober for 5 months. During his use, client experienced a progressive increase in use (starting with medication as prescribed and escalating to smoking Heroin) to the point where he was using "just to feel ok" and avoid withdrawals. He made several attempts to stop on his own without success and daily experiences of cravings. His use led to being fired from his job and putting himself and others in danger by driving under the influence. Despite dangers and loss, client continued to use. Although no longer in active use, as indicated by counselor's recommendations, client continues to meet medical necessity based on mild impairments in Dimensions 2, 3, 5, and 6. Client has made progress at the IOT level of care, but continues to need support in utilizing ways to manage his triggers and not all problems (medical, mental health, social, occupational) have been resolved fully. Client has some sleep difficulties as a result of chronic back pain and based on client's history of physical pain being a trigger for substance use, needs ongoing monitoring to ensure that he is managing appropriately and following through with physician's recommendations. In regards to his mental health, client would benefit from continuing to address management of triggers (sadness and decline in physical capabilities) in order to prevent possible relapse. Client has expressed desire to improve relationship with family as he continues to have instances of avoidance and isolation. Client would benefit from working on building family support and communication skills as a means of relapse prevention. Client is also experiencing transition in his employment with the possibility of moving to full-time employment and needs monitoring for potential stressors that may increase risk for return to use. As a result of ongoing impairments, client continues to meet medical necessity for services. Client is appropriate for a less restrictive treatment environment where he can focus on increasing his independent living skills and reliance on relapse prevention skills with the support of an outpatient program. Coordination will be provided in order to ensure a smooth transition.

**Printed LPHA Name and Credentials**

**Signature**

**Date**

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**Client Name:**

**MRN:**

Revised: 08.18.20

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## Appendix J: SUD Progress Note Checklist

### Format:

- GIRP
  - Goal
  - Intervention
  - Response
  - Plan

### Requirements:

- Date of session
- Start/End time of session
- Start/End time of documentation minutes
- Location (or indicate by telephone or telehealth if not face-to-face)
  - If session is conducted out in the community, there must be documentation of how confidentiality was ensured in that location.
- Type of service
- Topic or purpose of session
- Client's progress towards treatment plan goals (in the Plan)
- Counselor's printed name and credentials, signature, and date (date of documentation)
- Note written and signed within 7 days of date of service
  - If more than 7 days: note must be made non-compliant

## Appendix K: Progress Note Elements

### IS THIS BILLABLE, NON-BILLABLE, OR NON-COMPLIANT?

<b>BILLABLE</b>	<b>NON-BILLABLE</b>	<b>NON-COMPLIANT</b>
What Medi-Cal will pay for.	What Medi-Cal would NEVER pay for.	What Medi-Cal could have paid for, but we did something wrong.
<p>Examples:</p> <ul style="list-style-type: none"> <li>• Correct code to type of service provided</li> <li>• Interventions address SUD and meets medical necessity</li> <li>• Within scope of practice of the counselor</li> </ul>	<p>Examples:</p> <ul style="list-style-type: none"> <li>• Clerical</li> <li>• Solely social/recreational/vocational</li> <li>• Unrelated to SUD and no medical necessity established</li> </ul>	<p>Examples:</p> <ul style="list-style-type: none"> <li>• Two types of services provided under one code (blended)</li> <li>• Out of the timeframe</li> <li>• Out of scope of practice of the counselor</li> </ul>

### HOW DO I DETERMINE TIME SPENT ON AN ACTIVITY?

<b>Face-to-Face time</b>	Time with the client, in person.
<b>Non-Face-to-Face time</b>	<p>Billable or non-billable time spent on a service activity that does not include interaction with the client.</p> <p>Example: Analyzing information to determine risk rating levels for the dimensions of the ASAM Criteria outside of the session with client. The time spent working on this is billable.</p>
<b>Service Minutes</b>	The combination of time spent face-to-face with a client in session and/or any billable non-face-to-face time.
<b>Documentation Minutes</b>	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 what is written. Working on any other documents besides the progress note is not considered documentation time.
<b>Travel Minutes</b>	<p>Time it takes to travel from one location to another to meet with client or provide a service. <i>Transporting</i> a client does not count for this. If solely transporting a client from point A to point B, this time is non-billable (Medi-Cal will not reimburse for us being a taxi service).</p> <p>If during the course of transporting the client from point A to point B, some service is provided (such as discussing recent response to triggers and use of coping skills), the portion of the time that is spent counseling is considered Service Time because you provided a service. This does <i>not</i> mean that if 5 minutes of counseling was provided during a 30 minute drive, we can bill all 30 minutes! Only the time spent providing an actual service can be billed.</p>

Appendix L: Documentation Language by Service Type

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

INDIVIDUAL/GROUP COUNSELING:						
<i>Assessment:</i>	<i>Tx Planning:</i>	<i>Crisis:</i>	<i>Individual/family/group:</i>		<i>Collateral:</i>	<i>DC Planning:</i>
Asked	Analyzed	Assessed	Acknowledged	Redirected	Consulted	Developed
Assessed	Created	Assisted	Assisted	Reinforced	Collaborated	Discussed
Ascertained	Developed	Attempted	Attempted	Reiterated	Coordinated	Explored
Attempted	Established	Coordinated	Challenged	Reviewed	Shared	Reviewed
Clarified	Formed	De-escalated	Coached	Role played	Exchanged	Formulated
Determined	Formulated	Empathized	Discussed	Shared	Discussed	Established
Developed	Generated	Empowered	Demonstrated	Supported	Reviewed	Set
Elicited	Produced	Ensured	Described	Showed	Prepared for	Prepared
Evaluated	Synthesized	Evaluated	Empathized	Taught	Planned	Revised
Explored		Facilitated	Educated	Validated	Developed	Coordinated
Formulated		Focused on	Elicited	Verbalized	Inquired	Collaborated
Gathered		Fostered	Empowered		Asked	
Gauged		Helped	Encouraged		Questioned	
Inquired		Intervened	Engaged		Followed up	
Obtained information about...		Monitored for	Explained		Elicited	
Probed		Obtained	Explored			
Questioned		Offered	Expressed			
Reviewed		Promoted	Fostered			
Synthesized		Provided	Helped			
		Reassured	Introduced			
		Recommended	Inquired			
		Responded to	Maintained			
		Stabilized	Modeled			
		Supported	Motivated			
		Showed	Normalized			
			Offered			
			Practiced			
			Processed			
			Prompted			
			Promoted			
			Provided			
			Recommended			

## Appendix M: Sample Discharge Plan

Today's Date: 10/12/17	Admission Date: 9/29/17	Planned Discharge Date: 12/28/17
Name: Doe, Joe		Current Level of Care: Intensive Outpatient Treatment
My Counselor's Name: <u>Mary Sunshine, CADC II</u> Contact: <u>(714) 987-6543</u>		
Why I Want To Stay Sober: "I want to go back to being like how I was before the accident."		
My Treatment Goals: <ol style="list-style-type: none"> <li>1. To get help for my back pain</li> <li>2. Learn how to deal with triggers and cravings</li> <li>3. Go back to working</li> </ol>		
My Relapse Triggers: <ol style="list-style-type: none"> <li>1. Back pain</li> <li>2. Not having a job</li>   <li>3. Not having own place to live</li>   <li>4. Conflict with family</li> </ol>	Things I Can Do When I Get Triggered: <ol style="list-style-type: none"> <li>1. Deep breathing, meditation</li> <li>2. Positive self-talk (remind myself that I am working towards it), go to a meeting</li> <li>3. Positive self-talk (remind myself that I am working towards it), making a gratitude list, go to a meeting</li> <li>4. Talking to my sponsor, go to a meeting, listen to music</li> </ol>	
<b>SUPPORT PLAN:</b>		
People I Can Contact For Support When I Get Triggered: <ol style="list-style-type: none"> <li>1. Name: <u>David Goodguy</u>      Relationship: <u>Sponsor</u>      Contact: <u>(310) 222-1515</u></li> <li>2. Name: <u>James Peach</u>      Relationship: <u>Friend</u>      Contact: <u>(714) 111-2323</u></li> <li>3. Name: _____      Relationship: _____      Contact: _____</li> </ol>		
Community Resources I Can Access For Support: <ol style="list-style-type: none"> <li>1. Name of Organization: <u>OC Narcotics Anonymous</u>      Contact: <u>(714) 590-2388</u> Address: _____</li> <li>2. Name of Organization: <u>First United Methodist Church</u>      Contact: <u>(714) 542-2322</u> Address: <u>609 N. Spurgeon St., Santa Ana, CA 92701</u></li> <li>3. Name of Organization: <u>Orange County Rescue Mission</u>      Contact: <u>(714) 247-4300</u> Address: <u>1 Hope Drive, Tustin, CA 92782</u></li> </ol>		
Additional Resources To Help Me With My Treatment Goals: <ol style="list-style-type: none"> <li>1. Name of Organization: <u>One-Stop Center, Santa Ana</u>      Contact: <u>(714) 565-2600</u> Address: <u>1000 E. Santa Ana Blvd., Ste. 200, Santa Ana, CA 92701</u></li> <li>2. Name of Organization: <u>Orange County Housing Authority</u>      Contact: <u>(714) 480-2700</u> Address: <u>1770 N. Broadway, Santa Ana, CA 92706</u></li> <li>3. Name of Organization: _____      Contact: _____ Address: _____</li> </ol>		
Client's Name: _____      Signature: _____      Date: _____		
Counselor's Name: <u>Mary Sunshine, CADC II</u> Signature: _____      Date: _____		
<input checked="" type="checkbox"/> Copy of Discharge Plan provided to client; if no, provide reason: _____		

Appendix N: Sample Discharge Summary

<b>CONFIDENTIAL PATIENT INFORMATION</b> See: Cal W & I Code, Section 5328, 42CFR COUNTY OF ORANGE, CALIFORNIA HEALTH CARE AGENCY BEHAVIORAL HEALTH SERVICES SUBSTANCE USE DISORDER SERVICES		Client Name: Doe, John DOB: 01/01/1989 MRN: 0123-45-6789	
<b>SUBSTANCE USE DISORDER TRANSFER/DISCHARGE SUMMARY</b>			
Facility: Sober Up Recovery 123 N. Clean Way Santa Ana, CA 92702		Current LOC: <input type="checkbox"/> ODF <input checked="" type="checkbox"/> IOT <input type="checkbox"/> Recovery Services Transfer to LOC: <input checked="" type="checkbox"/> ODF <input type="checkbox"/> IOT <input type="checkbox"/> Recovery Services <input type="checkbox"/> Discharge from all Services at this Facility	
Front Office Use Only: <input type="checkbox"/> EOC Discharged <input type="checkbox"/> BCE Completed		Initials: _____ Date Processed: _____ <input type="checkbox"/> Facility Discharged if last Service at Facility MH Court/Consv Status: Not Applicable MH W&I Legal Class: Not Applicable	
<b>ENCOUNTER DOCUMENT DETAILS</b>			
Encounter Type: <b>Clinic Service</b>		CPT Code: <b>NB IOT Case Mgmt , 90899-570</b>	
Number of minutes to complete the discharge process: <b>16</b>			
Documentation Minutes: <b>8</b> <small>(only if completing a full discharge)</small>		Documentation Date: <b>03/08/2018</b>	
Last Client Contact Date: <b>03/01/2018</b> <small>(entered in DIS-1 on CalOMS form)                  Last client contact where information was collected directly from Client                  (individual, group, home, telephone)</small>		EOC and/or Facility Discharge Date: <b>03/08/2018</b> <small>(last charting date for this EOC)</small>	
<b>Discharge Diagnosis</b>			
F11.21 Opioid Use Disorder, Severe, In early remission			
Date of Last Drug Test: <b>03/01/2018</b>		Results of Last Drug Test: <b>neg</b>	
Discharge Reason (primary): <b>Lower Level Care Transfer</b>		Discharge Living Arrangement (primary): <b>No Support Req in House/Apt</b>	
Other: _____		Other: _____	
Behavioral Health Treatment Linkage / Referral (Primary): <b>ADAS Outpatient</b>		Prognosis: <b>Good</b>	
<input checked="" type="checkbox"/> See Continued Services Justification Dated <b>03/02/2018</b> for Discharge Summary		<input type="checkbox"/> See attached for Unplanned Discharge Summary	
Provider Signature: _____		Title: _____	
Print/Type Name: _____		Date Completed (chart Note date): _____	
<b>Facility Discharge Supervisory Review</b>			
<input type="checkbox"/> CalOMS Discharge Approved		<input type="checkbox"/> Facility Discharge Approved	
Supervisor Notes if not approved: _____			
Supervisor Signature: _____		Title: _____	
Print/Type Name: _____		Date Completed: _____	
SUD Transfer / Discharge Summary 1-28-20 <span style="float: right;">Page 1</span>			

<b>CONFIDENTIAL PATIENT INFORMATION</b> See: Cal W & I Code, Section 5328, 42CFR COUNTY OF ORANGE, CALIFORNIA HEALTH CARE AGENCY BEHAVIORAL HEALTH SERVICES SUBSTANCE USE DISORDER SERVICES	Client Name: Doe, John DOB: 01/01/1989 MRN: 0123-45-6789
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**Discharge Summary Details: (summary must include a description of services including the current alcohol/drug usage, vocational/educational achievements, legal status, reason for discharge and whether discharge was involuntary or successful completion, etc.)**

Client's prognosis is good as he has made significant progress in the IOT level of care. Client was admitted due to his F11.21 Opioid Use Disorder, Severe that had resulted in the primary impairments in Dimensions 2, 5, and 6 of the ASAM Criteria. Client's treatment goals included following through with linkages for pain management, following through with mental health linkages, learning to cope with triggers and cravings to use, and completing activities related to vocational achievement. Client has successfully been connected with a pain management provider that has suggested alternative approaches, such as acupuncture, that has been reported by client to be very effective. Client had initially complained of some sadness, low self-worth, and loss of interest following a bicycle accident and was referred for mental health services for further evaluation. Client was connected to Living Well Psychological Group where he received and evaluation and some short-term psychotherapy, which client reports has improved his mood and perceptions about self. Client was proactive in meeting his treatment goal to follow through with activities related to vocational achievement such as writing his resume, job searching, attending a career fair, and attending an interviewing workshop. Client has been able to obtain a sales position at \_\_\_\_\_ part-time, with plans to move into a full-time position after his probation period. Client has also been connected with community resources (NA, Pain Management Support Group) to help build his social support network. He has been able to increase his self-awareness in regards to triggers and cravings, having been challenged with day-to-day life stressors and opportunities to implement skills learned to self-soothe and maintain sobriety. Client says, "I learned a lot and it's helped me to meet other people who have the same issues." He reports that he wants to continue with the progress he has made in the next phase of his recovery.

**After Care Recommendations**

Recommendation is for client to continue with building relapse prevention support at the Outpatient level of care to practice managing triggers and cravings and ways to handle stress and unexpected changes in life in order to be able to transition to Recovery Services for maintenance.

Time billed to complete discharge process includes review of client's chart for determining length of stay, prognosis, and treatment outcomes for compiling narrative summary.

Provider Signature	Title	Print/Type Name	Date Completed (Chart Note Date)