Drug Medi-Cal Organized Delivery System

Documentation Manual

California Advancing and Innovating Medi-Cal (CalAIM)

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Orange County Health Care Agency

Behavioral Health Services

Contents

1. Introduction ... 7
Purpose ... 7
2. Authorized Service Providers ... 7
Scope of Practice ... 7
Provider Requirements ... 9
3. Continuum of care ... 10
4. Billing Prior to Assessment at Outpatient ... 12
Billing Prior to the Completion of Assessment FAQ ... 13
5. Medical Necessity ... 14
6. Access Criteria ... 15
Clients Over 21 Years of Age ... 15
Who Can Establish Whether a Client Over 21 Meets the Access Criteria? ... 16
How Do We Determine Whether a Client Over 21 Meets the Access Criteria? ... 16
When Do We Need to Determine Whether a Client Over 21 Meets the Access Criteria by? ... 16
What About Clients Over 21 Who Do Not Meet the Access Criteria? ... 16
Clients Under 21 Years of Age ... 16
Who Can Establish Whether a Client Under 21 Meets the Access Criteria? ... 17
How Do We Determine Whether a Client Under 21 Meets the Access Criteria? ... 17
When Do We Need to Determine Whether a Client Under 21 Meets the Access Criteria by? ... 17
7. Level of care determination ... 18
ASAM & Levels of Care ... 18
8. Initial Assessment ... 19
Requirements ... 19
Who Can Complete the Initial Assessment? ... 20
How is the Initial Assessment conducted? ... 20
When Do We Need to Complete the Initial Assessment by? ... 20
MAT Referral Assessment ... 21
Focus of the Initial Assessment ... 22
Treating Co-Occurring Disorders ... 23
Social Determinants of Health (SDOH) ... 23
Youth-Specific ... 25
Perinatal and Postpartum ... 25

Assessment Information within the ASAM Dimensions 25
What is the Case Formulation? 27
Components of the Case Formulation (or LPHA write-up/narrative) 28
Sample: Case Formulation 29
Non-LPHA and LPHA Consultation for the Initial Assessment 29
Completing Assessment Activities in the Proper Sequence 30
Clients Determined to Not Meet the Access Criteria 30
Treatment Authorization for Residential Treatment Services 31
Use of Assessments Across and Within Programs 31
Transitions in level of care within the same provider 31
Transitions in level of care across different providers 32
Transfers across programs under the same entity 33
Transfers in the same level of care across different providers 34
Important Reminders about the SUD Assessment Form 34
Initial Assessment FAQ 35
9. Problem List 36
Problem List vs. Treatment Plan 36
Requirements 37
Who Can Complete the Problem List? 38
When Does the Problem List Need to be completed? 38
When Does the Problem List Need to be updated? 39
How Should the Problem List be used? 39
Pregnant and Postpartum 40
Youth-Specific 40
What about the Physical Exam? 40
Problem List FAQ 41
Sample: Problem List 42
10. Re-Assessments 43
Requirements 43
Who needs to complete the Re-Assessment? 43
How is the Re-Assessment conducted? 44
Re-Assessments Used as the Initial Assessment 44
Re-Assessments at the Residential Level of Care 44

What needs to be in the Residential Re-Assessment? 45
County DUI/Drug Court ONLY: Keeping Cases Open in Outpatient While Receiving Residential Services 45
Re-Assessment FAQ 46
11. Progress Notes 47
Requirements 47
Group Counseling Service Documentation Requirements 48
Service and Documentation Start and End Time 49
When do progress notes need to be completed? 49
What format do the progress notes need to be in? 50
Who can document progress notes? 50
How do we document the brief description portion of the progress notes? 50
How do we document the next steps portion of the progress notes? 50
Progress notes for drug testing 51
Residential Treatment and Daily Notes 51
What is a daily note? 51
How should a daily note be written? 52
Required Clinical Hours vs. Structured Hours 52
Services via Telehealth & Telephone 54
Progress Note FAQ 55
Time Components of a Progress Note 57
Face-to-Face Minutes 57
Non-Face-to-Face Minutes 57
Service Minutes 58
Documentation Minutes 59
Travel Minutes 59
12. Codes & Types of Services 59
Billing 59
Billable Services 60
Non-Billable Services 60
Disallowance or Recoupment of Services 61
Billing and Coding FAQ 62
Types of Services 63

Collateral 64
Assessment 67
Crisis Intervention 75
Treatment Planning 77
Individual Counseling 78
Family Services 81
Group Counseling 83
List of Participants for Groups 84
Sample: Group Counseling Progress Note 86
Care Coordination 88
Same Day Billing 90
Review of Documents 90
Consultations 91
Sample: Care Coordination Progress Note 92
Care Coordination FAQ 92
Clinician Consultation 93
Physician Consultation 94
13. Discharge 94
Discharge Summary 95
What if the discharge summary is used to close the case? 95
Can we bill for completing the discharge summary? 95
14. Other Levels of Care 95
Residential Treatment Services 95
What are Residential Treatment Services? 95
Who can provide Residential Treatment Services? 96
How can Residential Treatment Services be provided? 96
Recovery Services (RS) 97
What is RS? 97
Who can provide RS? 98
How can RS be provided? 98
Where can RS be provided? 98
RS Scenarios 98
Withdrawal Management (WM) 101

What is WM? ... 101
Observations at WM ... 101
Trained personnel in detoxification services ... 101
Who can provide services at WM? ... 102
How can WM services be provided? ... 102
Assessments at WM ... 102
Narcotic Treatment Programs/Opioid Treatment Programs (NTP/OTP) ... 103
What is NTP/OTP? ... 103
Who can provide NTP/OTP Services? ... 106
How can NTP/OTP be provided? ... 106
NTP/OTP and the ASAM Assessment ... 106
NTP/OTP and the Treatment Plan ... 107
Medications for Addiction Treatment or Medication Assisted Treatment (MAT) ... 107
What is MAT? ... 107
Who can provide MAT services? ... 110
MAT and the Treatment Plan ... 110
Peer Support Services ... 111
What are Peer Support Services? ... 111
Who can provide Peer Support Services? ... 112
Where can Peer Support Services be provided? ... 113
Recovery Incentives (RI) Program (Contingency Management) ... 113
What is RI? ... 113
Who can provide RI Program services? ... 114
Eligibility Criteria for RI Programs ... 114
Treatment Schedule at RI Programs ... 115
Documentation at RI Programs ... 116
15. Appendix ... 120
Appendix A: Breakdown of the ICD-10 Codes of Z55-Z65 ... 120
Appendix B: Substance Use Disorder Diagnoses DSM-5-TR Criteria Guide ... 124
Appendix C: DMC-ODS Covered Diagnoses List For Residential & Withdrawal Management Levels of Care ... 125

1. INTRODUCTION

Purpose

The County of Orange provides Substance Use Disorder (SUD) services to adults who have a substance use disorder and adolescents who either have a substance use disorder or are at risk of developing a substance use disorder.

The County of Orange opted in to participate in the State's Drug Medi-Cal Organized Delivery System (DMC-ODS), which was first implemented in July 2018. At the time, it was a demonstration project that would allow for greater coordination of care for clients as they move from one level of care to another, with the hopes of increasing the likelihood of successful treatment outcomes. With the California Advancing and Innovating Medi-Cal (CalAIM) initiative in 2022, the State has moved towards further streamlining documentation requirements to "improve the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate and effective beneficiary care; address equity and disparities; and ensure quality and program integrity" (Behavioral Health Information Notice 23-068).

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 the Quality Management Services (QMS) Substance Use Disorder Support Team (SST).

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. Please keep in mind that the State sets the minimum requirements. Where there is no explicit guidance from the State or the State is silent, the County can impose standards based on the information available with consideration of internal program requirements. This 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. AUTHORIZED SERVICE PROVIDERS

Scope of Practice

All staff are expected to provide treatment services within his, her, or their 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 (Medical Doctor/Doctor of Osteopathy [MD/DO]), Nurse Practitioners (NPs), Physician Assistants (PAs),

Registered Nurses (RNs), Registered Pharmacists, Licensed Clinical Psychologists (LCPs), Registered Psychologists, Licensed Clinical Social Workers (LCSWs), Registered Clinical Social Workers, Licensed Professional Clinical Counselors (LPCCs), Registered Clinical Counselors, Licensed Marriage and Family Therapists (LMFTs), Registered Marriage and Family Therapist, Licensed Vocational Nurses (LVNs), Licensed Occupational Therapists (LOTs), and Licensed Psychiatric Technicians (LPTs). Those in the above disciplines must also abide by the scope of practice guidelines set forth by the respective certifying or licensing board.

- **Registered** individuals are candidates for licensure who are registered or have submitted a registration application and is in the process of obtaining registration in accordance with criteria established by the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations. Registered staff are considered LPHA but must receive the appropriate clinical supervision.
- **Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), Licensed Occupational Therapists (LOTs), Pharmacists, and Licensed Psychiatric Technicians (LPTs)** are considered LPHA; however, their scope of practice limits them from diagnosing and providing some of the clinical services more appropriate for other professional staff. Please refer to their respective licensing board standards for further information.

Medical Students in Clerkship are not LPHA as they do not have a Medical License and must be under the supervision of an MD/DO.

Clinical Trainees are unlicensed individuals enrolled in a post-secondary educational degree program in the State of California, participating in a practicum or internship. Clinical Trainees must receive the appropriate supervision by licensed staff. Clinical Trainees are not considered LPHA. They must be properly supervised by licensed staff in their provision of services. Clinical Trainees include: Nurse Practitioner Clinical Trainees, Physician Assistant Clinical Trainees, Registered Nurse Clinical Trainees, Pharmacist Clinical Trainees, Psychologist Clinical Trainees, Clinical Social Worker Clinical Trainees, Professional Clinical Counselor Clinical Trainees, Marriage and Family Therapist Clinical Trainees, Vocational Nurse Clinical Trainees, Occupational Therapist Clinical Trainees, Psychiatric Technician Clinical Trainees

Medical Assistants (MAs) are individuals 18 years of age and older who meet all education, training, and/or certification requirements and provide administrative, clerical, and non-invasive routine technical support services within their scope of practice, under the supervision of a licensed physician or physician assistant/nurse practitioner delegated supervisory authority by a physician. The licensed physician, physician assistant, or nurse practitioner must be physically present and on-site in the treatment facility during the provision of services by an MA.

MA training documentation maintained on-site must include the following: A) Diploma or certification from an accredited training program/school, or B) Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. C) Evidence of training or attendance at State audiometric training and vision training is documented.

MA scope of practice allows for the administration of pre-measured medications orally,

sublingually, topically, vaginally, or rectally, by providing a single dose to a patient for immediate self-administration, by inhalation or by simple injection. In every instance, prior to administration of medication by the MA, a licensed physician, or another person authorized by law to do so shall verify the correct medication and dosage. Administration of injections or scheduled drugs, including narcotic medications, is permitted only if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular. All medications administered by an MA must be specifically authorized by the supervising physician, which means a specific written order or standing order prepared by the supervising physician. To administer medications by intramuscular, subcutaneous, and intradermal injection, to perform skin tests or venipuncture for the purpose of withdrawing blood, an MA must have competed at least the minimum amount of training hours established in Title 16, section 1366.1. MAs are not permitted to place an intravenous (IV) needle, start, or disconnect the IV infusion tube, administer medications or injections into an IV line, or administer anesthesia.

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. Registered or certified AOD Counselors are considered non-LPHA.

Support Staff (i.e., Behavioral Technicians, House Staff, etc.) or non-credentialed/non-licensed workers in direct contact with clients to provide non-clinical, ancillary services (i.e., general supervision of clients, transportation, recreation, etc.) within the DMC-ODS are permitted. However, he/she/they are not able to provide and bill for any clinical services.

Staff, whose classification or job description require a license, waiver, certification, and/or registration to deliver Medi-Cal covered services would need to be credentialed through the County's Managed Care Support Team.

DISCLAIMER: Providers involved in patient care need to be listed on the provider directory and undergo credentialing if they possess a license, certification, or registration.

Provider Requirements

DMC-ODS also requires that counselors and clinicians receive training in American Society of Addiction Medicine (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. 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&Ps can be found by visiting BHS Policies And Procedures .

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.

Certification with the State as a DMC-ODS provider is required to provide and bill for services. Any DMC-ODS services provided and claimed without the proper certification will

result in disallowances and/or recoupments as these services may be considered fraud, waste, and/or abuse. For more information on credentialing and certification, please refer to the County's Managed Care Support Team.

The County's SUD Documentation Training is a County required training that is part of each program's contract. However, currently, there is no SUD Documentation Training available. Therefore, review of this Documentation Manual is acceptable to fulfill this requirement. An attestation page can be found at the end of the manual that may be used internally at each provider site to track completion of the review, if desired. It is expected that providers will understand the documentation and billing requirements to be able to deliver and bill for compliant services once they begin providing services to clients. Thus, referencing this Documentation Manual and the monthly SUD Newsletters for the most up-to-date changes is advised. See Drug Medi-Cal Organized Delivery System Provider Training Requirements P&P for more information.

3. CONTINUUM OF CARE

The continuum of care is a concept pertaining to placement of individuals within five broad levels of service that is flexible and seamless. The idea is to create an environment where clients can move up or down in intensity of services without "falling through the cracks" or ending up in a level that is not suited for them.

The goal of the DMC-ODS, under the CalAIM initiative, is to address the clients' needs across the continuum of care and ensure access to the right care, in the right place, at the right time. We know that treatment is not a "one-size-fits-all," and this model helps support that.

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 offers to improve treatment outcomes by accurately assessing the client's needs and ensuring that the services provided meet those needs. The ASAM Criteria has become the industry standard in the assessment and treatment of addiction and provides a streamlined way of determining where in the continuum of care the client may be most appropriate. The intention is to move clients along this continuum as a part of their journey towards a self-sufficient and sustainable life of recovery.

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 Treatment Services	Up to 9 hours of service/week (adults); Up to 6 hours of service/week (adolescents)

	or Outpatient Drug Free (ODF)	
Level 2.1	Intensive Outpatient Treatment (IOT) Services	Minimum of 9 hours, maximum of 19 hours/week (adults); Minimum of 6 hours, maximum of 19 hours/week (adolescents)
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 High-Intensity Residential Services	24-hour care with trained counselors; less intense milieu for those with cognitive or other impairments; at least 5 hours of clinical service/week.
Level 3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors; at least 5 hours of clinical service/week.
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
MAT	Medication-Assisted Treatment	FDA-approved medications and biological products to treat Alcohol Use Disorder, Opioid Use Disorder, and any SUD that is provided in clinical or non-clinical settings as a standalone service or as a service delivered as part of a level of care
Recovery Services		Provided based on self-assessment or provider assessment of relapse risk and delivered as a standalone service or concurrently with other levels of care that is designed to support recovery and prevent relapse to restore to best possible functioning

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 daytime withdrawal management and support and supervision in a non-residential setting; at night has supportive family or living situation.
Level 3.2-WM	Clinically managed residential withdrawal management	24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting.
Level 3.7-WM	Medically managed inpatient withdrawal management	Severe withdrawal, needs 24-hour nursing care & physician visits.
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.

Note that it is anticipated that the 4th edition of the ASAM Criteria will significantly alter the structure of the levels of cares…more information will be provided as it becomes available!

4. BILLING PRIOR TO ASSESSMENT AT OUTPATIENT

A full assessment utilizing the ASAM criteria is not required for clients to begin receiving DMC-ODS services. Billing is allowed prior to the completion of an assessment or the determination of a diagnosis at the outpatient levels of care. However, to bill DMC-ODS services, each claim must have an appropriate ICD-10 diagnosis code(s). As a result, the following are some options that will enable us to bill for services provided during the assessment period before a diagnosis is established:

1. **All providers** (non-LPHA and LPHA) may use the **ICD-10 codes Z55-Z65**, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances." For a list of the Z55-Z65 codes, see Appendix A.

  a. Additional specifiers that break each category of Z55-Z65 codes must be used. For example, Z63 "Other problems related to primary support group, including family circumstances" is NOT a billable code on its own. Instead, we need to be more specific, such as Z63.72 "Alcoholism and drug addiction in family."

  b. The Z55-Z65 codes can be used throughout the period leading up to the completion of the assessment. The exception for use after the completion of the assessment is for youth (up to the age of 21) who are receiving Early Intervention Services (Level 0.5). Once the client turns 21, the client must meet the criteria for a SUD diagnosis to continue treatment services.

2. **LPHA** (within their scope of practice) may use the **ICD-10 code Z03.89**, "Encounter for observation for other suspected diseases and conditions ruled out."

3. **LPHA** (within their scope of practice) may use **any clinically appropriate ICD-10 code** as a preliminary diagnosis or when a SUD is suspected, but not yet diagnosed. This includes Z codes and codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services."
LPHAs who are a Pharmacist, RN, LVN, LOT, or LPT (and their respective Clinical Trainees) are not able to diagnose.

For options **#2** and **#3**, if the LPHA is going to use these codes based on information gathered by a non-LPHA's encounters with the client, please note that a consultation between the LPHA and non-LPHA is required. Both the LPHA and non-LPHA may bill for the consultation as care coordination. The service can be billed using the Targeted Case Management, Each 15 Min (70899-120) T1017 code at all levels of care except Recovery Services. Consultations at the Recovery Services level of care can be claimed using the Community Support Services, per 15 Min (70899-121) H2015 code. A progress note is required to claim for the time. Each provider may claim the full duration of the consultation. Each provider will need to complete his/her/their own progress note documentation to do so. It is recommended that the service start and end times match between the LPHA and non-LPHA's progress notes. Start and end times for the service are required at the residential levels of care. The LPHA will also need to do his/her/their own documentation explaining the reasoning for the use of the diagnostic code. This may be done within the care coordination progress note (as the outcome of the consultation).

For County providers only:
The County's EHR does not restrict whom (or what roles) can assign a diagnosis. This means that ALL providers will have the capability to choose any diagnosis in the system. Under the DMC-ODS, only the LPHA (within their scope of practice) is allowed to diagnose a SUD. Therefore, non-LPHA providers will need to be mindful that the system will allow you to select any diagnosis, including the Z03.89 and any SUD related diagnoses. But just because you can, does not mean that you should! As noted above, non-LPHA are limited to using the Z55-Z65 codes. Please note that any action taken that is out of the scope of practice for a provider will be scrutinized and may lead to recoupment and a compliance investigation.

Best practice:
The point at which there is enough information to determine whether a client meets criteria for a SUD diagnosis is when the diagnosis should be given! This is applicable for youth clients under the age of 21 as well. For example, there may be times, upon completion of the intake, when a SUD diagnosis is more appropriate. If this is the case, the non-LPHA should consult with the LPHA so that a SUD diagnosis can be given at that time.

Billing Prior to the Completion of Assessment FAQ

1. ***Why doesn't this apply to Residential Treatment Services?*** Prior Authorization for residential services is required based on DSM and ASAM Criteria. Therefore, billing prior to

the completion of an assessment to determine the most appropriate level of care placement does not apply to the Residential Treatment Services.

2. ***Are we able to bill even if the initial assessment later determines that the client does not meet criteria for DMC-ODS services?*** Yes. All clinically appropriate and covered DMC-ODS services provided until the point at which the assessment is completed, or when it is determined that the client does or does not meet an SUD diagnosis are covered and reimbursable.
3. ***What diagnosis should I use if I know at intake that the client is not appropriate for SUD services?*** If you are a non-LPHA, you should consult with the LPHA about how the client does not meet medical necessity and the access criteria so that the LPHA may diagnose using the ICD-10 code Z03.89 to bill for that assessment service.
4. ***If a client being assessed for SUD services does not meet medical necessity, but is already receiving mental health services through the Mental Health Plan (MHP) and has a mental health diagnosis, can the provider bill the assessment session using the mental health diagnosis?*** If the provider is a non-LPHA, no. The Z codes (Z55-Z65) can be used by the non-LPHA in this case. If the provider who conducted the assessment is an LPHA, yes. This is due to scope of practice.

5. MEDICAL NECESSITY

Medical necessity is the foundation on which all treatment rests. All DMC-ODS services must be medically necessary. "Medically necessary" or "medical necessity" is defined as below:

For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For SUD, this means that the service or intervention will likely assist the client to reduce use, prevent further escalation of use, and/or prevent relapse. To determine whether a service or intervention is "medically necessary," some questions that might be helpful are:

1. How is this service going to benefit the client in treating his/her/their SUD?
2. In what ways does this intervention address the client's treatment problems/needs?
3. Does what I am providing fall within the standards of care for the types of issues my client is facing?
4. Is there existing research/evidence of this service/intervention that has been shown to be effective for clients with similar issues/needs as my client? (i.e., Evidence-Based Practices)

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate the substance use/misuse. Services need not be curative or completely restorative to ameliorate substance use/misuse. Services that sustain, support, improve, or make more tolerable substance misuse or a SUD are considered to ameliorate.

All DMC-ODS services provided must be based on medical necessity. Services claimed without the appropriate medical necessity are subject to disallowance as they may be considered fraud, waste, and/or abuse.

6. ACCESS CRITERIA

Clients Over 21 Years of Age

According to the DMC-ODS standards, clients *21 years of age and older* must meet one of the following access criteria:

1. Must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) for Substance-Related and Addictive Disorders except for Tobacco-Related Disorders and Non-Substance-Related Disorders; OR
2. Have had at least one diagnosis from the DSM-5-TR for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance Related Disorders, prior to being incarcerated or during incarceration, based on substance use history.

Change to the Covered Diagnoses List for Residential & Withdrawal Management Levels of Care: A Note About "Unspecified" and "Uncomplicated" Diagnoses

The State allows for FXX.99 "______use, unspecified with unspecified ______-induced disorder" for each substance classification and removed all other "unspecified" diagnoses. The use of an "unspecified" diagnosis is for those cases where there is insufficient information to establish that the individual meets the full criteria for any other diagnosis. The "uncomplicated" diagnoses are for those cases where there are no other diagnosed complicating factors.

To qualify for the residential levels of care, a client's symptomatology and functioning should be severe enough that it is evident that the client meets the full criteria for a substance use disorder. On the rare occasion that it is determined that there is insufficient information to establish a substance use disorder diagnosis, the FXX.99 "______use, unspecified with unspecified ______-induced disorder" diagnosis may be used. However, the documentation should clearly explain the reason for the use of this code and the plan for acquiring the necessary information to make a more definitive diagnosis. This diagnosis should be updated as soon as there is sufficient information gathered.

For the withdrawal management levels of care, in most cases, the intoxication or withdrawal diagnoses are most applicable. However, due to challenges with assessment while a client may be experiencing intoxication or withdrawal, it is possible that there may not be enough information to make an intoxication, withdrawal, or use diagnosis. In such cases, the FXX.99 "______use, unspecified with unspecified ______-induced disorder" diagnosis may be used. However, there should be an explanation in the documentation as to what led to the use of this code. Once there is sufficient information that is obtained, the diagnosis should be updated accordingly.

For the full list of Covered Diagnoses for the Residential & Withdrawal Management Levels of Care, see Appendix C.

Who Can Establish Whether a Client Over 21 Meets the Access Criteria?

Under the DMC-ODS, whether a client meets the access criteria can only be established by the LPHA, within the scope of practice of the LPHA's license. This is because the client's SUD diagnosis can only be determined by an LPHA, according to the State. For DSM-5-TR criteria for SUD diagnoses, see Appendix B. LPHAs who are a Pharmacist, RN, LVN, LOT, or LPT (and their respective Clinical Trainees) are not able to diagnose a client with a SUD.

How Do We Determine Whether a Client Over 21 Meets the Access Criteria?

A full initial ASAM assessment is used to document how the client meets the access criteria. For the County, this can be fulfilled through the SUD Assessment. County-contracted providers may use the County's SUD Assessment or another ASAM-based assessment document that contains all the relevant information.

When Do We Need to Determine Whether a Client Over 21 Meets the Access Criteria by?

Outpatient: As quickly as possible after the client's admission to the program, based on the clinical needs of the client and generally accepted standards of practice. We must ensure that clients receive the right service, at the right time, and in the right place.

Residential: Within seventy-two (72) hours of admission (prior to obtaining treatment authorization). This may be a brief, initial level of care assessment as a full, comprehensive ASAM-based assessment is not required for the authorization of treatment at the residential level. Once a client has been authorized and placed at the residential program, a full ASAM-based assessment must be completed as soon as possible, based on the clinical needs of the client and generally accepted standards of practice.

What About Clients Over 21 Who Do Not Meet the Access Criteria?

Adult clients who do not meet the full diagnostic criteria for a SUD cannot continue in treatment. They may, however, qualify for the 0.5 ASAM Level of Care (Early Intervention) and should be referred to the Beneficiary Access Line for resources. Services are covered and reimbursable until a diagnosis is determined, during the process of completing the assessment, or prior to determining whether the client meets the access criteria, even if the results of the assessment indicate that the client does not meet the access criteria for DMC-ODS services.

Clients Under 21 Years of Age

According to the DMC-ODS standards, clients *under the age of 21* must meet the following access criteria:

1. Based on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid mandate, clients who may be "at risk" of developing a SUD may receive SUD treatment. This includes treatment for risky substance use and early engagement services. A SUD diagnosis is not required.

Who Can Establish Whether a Client Under 21 Meets the Access Criteria?

Under the DMC-ODS, whether a client under the age of 21 meets the access criteria can be determined by a non-LPHA, without involvement or documentation by the LPHA, if the client falls under the "at risk" category and does not meet a SUD diagnosis. The LPHA, within the scope of practice for the LPHA's license, is the only provider who can determine that the client meets the criteria for a SUD diagnosis or the Z03.89 "Encounter for observation for other suspected disease and conditions ruled out." If this is the case and the assessment sessions have been conducted by a non-LPHA, there should be a consult with the LPHA to determine the appropriateness for a SUD diagnosis or the Z03.89 code. LPHAs who are a Pharmacist, RN, LVN, LOT, or LPT (and their respective Clinical Trainees) are not able to diagnose a client with a SUD.

How Do We Determine Whether a Client Under 21 Meets the Access Criteria?

A full initial ASAM-based assessment is not required for youth clients to access Early Intervention Services. A brief screening tool using ASAM Criteria is sufficient, such as the County's Brief Level of Care (LOC) Screening Tool. Adolescents up to the age of 21, may receive Early Intervention services as any service component covered under the outpatient level of care. Adolescents receiving Early Intervention under outpatient are not required to participate in the full array of outpatient treatment services. Early Intervention services can be provided in the community or home, in person, by telehealth, or by telephone.

Once a client turns 21 years of age, he/she/they must receive a full initial ASAM-based assessment and meet the access criteria for clients over the age of 21 to continue receiving DMC-ODS services.

Youth clients will need to receive a full initial assessment to access any other treatment level of care.

When Do We Need to Determine Whether a Client Under 21 Meets the Access Criteria by?

Outpatient: As quickly as possible after the client's admission to the program, based on the clinical needs of the client and generally accepted standards of practice. We must ensure that clients receive the right service, at the right time, and in the right place. Clients under the age of 21 are only eligible for Early Intervention Services if deemed "at risk" and do not meet a SUD diagnosis. To access any other treatment level of care, clients under the age of 21 must meet the criteria for a SUD diagnosis and a full ASAM-based assessment must be completed.

Residential: Within seventy-two (72) hours of admission (prior to obtaining treatment authorization). This may be a brief, initial level of care assessment as a full, comprehensive ASAM-based assessment is not required for the authorization of treatment at the residential level. Once a client has been authorized and placed at the residential program, a full ASAM-based assessment must be completed as soon as possible, based on the clinical needs of the client and generally accepted standards of practice.

7. LEVEL OF CARE DETERMINATION

ASAM & Levels of Care

The ASAM Criteria is required to be used to determine placement into the appropriate level of care for all clients. The level of care determination based on the ASAM Criteria is separate and distinct from determining medical necessity. A client's level of care determination must be made by an LPHA. However, an LPHA who is a Pharmacist, RN, LVN, LPT, or LOT (and their respective Clinical Trainees) cannot make the level of care determination due to scope of practice limitations.

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 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

The County's SUD Assessment is an ASAM-based assessment form that addresses each of the six (6) dimensions. The State does not currently dictate the format of the assessment document*. The County's SUD Assessment is considered the County's Initial Assessment (see more in the next section) and may be used by all providers. Gathering pertinent information in each of the dimensions will allow us to determine the severity of the client's functioning for each dimension. An analysis of the degree of severity for all dimensions will point to the level of care that will most appropriately address the client's areas of need. Clients should be placed in the least restrictive level of care that is clinically appropriate.

**The State has indicated that effective January 1, 2025, DMC-ODS providers will be required to use one of two ASAM assessment tools – The ASAM Criteria Assessment Interview Guide or the ASAM CONTINUUM software. More information will be provided as it becomes available!*

The ASAM Criteria dimensions' risk ratings or levels of severity range from 0 – 4. In general, the numbers correlate with the levels of care as shown below*:

ASAM Criteria Dimension Risk Ratings		
0	None	No services needed
1	Mild	Outpatient Drug Free
2	Moderate	Intensive Outpatient
3	Severe	Residential
4	Very Severe	Inpatient

*Remember that each of the six (6) dimensions will need its own risk rating. In most cases, clients will have a range of severities across the dimensions. For example, you may find that your client has a 1 rating for a few of the dimensions, but a 2 rating and even a 3 rating in the others. If all six (6) dimensions are not one rating, it will be up to your clinical judgment to determine if the client needs less intensive or more intensive services. Consider asking yourself:

1. What would my clinical concerns be if this client were placed in the level of care with lower intensity services? Are those concerns enough to justify the level of care with higher intensity services?
2. What evidence is there (based on current information as well as historical) that points to the client being most successful at X level of care?

There are changes to the ASAM Criteria and its structure in the 4th edition of the ASAM Criteria. This may result in changes to the assessment process and the level of care placement determination in the future. More information will be provided as further guidance becomes available from the State.

8. INITIAL ASSESSMENT

Requirements

The initial assessment is where the documentation of how the client meets the access criteria 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 County's SUD Assessment form has a dual purpose in that it assesses for how the client meets the access criteria while also determining the client's level of care placement needs. Thus, it consists of sections for the ASAM Criteria Dimensions 1-6, a Placement Summary, a Diagnosis form, and the Case Formulation. Providers may use the County's SUD Assessment or any format to fulfill the requirements for an initial assessment.

The initial assessment must establish a SUD diagnosis as the primary diagnosis by an LPHA, within the scope of practice for their license (see the Access Criteria section above). The exception for the diagnosis is when the client is under the age of 21. At the point where the SUD diagnosis is determined, the Z55-Z65 codes will no longer be the primary diagnosis or diagnoses. This does not necessarily mean that the Z55-Z65 codes go away as they may still be applicable areas of need for the client and continue to be addressed.

The initial assessment needs to include the provider's typed or printed name, credentials, signature, and date of signature.

***For Withdrawal Management level of care*:** A full ASAM Criteria assessment is not required for admission. The assessment tool utilized should be robust enough to identify the need for the stabilization and management of symptoms associated with withdrawal and coordination of care for effectively transitioning to a level of care for additional treatment services. For more information, see the Withdrawal Management section.

For Narcotic Treatment Programs (NTP)/Opioid Treatment Programs (OTP): A history and physical exam by an LPHA completed at admission qualifies for determining medical necessity under the DMC-ODS. This must be completed in-person. For more information, see the NTP/OTP section.

Who Can Complete the Initial Assessment?

An LPHA or registered or certified AOD counselor (non-LPHA) can complete the initial assessment. However, since the LPHA (within their scope of practice) is the only one who can establish how the client meets the access criteria and the level of care placement determination, he/she/they must be involved in the assessment process in one of two ways:

1. The LPHA conducts the assessment himself/herself/themselves by meeting (in person, by telehealth, or telephone) with the client for an assessment session(s) and documenting findings and observations in an assessment document, or
2. The LPHA needs to consult with the non-LPHA who conducted the assessment session (in person, by telehealth, or telephone) with the client prior to the LPHA documenting how the client meets the diagnostic criteria and the appropriate level of care placement. The consultation can be completed in person, by video conferencing, or by telephone.

County SUD Assessment Form (Who can complete what)	
Non-LPHA:	LPHA:
✓ Dimensions 1-6 ✓ Placement Summary	✓ Dimensions 1-6 ✓ Placement Summary ✓ Diagnosis form ✓ Case Formulation

LPHAs who are a Pharmacist, RN, LVN, LOT, or LPT (and their respective Clinical Trainees) are not able to diagnose a client with a SUD or make a level of care determination. RNs, LVNs, and LPTs (and their respective Clinical Trainees) may contribute to gathering information for the assessment. LOTs and Occupational Therapist Clinical Trainees cannot complete the ASAM-based assessment. ASAM-based assessments completed by a Pharmacist, RN, LVN, or LPT (and their respective Clinical Trainees) will require a consultation and separate documentation from a qualified LPHA who can diagnose and determine the appropriate level of care placement.

How is the Initial Assessment conducted?

It can be performed either face-to-face, by telehealth, or by telephone-anywhere in the community.

When Do We Need to Complete the Initial Assessment by?

The SUD Assessment form or similar ASAM-based assessment is required for every admission at a new provider or level of care.

Residential Treatment: The brief, initial level of care assessment used to authorize treatment at this level of care is to be completed and signed within seventy-two (72) hours of the client's admission (see more in the Treatment Authorization section). Once a client has been authorized and placed at the residential program, a full ASAM-based assessment must be completed as soon

as possible, based on the clinical needs of the client and generally accepted standards of practice. Assessments are to be updated every thirty (30) days, as needed, to demonstrate how the client continues to meet the access criteria for residential level of care and completion of a review of the client's treatment progress (see more in the Re-Assessment section).

Intensive Outpatient and Outpatient Drug Free: As quickly as possible after the client's admission to the program, based on the clinical needs of the client and generally accepted standards of practice. We must ensure that clients receive the right service, at the right time, and in the right place.

Withdrawal Management: A full assessment is not required for admission to Withdrawal Management. A brief screening or other tool may be used, such as the Brief SUD Level of Care Screening, within seventy-two (72) hours of the client's admission. Since documentation to substantiate the client's diagnosis and placement is still required for Withdrawal Management, the LPHA (within their scope of practice) will need to document this information in the client's chart. A full assessment, brief screening, or other tool completed by a non-LPHA will necessitate a consultation with an LPHA in addition to the LPHA's documentation. An LPHA who is a Pharmacist, RN, LVN, LPT, or LOT (and their respective Clinical Trainees) cannot complete this consultation and documentation. See more in the Withdrawal Management section.

Narcotic Treatment Program (NTP): Follow Title 9 requirements. An ASAM-based assessment is required for determining the level of care placement for NTP. See more in the NTP/OTP section.

Providers that must also follow other regulatory requirements, such as the current Alcohol and Other Drugs (AOD) Certification Guidelines, Adolescent Substance Use Disorder Best Practices Guide, Perinatal Treatment Guidelines, or Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), should consult with their internal compliance program or counsel for program specific guidance. Likewise, if any other accrediting bodies monitor your program, you will need to abide by those requirements.

Timely Completion of Assessments

There may be occasions where an assessment may take more time than expected based on generally accepted standards of practice due to a client's individual clinical need. It is recommended that any extenuating circumstances that arise for a client that does not allow for adequate time to complete the assessment should be documented and explained in the client's chart. The County will be responsible for monitoring the timely completion of assessments to ensure that clients have appropriate access and utilization of services and to prevent potential fraud, waste, and/or abuse.

MAT Referral Assessment

All clients are required to be assessed to determine the need for a referral to MAT. Regardless of whether your program offers MAT on-site, an evidence-based MAT assessment must be conducted, in accordance with your program's MAT policy and procedures. This must be completed within twenty-four (24) hours of the client's admission to the program. With such a

short timeline, it is likely that you will be conducting this assessment in the intake session. If so, it will be important to document the completion of this in the session/service progress note. Be sure to also include information on the outcome and the next steps that will be taken to ensure that a client who needs a MAT referral is linked properly. Keep in mind that this warm hand-off needs to happen quickly, as the receiving MAT provider has a timeline of forty-eight (48) hours from admission to your program to complete the MAT evaluation. Care coordination progress notes should also capture the interventions provided to demonstrate our compliance with linkages given.

For the residential programs where the client is entering through ART, please be advised that it is the responsibility of the receiving provider to complete the MAT referral assessment. The timeline to complete it within twenty-four (24) hours of the client's admission begins once the client enters the residential program. If a client coming to the residential program has already been administered an evidence-based MAT assessment by the ART team and the client has been appropriately linked to a MAT provider, the residential provider should document this. It is also advised that the residential provider obtain documentation from the ART team that confirms the completion of the assessment and subsequent linkage (if applicable) for the client's chart. The residential provider should coordinate care with the client's MAT provider as needed. If, in the case where a client sent from ART has not yet been linked to a MAT provider, the receiving residential provider should request documentation from ART regarding the evidence-based MAT assessment and its outcome for the client's chart. Based on this documentation and any additional coordination with the ART that may be needed, the residential provider should conduct any necessary care coordination to ensure follow through with the warm hand-off to a MAT provider within forty-eight (48) hours of the client's initial encounter with ART. It is advised that any delays be documented.

Focus of the Initial Assessment

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

"How does this relate to the substance use?"

This will eventually help us with a diagnosis as well as determining how the substance use has led to problems in different areas of the client's life. These are the problems that we will be addressing in the client's treatment and will inform the problem list. Therefore, what is relevant to the substance use is what we need to clearly document. 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 determine whether the client meets the DSM-5-TR 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-TR criteria for a substance use disorder, refer to Appendix B. 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.

Treating Co-Occurring Disorders

The State recognizes that many of the individuals we serve in our substance use disorder (SUD) treatment programs also have mental health issues that need attention. As providers, you know firsthand the challenges of determining whether a presenting individual has a primary diagnosis of SUD or mental health and working with individuals on their SUD recovery while they also struggle with mental health issues. The State continues to focus on Integrated Treatment (or co-occurring treatment), which is the simultaneous treatment for SUD and mental health within the same program. Integrated Treatment has reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalizations, increased housing stability, decreased arrests, and improved quality of life ("The Case for Screening and Treatment of Co-Occurring Disorders," https://www.samhsa.gov/co-occurring-disorders). Therefore, the hope is that with the DMC-ODS, we can continue to move towards providing a more effective recovery from both SUD and mental health through an Integrated Treatment approach.

How does an Integrated Treatment approach look within the DMC-ODS?

For admission under the DMC-ODS, the client's primary diagnosis must be a SUD-related disorder. DMC-ODS services are reimbursable for clients who have a co-occurring mental health condition. Those presenting with both SUD and mental health can have secondary/tertiary diagnoses of mental health disorders. Remember: the LPHA (within their scope of practice) is the only one who can diagnose within the ODS.

How do we need to document co-occurring disorders?

It is important to note that mental health issues can be addressed within the context of SUD treatment. For the ASAM-based assessment, this means that Dimension 3 (Emotional, Cognitive, and Behavioral Conditions/Implications) will be one section that could address this. A few points to remember:

a. Non-LPHAs cannot diagnose, but they can gather information about the client's mental health history, current symptoms, and challenges.
b. Consider the impact of mental health on the client's substance use/recovery (i.e., self-medication, use to avoid distressing events/experiences, relapse risk, etc.)!

Social Determinants of Health (SDOH)

With the CalAIM initiative, the State is looking to collect data to identify health, social and risk needs, and ensure that clients are receiving the services and programs needed. The goal is to assist in driving improvements in health equity and identifying health disparities as well as their root causes across the State. Therefore, we will need to focus on health-related social factors that can be addressed within our programs.

The following is a list of twenty-five (25) Department of Health Care Services (DHCS) Priority Social Determinants of Health (SDOH) Codes:

DHCS Priority SDOH Codes	
Code	**Description**

Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness, or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

The above codes fall within the Z55-Z65 codes noted in the Billing Prior to Assessment and Access Criteria sections of this manual. Although all codes between Z55-Z65 are permitted for use, the State will be prioritizing and collecting data on the twenty-five (25) SDOH codes. Codes should be selected based on information gathered from the client regarding his/her/their needs and added to the problem list as needed. Services provided to the client should be reflective of addressing these needs. Likewise, the documentation throughout the client's episode of care should demonstrate how we are using services to adequately address these needs.

As you can see from the list, the codes are broad categories under which specific issues pertaining to the client may fall. The State does not provide any further guidance on the breakdown of each code and what specific issues would fall under each. Therefore, it is up to your clinical judgement to make the most appropriate selection based on your knowledge of the client.

For a full list of the ICD-10 Z55-Z65 codes, including SDOH, see Appendix A.

Youth-Specific

A full initial assessment is not required for youth clients under the age of 21 to access Early Intervention Services. Once youth clients turn 21, they are no longer eligible for DMC-ODS services unless a full initial ASAM-based assessment is completed that determines the client meets the criteria for at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) for Substance-Related and Addictive Disorders except for Tobacco-Related Disorders and Non-Substance-Related Disorder.

Youth clients under the age of 21 may receive a full ASAM-based assessment at any time, as clinically indicated. Please remember that a full ASAM-based assessment is required for youth clients to access any other treatment level of care. The Adolescent SUD Best Practices Guide should be adhered to for incorporating elements pertinent to the youth population in conducting a comprehensive assessment.

Perinatal and Postpartum

For clients who are pregnant or postpartum (up to 12 months), regardless of enrollment in a perinatal-specific program, the Perinatal Treatment Guidelines should be adhered to. To claim a service using the Perinatal billing codes, the service must be provided in a perinatal-designated facility and there must be medical documentation on file to support the client's pregnancy or post-partum status. "Postpartum," under the DMC-ODS, is defined as the 365-day period beginning on the last day of pregnancy. The coverage is regardless of income changes, citizenship, or immigration status or how the pregnancy ends (i.e., live birth, stillbirth, miscarriage, or termination). Eligibility for the use of the perinatal code ends on the last day of the month on which the 365th day occurs.

Assessment Information within the ASAM Dimensions

Below is a table showing how information may fall within the County's SUD Assessment form that is structured to align with the Dimensions of the ASAM Criteria, as well as where information related to the DSM-5-TR criteria can be included:

ASAM Criteria Dimensions:	Assessment Information:	DSM-5 Criteria for SUD Diagnosis:
Dimension 1 – Acute Intoxication and/or Withdrawal Potential	• Drug and/or alcohol use history; • Previous SUD treatment history	• Tolerance • Needing to use more to get the same effect • Using the same amount but not getting the same effect • Using more or for longer than anticipated • Withdrawal

Dimension 2 – Biomedical Conditions and/or Complications	• Medical history (including whether the client has received a physical exam within the 12 months prior to the client's admission)	• Keep using even when it is physically dangerous to do so • Keep using even though the client knows that there are physical problems caused by or made worse by the use
Dimension 3 – Emotional, Behavioral, and/or Cognitive Conditions and/or Complications	• Psychiatric/psychological history	• Keep using even when it is psychiatrically dangerous to do so • Keep using even though the client knows that there are psychological problems caused by or made worse by the use
Dimension 4 – Readiness to Change	• Previous SUD treatment history (as it relates to motivation and willingness for treatment); • 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)	• Ongoing use impacting work, school, home; interpersonal problems • Keep using despite knowing it is causing problems • Desire to discontinue, but unable to
Dimension 5 – Relapse and/or Continued Use Potential	• Previous SUD treatment history (as it relates to occurrences of relapse)	• Desire to discontinue, but unable to • Keep using despite knowing it is causing problems or is a danger • Inability to tolerate withdrawal (using to avoid withdrawals)

Dimension 6 – Recovery/Living Environment	• Family history; • Social/recreational history; • Financial status/history; • Educational history; • Employment history; • Criminal history, legal status	• School, work, home situation that has suffered as a result of use • Not following through or taking care of responsibilities at home, school, or work because of use • A lot of time and energy going towards trying to get, use, or recover from the use

What is the Case Formulation?

With CalAIM, it has been made clear that the level of care placement determination is separate and distinct from the medical necessity determination and the access criteria. In addition to the access criteria, the level of care placement determination must also be established by the LPHA, within their scope of practice. LPHAs who are a Pharmacist, RN, LVN, LPT, or LOT (and their respective Clinical Trainees) are not able to make this designation and cannot complete the required consultation or write-up (or Case Formulation). Although the State allows for both the non-LPHA and LPHA to contribute to the assessment, it is the LPHA who must provide separate documentation in the client's chart regarding the recommended ASAM level of care. This is considered part of the overall assessment process for each client. The State does not dictate the format for this documentation.

For the County's SUD Assessment form, the Case Formulation section is used to fulfill this requirement. The Case Formulation is where the LPHA can clearly document their clinical impressions and how the analysis of the severity of the client's functioning across the six (6) ASAM Criteria dimensions exhibit the client's need for the level of care placement indicated. If the client is accepting a lower level of care than what is indicated, the Case Formulation should also address how the lower intensity services will be used to properly accommodate for the client's needs. The assessment is not complete and valid if there is no Case Formulation (or write-up) or documentation elsewhere in the chart by an LPHA that speaks to the appropriate level of care placement.

The State does not require that the LPHA document a long narrative to explain the client's SUD diagnosis. The County is advising that this documentation continues to be included in the Case Formulation or write-up/narrative elsewhere in the client's chart. However, Case Formulations or documentation elsewhere in the chart reviewed during the County's clinical chart review that do not contain an explanation of the SUD diagnosis will not lead to disallowance or recoupment if the problem list identifies a SUD diagnosis and the basis for the diagnosis can be substantiated in the documentation.

The subsequent problem list and progress notes will need to be based on the medical necessity established in the initial assessment.

Components of the Case Formulation (or LPHA write-up/narrative)

To simplify, the Case Formulation or write-up/narrative can be broken down into the following components:

1. Basis for the DSM-5-TR SUD diagnosis → description of how the client meets criteria for the diagnosis (recommended)
2. Corresponding level of care → what is indicated based on severity of risk in the 6 ASAM Dimensions and will best meet the client's needs

Sample Format:

"Client meets the access criteria for DMC-ODS services because he/she/they meet the DSM-5-TR diagnosis of ________________________(DSM-5-TR SUD diagnosis). Severity is ______________ (mild, moderate, severe) as he/she/they meets ________ (number of DSM-5-TR criteria for SUD diagnosis) of the criteria. Client endorses _________________________ (individualized summary of criteria). Client has had a pattern of problematic use over/within the last __________ (duration of use). Client's severity of impairment in dimensions ___________ (numbers with most severe risk ratings) of the ASAM Criteria demonstrate the need for the ____________________ (level of care). Due to client's ___________ (symptoms of SUD), client ____________________ (behaviors) resulting in _____________________ (impairment). (Continue with other dimensions with the most severe risk ratings). The ____________ (level of care) will enable client to receive ___________ (recommended services that will address client's problems)."

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

Important: If using a standardized format like the one above, be sure the information is specific to each client.

Sample: Case Formulation

SAMPLE

LPHA Case Formulation

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

Client meets the access criteria for DMC-ODS services based on fulfilling the diagnosis of Alcohol Use Disorder, Moderate (F10.10). 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 waiter 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 is most appropriate for the Intensive Outpatient Services level of care placement based primarily on impairments 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 without the support of services. Being that this is the client's first time in treatment, she would benefit most from the Intensive Outpatient Treatment Services level of care to prevent further worsening of use and symptoms. Client will need to increase her understanding and awareness of the effects of drinking as well as cravings and triggers. A moderate intensity of support through individual and group counseling is clinically appropriate to be able to assist client in acquiring healthy coping skills and relapse prevention skills in order to take steps towards becoming self-sufficient in applying them. Client will also be in need of Care Coordination services to address job loss and in building a sober community of support through engagement in self-help activities outside of treatment. Family therapy may also be indicated to help client re-establish current family/social relationships that have been strained.

Non-LPHA and LPHA Consultation for the Initial Assessment

If a non-LPHA counselor completes the assessment, there must be a consultation (by face-to-face, telehealth, or telephone) between the non-LPHA counselor and the LPHA who reviews 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 care coordination progress note using the Targeted Case Management, Each 15 Min (70899-120) T1017 code. This consultation activity may be claimed at all levels of care, except for Recovery Services. At Recovery Services, the LPHA should claim the time using the Community Support Services, per 15 Min (70899-121) H2015 code. 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. It is recommended that the start and end times for the consultation on each note match. Providers at the residential levels of care are required to include the start and end times for the consultation progress note. The LPHA must then

complete the Case Formulation and the Diagnosis section of the SUD Assessment form or document elsewhere in the client's chart, based on review of the assessment and consultation with the non-LPHA. The LPHA must complete and sign the Case Formulation or required write-up/narrative in a timely manner. 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.

Completing Assessment Activities in the Proper Sequence

Be mindful of the sequence in which the assessment activities are completed. For example, it does not make clinical sense for the non-LPHA and LPHA to complete the consultation if the non-LPHA has not yet gathered all the information needed for Dimensions 1-6. The purpose of the consultation is for a discussion about the information pertaining to Dimensions 1-6 that is applicable for determining the client's appropriateness for the level of care indicated as well as information to support the diagnosis or diagnoses. The proper sequence is as follows: Dimensions 1-6 should be completed prior to the consultation between the non-LPHA and LPHA. The consultation may lead to modifications of some of the information in Dimensions 1-6, as needed. The LPHA should be documenting the Case Formulation, or write-up/narrative elsewhere in the client's chart, upon completion of the consultation (see the Assessment section below for how to bill for this). If the consultation session is utilized by the LPHA to construct the Case Formulation or write-up/narrative elsewhere in the client's chart, in the presence of the non-LPHA, this is acceptable. In such cases, time should be claimed as part of the consultation in a billable care coordination progress note.

Services will not be disallowed for activities completed out of sequence unless there appears to be a significant issue or pattern across either an individual provider or an organization that may indicate potential fraud, waste, and/or abuse.

Clients Determined to Not Meet the Access Criteria

The Z03.89 code, "Encounter for observation for other suspected diseases and conditions ruled out," allows us to bill for services, like assessment activities, for those individuals that present to treatment and are evaluated using the ASAM Criteria, but do not meet medical necessity for DMC-ODS. This means that a full assessment has determined that the client does not meet the criteria for a substance use disorder-related diagnosis and/or do not demonstrate impairment in functioning that warrants treatment or Recovery Services levels of care.

Important note: The Z03.89 code is a diagnosis that can only be established by an LPHA, within their scope of practice. LPHA who are a Pharmacist, RN, LVN, LPT, and LOT (and their respective Clinical Trainees) cannot diagnose. Therefore, please make sure there is documentation that a consultation was conducted between the appropriate LPHA and non-LPHA in those instances where the intake has been completed by a non-LPHA. Based on the completed assessment, the appropriate LPHA must determine and document if the client does not meet the access criteria.

Treatment Authorization for Residential Treatment Services

Prior Authorization for residential services is required based on the DSM and ASAM Criteria. This means that for clients to receive the Residential Treatment level of care, he/she/they must demonstrate severity in functioning that warrants the residential level of care and be authorized by the County.

The County's Authorization for Residential Treatment (ART) team determines, based on client assessment and/or documentation presented by providers, whether a client may be authorized for Residential Treatment. The County's residential authorization process P&P is posted on the BHS website and will be revised as needed.

Use of Assessments Across and Within Programs

In general, a new Assessment or Re-Assessment is only needed for a change in the client's condition. This means that if there is a change in the client's diagnosis that coincides with a change in the level of care needed or if there is no change in diagnosis, but there is a change in the level of care needed, a new Assessment or Re-Assessment must be completed.

Below is an overview of a few scenarios and whether a new Assessment or Re-Assessment is required, followed by a description of each below:

Assessments Across and Within Programs	
Situation:	Assessment/Re-Assessment Required?
Change in Level of Care within the Same Provider	YES
Change in Level of Care Across Different Providers	YES
Same Level of Care, Change in Location at Same Provider	NO*
Same Level of Care, Change to New Provider	NO*

*Assuming the assessment document sufficiently meets all requirements, including establishing medical necessity.

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. Be sure the SUD Re-Assessment clearly demonstrates how the client meets the access criteria and is most appropriate for the level of care indicated.

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 and LPHA complete 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 (assuming the client is not already involved with 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.

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 how the client meets the access criteria 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.

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 from one level of Residential Treatment to another (e.g., transition from 3.5 to 3.1) within the same provider, requires an ASAM-based assessment (such as the SUD Re-Assessment) to justify the change in level of care. A separate treatment authorization is not necessary if an authorization has already been obtained for initial admission to the residential level of care. The ASAM-based assessment should be filed in the client's chart and documentation should clearly explain the need for the transition. The change needs to be made in the County IRIS billing system, which means that the episode of care (EOC) needs to be closed and a new EOC opened in the new level of care. No new intake paperwork is necessary. However, there should be documentation to show that the client was properly involved and informed of the changes and what this entails as well as any need for updates to the treatment plan and/or problem list. The timeline for a re-assessment of the client's continued need for the residential level of care and documentation of the client's treatment progress every 30 days should start over effective the first day of the new level of care.

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. It will be the responsibility of the receiving provider to thoroughly review the assessment document received from the client's previous provider. The receiving provider will need to make sure that the assessment document sufficiently establishes how the client meets the access criteria and justifies 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. Relevant information from the previous provider's assessment document can be referenced as appropriate. If clinically appropriate, it is acceptable to utilize an addendum (such as the Case Formulation section of the SUD Assessment) to capture information that may have been missing from the

assessment document. However, if there are several significant changes that are needed or if changes will alter the diagnosis or level of care, a full assessment document should be completed.

*If the previous provider has only utilized a brief screening tool to refer the client to the receiving provider, it is the responsibility of the receiving provider to ensure that a comprehensive assessment is completed to demonstrate how the client meets the access criteria and the need for the level of care.

The time spent by the receiving LPHA reviewing the information on the assessment document received from the previous provider, to confirm or modify the diagnosis, is a billable activity coded as Psychiatric Evaluation of Hospital Record (90885-1). In order to justify billing for the time, the LPHA needs to clearly describe in a progress note what he or she did (review the client's previous provider's SUD Re-Assessment), what the purpose for doing so was (to confirm the client's diagnosis and determine the client's appropriateness for the receiving services at the provider's program), and what the results of this review are (what clinical determination was made based on the review). LPHA who are a Pharmacist, RN, LVN, LPT, or LOT (and their respective Clinical Trainees) are not eligible to determine the appropriateness of the client's placement in a level of care.

Transfers across programs under the same entity

If your organization has several locations that are providing DMC-ODS services, there may be instances where a client may need to transfer from receiving services in one location to another without any change in level of care. There are two options for transfers:

Option 1: If a client transfers between your locations (within the same level of care), the State allows the client's case to remain open. As you know, for the purposes of the County's billing system (IRIS), we must close the client's Episode of Care (EOC) with the first location and open a new EOC at the next location. This will trigger a new admission or start date for the EOC in IRIS. The legal paperwork (i.e., Informed Consent, Receipt of Notice of Privacy Practices, etc.) obtained at intake at the first location can carry over to the new location. In essence, the chart will "move" with the client. If the client has already been open at the first location for the Outpatient level of care at the point at which they transfer to another location, a valid assessment should be completed as soon as possible. If an assessment was started or finished at the first location, the documents can be used at the second location. If the assigned primary counselor or provider is changing from one location to the next, the receiving provider should confirm the accuracy and relevancy of the information contained in the assessment document. The new provider should then document on how information from the first location is still applicable or what needs to be updated.

Option 2: Client cases for transfers (across the same level of care, under the same legal entity) can be completed by discharging the client from the first location and re-admitting them as a brand-new client at the next location. Doing so will be in line with the process in IRIS (closing of one EOC at the first location and the opening of a new EOC at the next location). However, this will mean that all new intake paperwork is needed for the new location. The assessment document can be used across locations, but it will be the responsibility of the receiving provider

to ensure that all the necessary information has been obtained and adequately demonstrates how the client meets the access criteria and justification for the level of care. The receiving provider should document that the information has been reviewed and continues to be relevant.

Transfers in the same level of care across different providers

If the client transferring from a different provider (within the same level of care), has an established assessment and problem list with the previous provider, it may be used if reviewed and deemed appropriate and applicable for the client at the new location. This would mean that if Provider A has completed a problem list, Provider B could use this problem list upon receipt of the client. There should be documentation from Provider B (or the receiving provider) that it was reviewed with the client in a session to confirm that nothing needs to be changed, and it is still appropriate. If the client transfers without an assessment and/or the problem list already in place, the receiving provider will be responsible for ensuring that an assessment and problem list are completed as soon as reasonably possible. Services can be claimed using the billable code upon the client's transfer without any period of non-compliance, even if there is no valid assessment and/or problem list in place. However, this should be documented along with the plan for completing the assessment and/or problem list.

Important Reminders about the SUD Assessment Form

1. Providers that must also follow other regulatory requirements, such as the current Alcohol and Other Drugs (AOD) Certification Guidelines, Adolescent Substance Use Disorder Best Practices Guide, Perinatal Treatment Guidelines, or Substance Use Prevention, Treatment and Recovery Services Block Grant (SUBG), should consult with their internal compliance program or counsel for program specific guidance. Likewise, if any other accrediting bodies monitor your program, you will need to abide by those requirements.
2. The non-LPHA counselor or LPHA may complete the Dimensions 1-6 and the Placement Summary. The LPHA, within their scope of practice, must complete the Diagnosis and Case Formulation.
3. The SUD Assessment form is not considered complete and valid without the Case Formulation or other write-up/narrative by an LPHA. For programs not utilizing the County's SUD Assessment form, please note that without documentation of medical necessity by the appropriate LPHA, the client's initial assessment is incomplete/invalid. Depending on the situation, this may result in disallowance and/or recoupment due to the potential for fraud, waste, and/or abuse.
4. For Narcotic Treatment Programs/Opioid Treatment Programs (NTP/OTP), a history and physical exam done by a physician at the time of a client's admission to an NTP/OTP, qualifies for determining medical necessity. This is part of the dosing services (see the section on NTP/OTP for more information).
5. For providers using the hard-copy version of the County's SUD Assessment:
    a. If the SUD Assessment form is completed over multiple sessions, the initials and date on the 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 completed on that date.

b. If the LPHA, within their scope of practice, 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.
c. The diagnosis page should be initialed and dated by the appropriate LPHA since the LPHA, within their scope of practice, is the only provider who is able to diagnose.

6. 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, and all subsequent services, will be disallowed, as it would fall under fraud, waste, and/or abuse. 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) to bring the chart into compliance.
7. If it is discovered that a person conducting the assessments is not a certified and credentialed DMC provider or has a lapsed/expired license, credential, or registration, then the entire assessment service and all subsequent services will be disallowed, as it would fall under fraud, waste, and/or abuse.
8. If it is discovered that a person conducting the assessments has not been receiving the proper clinical supervision or is unable to demonstrate the appropriate documentation of clinical supervision, then the entire assessment service and all subsequent services will be disallowed, as it would fall under fraud, waste, and/or abuse.

Initial Assessment FAQ

1. ***What if there is no Case Formulation or additional documentation by the LPHA completed?*** Without a Case Formulation or some kind of documentation by the LPHA, that explains how the client meets the access criteria and is appropriately placed in the most suitable level of care; medical necessity has not been established to warrant the billing of services under the DMC-ODS. This means that services provided after the assessment was completed without demonstration of how the client meets the access criteria may be considered fraud, waste, and/or abuse resulting in disallowed services.
2. ***What if the Case Formulation does not demonstrate medical necessity?*** If there is not enough information documented to clearly demonstrate how the client meets medical necessity and the access criteria, the initial assessment is considered invalid. This will result in disallowed services, as it would be considered fraud, waste, and/or abuse.
3. ***What if the non-LPHA and/or LPHA forgets to sign the assessment?*** At the point at which it is discovered that a signature is missing, the provider may sign the assessment with the date of signature and add, "Late entry for (date assessment was completed and should have been signed)." DO NOT BACKDATE! Best practice would be to document the reason for the late signature; however, this is not required. Missing signatures will not result in disallowance of services, unless there is a pattern or a particular situation that may suggest fraud, waste, and/or abuse. For staff who are no longer with the agency, the Program Directors, Service Chiefs, or other Head of Service administrator who is also a certified DMC provider, may sign the assessment and add a statement indicating that the rendering provider is no longer available to sign.

4. ***Can the non-LPHA write the Case Formulation and have the LPHA sign it?*** No. It is not within the non-LPHA's scope of practice to complete the Case Formulation, due to the establishment of the SUD diagnosis and level of care placement determination. Additionally, the LPHA must do his/her/their own documentation and sign. Signing documentation that was not completed by the signer with the intention to make it appear as though he/she/they were the writer is fraudulent and will result in disallowance and a compliance investigation.
5. ***What happens if an LPHA who is a Pharmacist, RN, LVN, LPT, or LOT (and their respective Clinical Trainees) completes the Case Formulation or required documentation?*** It would be considered out of scope of practice, making the determination of access criteria and/or level of care placement invalid. This could be considered fraud, waste, and/or abuse resulting in disallowed services.
6. ***If most of the clients in our program have similar issues, can we just use a template for the Case Formulation?*** No. "Templating" or the "copy/paste" of the same Case Formulation across multiple clients is considered fraud, waste, and/or abuse. Such a pattern will result in disallowance of services. Even if most of your clients have a similar presentation, no two individuals are exactly alike and will have aspects of their lives that are unique. Please do your due diligence to identify what those differences are that may significantly affect the course of treatment for that individual and be sure to document it.

9. PROBLEM LIST

Problem List vs. Treatment Plan

The State has moved towards viewing care planning as an ongoing treatment activity rather than a one-time event. This parallels the State's efforts through CalAIM to enhance service access and delivery across substance use, mental health, and medical/physical health care and achieve greater "whole person" care. The problem list is intended to foster greater coordination and continuity of care. To align with these efforts, the State has clarified that their Behavioral Health Information Notices supersede treatment plan requirements for the AOD Certification Standards, Adolescent SUD Best Practices Guide, and Perinatal Treatment Guidelines. This means that a problem list is sufficient for programs under these requirements.

For those programs that are under SUBG, a treatment plan is required, however, it does not need to be a standalone treatment plan. The State uses "treatment planning" and "treatment plans" in general terms to describe activities and requirements of a treatment plan, rather than a standalone treatment plan document. The treatment plan elements may be captured in the problem list (or other document such as a progress note). The State requires that providers be able to produce and communicate the contents of the care plan to others (i.e., the client, other providers, etc.) for the purpose of supporting care coordination efforts.

For the Residential Treatment Services levels of care, the licensing and certification standards require a treatment plan. However, just as it is the case for SUBG programs described above, this does not need to be a standalone treatment plan, and the required elements may be captured in the problem list (or other document such as a progress note). Providers at these levels of care will need to make sure that no matter where the treatment plan elements are incorporated, the contents are able to be produced and communicated to others as needed for care coordination.

The Withdrawal Management levels of care are exempt from the treatment plan requirements under the licensing and certification standards. A problem list is sufficient. NTPs and Peer Support Services will continue to complete standalone treatment plans.

If any other accrediting bodies are monitoring your program, you will need to continue to abide by those requirements.

For programs that no longer require a treatment plan, a standalone treatment plan may continue to be utilized according to your agency's specific needs or practices, however, it cannot replace or be used in place of a problem list.

Requirements

According to the State, the problem list is a list of problems (i.e., symptoms, conditions, diagnoses, social drivers, and/or risk factors) identified during any service encounter, including at the time of assessment, psychiatric diagnostic evaluation, or crisis. Any problems identified during a service encounter can be addressed at the time of the encounter, if it is within the scope of practice of the provider, and then added to the problem list. This means that it is permissible for problems to be identified prior to the completion of the initial assessment as well. In essence, the problem list can potentially begin taking shape at the first encounter with the client.

Current International Classification of Diseases (ICD) Clinical Modification (CM) codes should be used, as applicable. Diagnoses identified by a provider within his/her/their scope of practice should include diagnosis-specific specifiers from the DSM-5-TR, as needed. An example of a diagnosis-specific specifier is the "mild," "moderate," or "severe" for the substance use disorders (i.e., Alcohol Use Disorder, Severe).

Health-related social factors, or the Social Determinants of Health (SDOH), should be included as applicable. Any of the Z55-Z65 codes are permitted for use. However, the State has also determined a list of Priority SDOH Codes that should be utilized when applicable. For a list of the Z55-Z65 codes, including the Priority SDOH Codes, see Appendix A.

Clients and/or significant support persons in the client's life should contribute to the development of the problem list whenever possible and may identify specific issues or problems to be included. It is acceptable to include diagnoses that are self-reported but be sure there is documentation explaining this in the client's chart.

The problem list is to be updated on a regular basis, as needed, so that it is representative of the client's current presentation. Providers, within their scope of practice, can identify, add, or resolve problems at any time throughout the client's treatment. Problems will not be removed from the problem list. Rather, there will be a resolution date, which indicates the date when the client has achieved what is necessary to conclude that the problem is no longer a treatment need or concern or when the issue is no longer applicable. This makes it clear what has already been addressed.

The provider who has identified, added, or resolved the problem needs to include his/her/their name, credentials, and date of the problem that was identified, added, or resolved.

Who Can Complete the Problem List?

The primary counselor (non-LPHA or LPHA) for the client is responsible for creating and maintaining the problem list. Problems should be identified, added, and/or resolved whenever there is a relevant change in the client's condition.

A non-LPHA or LPHA can complete the problem list, however, keep in mind that the LPHA, within their scope of practice, is the only provider who can diagnose. This means that non-LPHA are limited to the Z55-Z65 ICD-10 codes. It is permissible for the non-LPHA to add an SUD diagnosis established by the qualified LPHA. For a non-LPHA to add a diagnosis established by the qualified LPHA, it must be clear in the chart documentation that it was the LPHA who determined that the client meets the SUD diagnosis so there is no question as to whether the non-LPHA is acting out of scope of practice.

The client and/or significant individuals in the client's life can contribute to identifying issues for inclusion.

When Does the Problem List Need to be completed?

The State does not require the problem list to be completed or updated within a specific timeframe and there is no set frequency at which it needs to be updated. Therefore, the problem list should be updated within a reasonable time based on generally accepted standards of practice. It is reasonable to expect that upon completion of the initial assessment, the problem list would be reflective of those areas of need identified through the assessment process. This is because the completion of the initial assessment means that a thorough inventory has been taken on what the client may be having difficulties with because of the substance use. Additionally, the assessment has highlighted factors in the client's life that may not be directly associated with the substance use but may have implications on his/her/their ability to abstain or reduce use. These are the problems that may need to be addressed on the problem list. In this way, there should be consistency across the assessment and problem list.

Below are a few examples of how the problem list may be initiated and updated at different levels of care:

<u>Outpatient:</u> Problem lists may be initiated upon the first encounter with the client, such as with the identification of any Z55-Z65 codes used for billing prior to the completion of the assessment and updated as information is gathered through assessment activities. Once a full ASAM-based assessment is completed, the problem list should be updated with the client's SUD diagnosis or diagnoses and be congruent with information in the assessment. It is recommended that as the client progresses through the treatment episode, the problem list is reviewed and amended as needed on a regular basis to ensure that at any given point in time, it accurately depicts the client's current presentation. Although not required, it is recommended that, if there are any issues identified in the assessment that are not going to be reflected on problem list, there be documentation of the reason(s).

<u>Residential:</u> If the client has entered the residential program with a brief assessment that has authorized treatment at the residential level of care, the information and SUD diagnosis (once confirmed by the LPHA of the receiving provider) can be used to start the creation of the

treatment plan (or treatment plan elements captured in a problem list, progress note, or other document). Upon completion of the full ASAM-based assessment, the treatment plan or document containing the treatment plan elements should be updated to capture all relevant areas of need and any changes to the client's SUD diagnosis that may be necessary. It is recommended that, at minimum, the treatment plan document or other document containing the treatment plan elements be reviewed and updated with the client at the time of re-assessment. Although not required, it is recommended that, if there are any issues identified in the assessment that are not going to be reflected on problem list, there be documentation of the reason(s).

Withdrawal Management: The problem list is sufficient for this level of care and can be initiated upon the client's intake. Completion of the initial assessment or Brief SUD Level of Care Screening should also inform any changes or updates to the problem list and then be reviewed as needed through the client's stay. Although not required, it is recommended that, if there are any issues identified in the assessment that are not going to be reflected on problem list, there be documentation of the reason(s).

Narcotic Treatment Program (NTP): Per Title 9 requirements, the requirement for a treatment plan remains.

When Does the Problem List Need to be updated?

There is no set frequency with which the problem list needs to be updated. It is best to think of it as a living document as problems are added and resolved as clinically appropriate. The problem list should be updated whenever there is a change in the client's presentation so that it is an accurate reflection of the client's current needs. For example, you may learn in a session with the client that they have just lost their job and will need some assistance with obtaining unemployment benefits and looking for other work. It is possible that you will begin exploring needs and potential resources in that session and then add it to the problem list as Z56.0 "Unemployment, unspecified."

How Should the Problem List be used?

At the point of its initial development, the provider can utilize the client's problem list as a guide for conceptualizing the course of treatment. Seeing all the problems in one succinct view can help in prioritizing the areas of need for the client. It may also include thinking about what types of services the client may need within the current treatment episode or level of care to properly address the identified problems.

As a provider who may be receiving a transfer case, the problem list can alert you to what the client has been working on. This can help promote a smoother transition and continuity of care. It can also alert the new provider of any ongoing care coordination activities that may be necessary.

Since one of the areas of focus for the CalAIM initiative is on improving the client's treatment experience, it is important to engage the client in this process of developing a problem list as much as possible. The client and any significant individuals in his/her/their life should be encouraged to participate in the development and modification of the problem list. Throughout the course of treatment, the problem list serves as a good way to "check in" with the client on

how treatment is progressing, which may also prompt further collaboration between the provider, client, and any other parties involved to support the client's treatment. This collaboration should also be evident in the session progress notes where specific problems are explored, identified, and/or addressed.

Pregnant and Postpartum

Regardless of whether enrolled in a perinatal program or not, if the client is pregnant or postpartum, the problem list should address applicable areas of concern relevant to the Perinatal Treatment Guidelines. These may include 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. Please remember that to claim services using the Perinatal billing codes, there must be medical documentation on file that supports the client's pregnancy or postpartum status. "Postpartum," under the DMC-ODS, is defined as the twelve (12) month period beginning on the last day of pregnancy. Eligibility for the use of the perinatal code ends on the last day of the calendar month in which the 365th day occurs.

Youth-Specific

For clients under the age of 21 receiving services in an adolescent SUD program, please be sure to address problems pertinent to youth, such as education and family/peer relationships, considering the youth's gender, chronological, emotional, and psychological age. Be sure to refer to the Adolescent SUD Best Practices Guide.

What about the Physical Exam?

There are no changes with the physical exam requirement. We still need to find out whether a client has received a physical exam within the prior twelve (12) months from the date of admission. This should have been addressed in Dimension 2 of the ASAM Criteria dimensions for the County's SUD Assessment form (or other ASAM-based assessment). For those clients who have not had a physical exam within the twelve (12) months prior to admission to treatment, we will need to coordinate care to help the client obtain one. The State is not explicit on how this needs to be accounted for. Therefore, the client's need for a physical exam can best be addressed by placing it on the problem list. The ICD-10 code of Z75.8 – "Other problems related to medical facilities and other health care" can be used for this purpose. The physical exam requirement is applicable for ALL levels of care, including Withdrawal Management and Recovery Services.

Please be mindful of any other regulatory authorities that your program must comply with that may have additional requirements (i.e., Health Questionnaire).

If the client has had a Physical Exam within the 12-month period prior to the admit date (such as presenting to treatment having already completed or received a Physical Exam), the status should be documented. Efforts should then be made to obtain a copy of the Physical Exam to fulfill the requirement for the Medical Director (or a Physician Extender) to review the Physical Exam document within thirty (30) calendar days of the admit date. Be sure to document interventions

provided to obtain a copy to show the attempts made in the event we are unable to acquire the copy. If a copy can be obtained and reviewed, the Physician or Physician Extender should document that the review was completed to evidence compliance with this requirement.

Problem List FAQ

1. ***The client transferred to my caseload and there is no problem list. Are we unable to bill for services?*** Services can continue to be billed using the billable code. However, at the point at which it is discovered that there is no problem list in place, the provider should complete one as soon as possible. It is recommended that the new provider document that the client was transferred without a problem list in place and what the plan is for completing one.
2. ***Does the problem list need to be signed?*** There are no signature requirements for the problem list. This means that the provider and the client do not need to sign the problem list. Only the provider who has added or resolved problems should clearly specify his/her/their name, credentials, and date on which the problem was added or resolved.
3. ***Do I remove the problems from the problem list when the client discharges?*** No. Problems should not be removed from the problem list at the time of client's discharge. If the item is no longer an area of need, the date on which the issue was resolved should be indicated on the problem list, along with the name and credentials of the provider resolving it. This demonstrates to any other providers who may view the problem list that this was addressed and no longer a treatment need. It is recommended that the discharge summary or termination session progress note indicate those areas that may be of ongoing need.
4. ***The provider who was the primary counselor for the case is no longer working at the agency. Who can "end date" or indicate a problem as "resolved?"*** If the client's case is being transferred to another provider, the receiving provider is now the primary counselor and may identify, add, and/or resolve problems as clinically appropriate. If the client's case is closed and the assigned counselor for the case is no longer with the agency/program, the Program Director, Service Chief, or other Head of Service administrator who is also a certified DMC provider, may add a note to explain that the status of the problem is missing, and the provider is no longer with the agency.
5. ***What about the Physical Exam requirement for youth clients under the age of 21 receiving Early Intervention Services?*** Although not explicitly required by the State, best practice would be to address this with our youth clients, even in Early Intervention.
6. ***What about the use of SNOMED codes?*** There is no requirement to use the codes under the Systematized Nomenclature of Medicine (SNOMED) Clinical Terms. If your agency's electronic health record (EHR) allows for the use of SNOMED codes, this is permissible. Please bear in mind scope of practice implications when using the SNOMED codes.
7. ***Should Tobacco Use be added to the problem list?*** Yes, although a Tobacco-Related Disorder on its own is not a qualifying diagnosis to meet the access criteria for DMC-ODS and it cannot be "treated," it should still be added to the problem list, if applicable. For example, it may be that a client will need some referrals and resources to address this issue, in which case you may be providing some care coordination. For county electronic health

record (EHR) users, the Tobacco-Related Disorder should not be identified as a "Diagnosis Treated Today."

8. ***Is a problem list needed for youth clients in Early Intervention?*** Although we are not treating a SUD diagnosis for clients under the age of 21 at the Early Intervention level of care, we are still going to be addressing needs and problems in the client's life that are associated with misuse or abuse. Therefore, a problem list is still relevant for youth clients in Early Intervention Services and should be completed.
9. ***Can the non-LPHA add the SUD diagnosis to the problem list?*** Best practice is for the LPHA, who established the diagnosis, to add the SUD diagnosis to the problem list as it is only the LPHA who can diagnose. However, it is permissible for the non-LPHA (or LPHA who are not qualified to diagnose) to add an SUD diagnosis established by a qualified LPHA to the problem list. This is only permissible if it is clear in the documentation that the non-LPHA or LPHA who is not qualified to diagnose is not diagnosing. This means that there is documentation elsewhere in the client's chart by the qualified LPHA on establishing or confirming the client's SUD diagnosis.

Sample: Problem List

ODF Problem List

	ICD-10 Code	Descriptor	Date Problem Identified	Provider Name/Credentials for Problem Identified/Added	Date Problem Resolved	Provider Name/Credentials for Problem Resolved
1	Z56.0	Unemployment, unspecified	10/03/22	Bruce Wayne, CATC		
2	Z59.1	Inadequate housing	10/03/22	Bruce Wayne, CATC	11/10/22	Peter Parker, RADT-1
3	Z63.8	Other specified problems related to primary support group	10/03/22	Bruce Wayne, CATC		
4	F15.2	Methamphetamine Use Disorder, Moderate	11/1/22	Clark Kent, LMFT		

10. RE-ASSESSMENTS

Requirements

A re-assessment can be completed at any time during the client's episode of care at all levels of care as clinically needed. The State requires a new assessment when there is a change in the client's condition. A change in condition may include:

- Change in diagnosis*
- Change in level of care

*A change in the client's SUD diagnosis alone may not necessitate a full re-assessment if there is no change in the level of care placement. It is permissible to document the explanation for the change in a progress note or another document. This documentation needs to be completed by an LPHA, within their scope of practice, as it is only the LPHA who can establish, confirm, or make changes to an SUD diagnosis. LPHA who are a Pharmacist, RN, LVN, LPT, or LOT (and their respective Clinical Trainees) are not permitted to diagnose or make modifications to a diagnosis in the ODS.

Who needs to complete the Re-Assessment?

Like the initial assessment, an LPHA (within their scope of practice) or registered or certified counselor (non-LPHA) can complete the re-assessment. Since the LPHA is the only one who can establish how the client continues to meet the access criteria, he/she/they must be involved in one of two ways:

1. The LPHA conducts the re-assessment himself/herself/themselves by meeting (in person, by telehealth, or telephone) with the client and documenting findings/observations focusing on updates and changes in a re-assessment document (the entire re-assessment document is completed by the LPHA), or

2. The LPHA needs to complete the Diagnosis and Case Formulation section (or write-up/narrative) based on the non-LPHA's documentation of the client's presentation in the ASAM Criteria Dimensions 1-6. Unlike the initial assessment, there is no requirement for a consultation between the non-LPHA and LPHA. However, it is clinically appropriate to conduct a consultation if the documentation is insufficient to establish how the client meets the access criteria and need for the level of care indicated. If a consultation is completed, the service can be billed.

County SUD Re-Assessment Form (Who can complete what)	
Non-LPHA:	LPHA:
✓ Dimensions 1-6	✓ Dimensions 1-6 ✓ Diagnosis form ✓ Case Formulation

LPHAs who are a Pharmacist, RN, LVN, LPT, or LOT (and their respective Clinical Trainees) are not able to diagnose a client with a SUD or make a level of care determination. RNs, LVNs,

and LPTs (and their respective Clinical Trainees) may contribute to gathering information for the re-assessment. LOTs and Occupational Therapist Clinical Trainees cannot complete the ASAM-based re-assessment. ASAM-based re-assessments completed by a Pharmacist, RN, LVN, or LPT (and their respective Clinical Trainees) will require a consultation and separate documentation from a qualified LPHA who can diagnose and determine the appropriate level of care placement.

How is the Re-Assessment conducted?

It can be performed either face-to-face, by telehealth (synchronous audio and video) or by telephone (synchronous audio-only) anywhere in the community.

Re-Assessments Used as the Initial Assessment

For effectively and efficiently transitioning clients from one level of care to another or from one provider to another, the County's SUD Re-Assessment form (or other ASAM-based re-assessment) may be utilized as the initial assessment for the next indicated level of care (see the Use of Assessments Across and Within Programs section above).

Re-Assessments at the Residential Level of Care

Although there is no State requirement for a client to be re-assessed at any specific point, the licensing and certification requirements do indicate the need for a review of the client's treatment plan every thirty (30) calendar days. Since a standalone treatment plan is not required, one of the ways we can demonstrate that the client's progress has been reviewed and any modifications to the course of treatment have been considered or made would be through a re-assessment. The re-assessment will also be where ongoing medical necessity can be demonstrated. The County is strongly recommending a re-assessment every thirty (30) days from the date of admission for Residential Treatment to align with the statewide goal for the average length of stay of thirty (30) days at the residential levels of care. The length of stay is based on individual clinical need. A good question to ask to determine this might be: Is Residential Treatment the least intensive level of care that is clinically appropriate to treat the client's SUD at this time? The re-assessment will allow us to determine treatment progress and justify the client's continued need for the residential level of care or readiness to transition clients to another level of care as needed.

There is no Treatment Authorization Request (TAR) needed for the thirty (30) day re-assessment. There is no documentation that needs to be submitted to the Authorization for Residential Treatment (ART) team for approval or denial. Authorization is only required at the time of the client's initial enrollment in the residential level of care. However, the re-assessment document should be on file in the client's chart as evidence of the client's appropriateness for the residential level of care.

There is no required format for the re-assessment. The County's SUD Re-Assessment form may be used by all providers. Since the purpose of the re-assessment at the residential level of care is to re-establish medical necessity and access criteria as well as appropriateness for this level of care, the LPHA, within their scope of practice, will need to document. If the County's SUD Re-Assessment form is utilized, the diagnosis section and Case Formulation needs to be completed by the LPHA. Remember that LPHA who are a Pharmacist, RN, LVN, LPT, or LOT (and their respective Clinical Trainees) are not able to complete these parts of the re-assessment.

Client charts for the residential level of care that do not have a re-assessment completed every thirty (30) days from the date of admission will not automatically result in disallowance. However, if the chart documents that are in place do not clearly demonstrate the clinical need for the residential level of care, treatment days claimed will be disallowed as such billing may be considered fraud, waste, and/or abuse.

What needs to be in the Residential Re-Assessment?

Each re-assessment, every thirty (30) days, should address the severity of impairments across the six (6) ASAM Criteria dimensions that evidences the client's need for this level of care. In other words, the re-assessment should clearly document what the client continues to struggle with that warrants the need for the residential level of care. Be sure to indicate the client's progress towards resolving issues on his/her/their problem list and consider potential new areas of challenges that will need to be addressed. As a result of the re-assessment, updates or modifications to the problem list may be needed.

If the client is making little to no progress, be sure to document what the barriers appear to be and how the course of treatment will be adjusted to address these barriers and encourage movement towards resolution of problems.

The re-assessment is the time to consider whether the client is appropriate for a stepdown to a lower level of care. If the client is progressing in his/her/their treatment, be sure to document the areas of need that can now be addressed at a lower intensity level of care. The re-assessment should document how the client meets the criteria for the new level of care. At this point, we will focus on assisting the client through a smooth transition to the new level of care and care coordination will be very important.

If the client is appropriate for a different level of care and needs to be transitioned, it is permissible, for quality of care, to provide clients with a few transition/termination services. The services that are provided once it is determined that the client is ready for discharge (such as care coordination), should be documented with information to support the need for that service and indicate that it is for the purpose of successfully preparing the client for discharge and/or access to the next indicated level of care.

County DUI/Drug Court ONLY: Keeping Cases Open in Outpatient While Receiving Residential Services

When clients are referred to a County DUI/Drug Court outpatient program and are assessed to need the residential level of care and transitioned, the clinics have a few options at this point because the client will eventually be returning to receive outpatient services. The client's case can remain open while the client receives the residential level of care, or the case can be closed at the time of transition with a new episode of care being opened upon the client's return.

Keeping the case open allows the client to maintain the taxi voucher, decreases paperwork (for provider and client), reduces the potential for CalOMS Discharge/Admission errors, and eliminates the need to complete the discharge process only to reopen the case a few months later.

To keep the case open at the DUI/Drug Court ODF/IOT, contact must be made with the client at minimum one (1) time every thirty (30) days. A problem list that will address the need for care coordination must be completed. No other treatment needs can be addressed, as the client will be receiving the appropriate services to address his/her/their treatment needs at the residential program. This means that the client cannot receive individual or group counseling, only care coordination. Activities may include a conversation with the client at court by the court lead and does not necessarily need to be with the assigned provider. It may also be a check in with the client regarding impending discharge from a residential program or a consultation with a residential services provider.

Once the client leaves the residential program (either by planned or unplanned discharge) and returns to the DUI/Drug Court clinic, a re-assessment is needed to document how the client meets the access criteria and demonstrates a need for the ODF/IOT level of care.

If the client had a planned discharge, such as a successful completion, from the residential program and a re-assessment was completed by the residential provider that demonstrates the need for ODF/IOT, the document may be used by the DUI/Drug Court outpatient provider. An LPHA, within their scope of practice, from the receiving program will need to review and ensure that the information documented is sufficient to establish how the client meets the access criteria and the need for the ODF/IOT level of care. The LPHA should document that the re-assessment document from the previous provider was reviewed and indicate concurrence or what needs to be amended or enhanced to fulfill the requirement for an initial assessment. A problem list that addresses the needs of the client at this level of care needs to be developed.

Re-Assessment FAQ

1. ***A consultation between the non-LPHA and LPHA is not required for a re-assessment, but if one is conducted, is it billable?*** Yes, if there is a clinical need for the consultation, this is billable as a Care Coordination service. Both the non-LPHA and LPHA can bill for the time spent when each party completes a progress note for the encounter. The Targeted Case Management, Each 15 Min (70899-120) T1017 code can be used for billing this consultation at all levels of care, except Recovery Services. Consultations at Recovery Services can be claimed using the Community Support Services, per 15 Min (70899-121) H2015 code.
2. ***What happens if a re-assessment does not establish the client meeting the access criteria and justification for the level of care?*** Services claimed based on a re-assessment that has not properly established how the client meets the access criteria and appropriateness for the level of care received will result in disallowance and recoupment. To receive treatment within the DMC-ODS, the client must meet the access criteria and demonstrate a need for the level of care. The documentation in the client's chart must support this; otherwise, such instances may be considered fraud, waste, and/or abuse.
3. ***What happens if the non-LPHA completes Dimensions 1-6, but the LPHA does not complete the diagnosis form and Case Formulation section until a month later?*** The billable codes can continue to be used for the period until the LPHA has completed the required sections. Depending on the nature of the issue, services may or may not be disallowed and/or recouped in a review. For example, if there is enough information in other documentation by the LPHA elsewhere in the client's chart that supports the client's need for the level of care indicated, this would be sufficient.

4. ***What happens if a re-assessment is missing the LPHA's documentation of the client's diagnosis and how the client meets the access criteria?*** The LPHA, within their scope of practice, is the only provider who can diagnose and determine whether the client meets the access criteria. Therefore, any changes to the diagnosis and establishing (or re-establishing) the client's need for a particular level of care must involve the LPHA. As a result, if there is no re-assessment document or other documentation in the client's chart by the LPHA to substantiate the access criteria, the re-assessment is not considered complete and valid. Services provided without the proper documentation, may be considered fraud, waste, and/or abuse and may result in disallowance and/or recoupment.
5. ***I just received a client transitioning from a higher level of care. How can I use the SUD Re-Assessment form that was completed for discharge?*** The LPHA, within their scope of practice, can review the SUD Re-Assessment form completed at discharge for the former level of care to confirm that the information documented is sufficient to stand as the initial assessment for the new level of care. The information should also clearly demonstrate how the client is appropriately placed in the current level of care. The LPHA should document the review of the re-assessment document and the results of doing so. At the outpatient levels of care, this is billable using the Psychiatric Evaluation of Hospital Record, 60 Min (90885-1) code as the focus is on the confirmation and/or change of the client's SUD diagnosis. Progress note documentation is necessary to bill for the time spent reviewing the document.
6. ***For Residential Treatment, if there are no re-assessments every thirty (30) days, what happens?*** The services provided without a valid re-assessment(s) are susceptible to disallowance and/or recoupment if there is no other documentation that substantiates the client's ongoing need for Residential Treatment. Even though a prior authorization for treatment has been obtained for a client at the time of enrollment into the residential level of care, the client must continue to demonstrate the need for this level of care throughout the length of stay. Provision of services without clear documentation of this may be considered fraud, waste, and/or abuse. At the residential levels of care, it is also important to consider that licensing and certification requirements necessitate a review of the client's treatment progress, and the re-assessment is one way to demonstrate that this is being done.
7. ***Do we have to do a re-assessment at discharge?*** Clinically, the re-assessment is where the client's readiness for discharge is documented. It is not the discharge that triggers the need for a re-assessment. Some type of change has occurred with the client (such as improved functioning in the ASAM dimensions) that necessitates a thorough re-assessment to determine how the client may meet the access criteria for a different level of care. Although a re-assessment document is not required, it is clinically best practice to ensure there is some type of documentation (i.e., session progress note with inclusion of the consideration of changes in each of the ASAM dimensions) to note how the client's needs at the current level of care have been resolved and/or the client's problems can be better addressed at a different level of care.

11. PROGRESS NOTES

Requirements

Progress notes are required for all services claimed and must sufficiently provide information that supports the service code claimed for the type of service provided.

Progress notes are vital in showing a client's journey within any given episode of care. It should reflect the issues noted in the assessment and captured on the problem list, taking into consideration new challenges and obstacles that arise along the way. The assessment and problem list can be the roadmap or guide for the client's recovery process. You can think of the collection of progress notes in a client's chart as stops on a trail, with each evidencing how the client is doing towards achieving desired gains, and eventually leading to the juncture where the client is ready to move on to the next phase of the recovery. The progress notes help to tell the story of the client's voyage!

The following information must be on each progress note:

- The type of service that was provided
- The date that the service was provided to the client
- Duration of the service (direct patient care)
- Start and end time of the service (Residential ONLY)
- Topic of the service (Residential ONLY)
- The location of the client at the time of service
- A brief description of how the service addressed the client's SUD and/or problems from the problem list* (i.e., activities or interventions that occurred during the session/service, issues discussed, and progress toward treatment outcomes)
- Next steps* (planned action steps by the provider or the client; collaboration with the client; collaboration with other provider(s); and goals and actions to address any health, social, educational, or other service needs; referrals; and discharge and continuing care planning)
- The service provider's typed or printed name, signature, and date of signature (it is advised that the provider also indicate their credentials whenever signing documents in the client's records)

For Residential Treatment Services ONLY:

Due to the licensing and certification requirements, there are additional progress note documentation requirements for the residential levels of care. The session or service topic and the start and end times of the service must be included in each progress note. Daily notes that include documentation of several services provided on any given day should also include the topic and start and end times for each service described.

Group Counseling Service Documentation Requirements

*The **brief description** and **next steps** are not required elements of a progress note for group sessions/services, however, it is strongly recommended that these continue to be documented. It is important because we need to be able to justify the use of the corresponding billing codes for the service type and each service that is claimed must be medically necessary. The brief description is how we demonstrate that the service provided was claimed appropriately and prevent the appearance of potential fraud, waste, and/or abuse.

The State is clear about the **requirement for the client's response to be included in the progress note for group encounters.** Some examples of the type of information to indicate

include the effectiveness of the intervention, progress or problems addressed, group dynamics, or documentation that relays information on the client's participation, comments, or reactions during the service/session. Depending on the encounter, some progress notes may be less descriptive than others. For example, a client who is not as engaged or does not speak/participate in the group will not have as much detail for the progress note. It is recommended that this be documented along with any efforts made by the provider to encourage engagement.

Group services will also require a list of participants to be documented and maintained (outside of the client's record/chart). For more information, see the Group Counseling section.

Service and Documentation Start and End Time

Except for the Residential Treatment Services levels of care, the State does not require start and end times. For the Residential levels of care, the start and end time for the service is required. For all other levels of care, it is recommended to continue documenting the start and end times for the service and documentation minutes on the progress notes. With the billing codes that have specific time requirements now, the inclusion of the service start and end times helps to support the selected billing code. Times should be documented to the minute. Avoid estimating and rounding to the nearest quarter-hour/half-hour/hour. As has been in the past, it is important that the start and end times on the progress notes match up with the number of minutes claimed in the billing system. All time that is claimed should be appropriately justified by the documentation. Due to licensing and certification requirements, the progress note documentation at the residential programs will be required to include the start and end times of each service as well as the topic of the session or service.

When do progress notes need to be completed?

Progress notes must be completed within three (3) business days of the date of service. The date of service counts as day zero (0).

The State has updated the definition of business days as "Monday through Friday, excluding holidays observed by the State of California." This applies to all programs and levels of care, including 24-hour programs like Residential. For example, if a provider needs to document a service provided on a Friday, the timeline of three (3) business days will mean that it needs to be completed by Wednesday.

The billable code for the service can still be used even in those instances where a progress note is unable to be completed within three (3) business days. Late documentation will not automatically result in disallowances or recoupment. Yet, keep in mind that a pattern of late documentation may appear as fraud, waste, and/or abuse and can lead to disallowances or recoupment. It is best practice to complete documentation as soon as possible, so do try to stick to the requirement as best you can.

For any Crisis Intervention services provided, the progress notes must be completed within twenty-four (24) hours of the service.

What format do the progress notes need to be in?

The State does not require a specific format for the progress notes. If the above requirements are met, it may be written in any way. The most important part is to ensure that there is enough information in the documentation to support the type of service and amount of time that is claimed.

Who can document progress notes?

The rendering provider for the service, who is a DMC-ODS certified provider, should write the progress note (non-LPHA or LPHA).

Be sure to keep your license, certification, or registration up to date! Expired or lapsed licenses, certifications, or registrations means that you cannot provide and bill for DMC-ODS services until you are back in good standing. Services claimed for any period during which there is an expiration or lapse will result in recoupment and/or disallowance as these services may be considered fraud, waste, and/or abuse.

Additionally, be aware that interventions provided must be within the scope of practice of the rendering provider. Documentation of interventions that are out of the scope of practice for the provider, that is discovered during a clinical chart review will result in disallowance and/or recoupment due to the potential for fraud, waste, and/or abuse in these situations.

How do we document the brief description portion of the progress notes?

It should give the reader a good understanding of what the issue was (or issues), how you addressed it, and how the client responded to that. The focus is on documenting a concise summary or recounting of what you as the provider did in that session that supports the type of service provided and the corresponding billing code used. If the care coordination billing code is used, there should be information about the activities that make it clear it was a care coordination service. You will also want to make sure that it clearly shows how what you provided was necessary or relevant to the client's SUD treatment to establish medical necessity. Perhaps it directly addresses a physical health care or housing issue item on the client's problem list, for example. It may be helpful to include information about how the client presented in the session and what he/she/they did. You can include quotes if this illustrates the nuances of the session that may give insight into how the client is or is not progressing.

If an Evidence Based Practice (EBP) is utilized in a service/session, it should be clearly documented. The County is responsible for monitoring the use of EBPs across the network and the documentation of its use in the progress notes is part of how that data is collected. When an EBP is utilized, it will be important to describe how it was used. Rather than simply stating that Motivational Interviewing was used, explaining how it was applied specifically for that client would be more helpful. An example would be to indicate that the concept of rolling with resistance was used to address client's ambivalence. Or, instead of documenting that "Cognitive-Behavioral Therapy was used in this session," indicating more specifically that "the Cognitive-Behavioral Therapy technique of reframing negative thought patterns was used to address client's overgeneralization that they will "always" end up relapsing."

How do we document the next steps portion of the progress notes?

This can pertain to actions needed to be taken by you, the client, or other providers. If you have assigned the client any homework or tasks to follow up with in between sessions, this would be

good to note here (it's also a great way to keep track for yourself on what you need to follow up on with the client in your next encounter!). Perhaps there is a task that you as the provider need to follow up with as well, such as a consult with the client's case manager or looking into resources that would address the client's needs. Maybe the client has come upon a new stressor or issue that needs to be addressed going forward or added to the problem list. If you are providing interventions from a particular curriculum, it may also be information on what will be addressed in the next session.

Progress notes for drug testing

All services claimed must have a corresponding progress note that demonstrates medical necessity. Therefore, each drug test administered must be documented, at minimum, with the type of service provided, date of service, duration of the service (direct client care), location of the service, description of the service (i.e., type of test administered, relevance to the client's SUD treatment, results, or outcome), next steps, rendering provider's name/credentials/signature, and date of signature. In addition to the documentation for each drug test performed, it is vital that there be documentation in the chart that speaks to the client's need for drug testing. Historically, drug testing in the substance use disorder treatment industry has been a significant source of fraud, waste, and/or abuse. Given this, along with the State's emphasis on recoupments based on fraud, waste, and/or abuse, we need to be cautious and diligent in our documentation. A few examples of where this documentation can be included is in the Case Formulation or LPHA write-up where an explanation of the client's service needs for the level of care indicated is explained or in progress notes for treatment planning services where the anticipated course of treatment is discussed with the client. If, at some point in the treatment episode, a change in the frequency of the drug testing becomes necessary, there must be documentation on file to support this modification. Without this documentation of medical necessity, please be advised that drug testing services may be disallowed due to the potential for the appearance of fraud, waste, and/or abuse.

Residential Treatment and Daily Notes

At the Residential Treatment level of care, a daily progress note is needed to capture all claimed services for the day. The State has made it clear that weekly summaries are no longer needed for those programs under SUBG.

What is a daily note?

The intention of the daily note requirement at the Residential levels of care is to demonstrate that a valid service was provided to justify the billing of the treatment day. Thus, the requirement can be fulfilled in one of the following ways:

1. A summary note of all services provided to the client for that day; or
2. A progress note for an individual counseling or group counseling session for that day*

**Note: Care Coordination DOES NOT count as it is billed separately*

Please note that there is no explicit guidance from the State regarding the format of a daily note. It is up to the discretion of each provider or agency as to how the daily note "looks" and the important piece is making sure that it incorporates the required elements.

It is advised that a daily note that contains information on all services provided to the client on any given day include the service start and end times as well as the topics for each service. This guidance is based on the State's licensing and certification requirement for the inclusion of the start and end times and the topic of the session/service for each service documentation at the residential programs.

How should a daily note be written?

If taking option #1 above, think of the daily note as a bird's eye view of the client's day. It should give the reader a good picture of all that was provided to the client on any given day. Consider…

- What clinical services were provided?
- What structured activities did the client participate in?
- Was programming missed due to an off-site appointment?

Important! Demonstrating medical necessity: Including information about how the client responded to the services (i.e., whether the client was engaged, interacted appropriately with peers, expressing ambivalence about being in treatment, etc.) gives insight into how the treatment services are benefitting the client and is helpful for tracking progress towards resolution of problems/needs.

If taking option #2, it is permissible for providers at Residential Treatment to document per service, to ensure that there is at least one (1) service (assessment, individual/group counseling, family therapy, medication service, patient education, or SUD crisis intervention session progress note) that is documented on any given day to fulfill the requirement for a daily note. This remains the County's recommendation for Residential Treatment providers to document each clinical service separately to accurately capture all services intended to count towards the weekly required five (5) clinical hours.

Required Clinical Hours vs. Structured Hours

All clients enrolled in a residential program will need to receive a minimum of five (5) clinical hours each week. This includes individual and group counseling services. As far as the types of groups that will count towards the clinical hours, the content of the group must be clinical in nature and within the scope of practice for the facilitating provider. Those groups utilizing evidence-based practices (EBPs) are considered clinical groups. Intake and assessment sessions with the client to gather information needed to complete the client's assessment, problem list development sessions with the client, and discharge planning sessions with the client (specifically to discuss non-care coordination related issues pertinent to discharge, such as how the client will prepare to return to a home where the family member may have a tendency to enable the client) are part of the bundle of services and cannot be claimed separately on top of the treatment day. However, intake and assessment sessions are clinical services that can count towards the required five (5) clinical hours when properly documented. Family therapy services are also included as clinical services and may count towards the required hours for the week when the client is present.

Care coordination is not a service that can count towards the five (5) clinical hours as it is billed separately.

Keep in mind that only sessions with the client present will count towards the five (5) clinical hours.

Groups such as House meetings, chore groups, and in-house 12-Step meetings are part of the structured groups and cannot count towards the clinical hours.

If a client is unable to meet the five (5) clinical hours in a week, it is recommended that documentation be included in the client's chart regarding the reason. Charts reviewed where the client was unable to meet the five (5) clinical hours in a week will not automatically result in disallowance and/or recoupment. However, if a client is found to consistently be lacking the required number of clinical hours, this may result in disallowance and/or recoupment of treatment days. Likewise, if a program or agency has a pattern of clients not meeting the required number of clinical hours, this may be investigated for potential fraud, waste, and/or abuse.

Transportation at Residential

The time spent providing transportation to a client is not billable and cannot count towards the required structured or clinical hours at the Residential programs. The expectation under DMC-ODS is that all clients will have transportation, which can be provided by CalOptima. Thus, billing of the residential treatment day is not permissible if the client receives no other services on that day, other than transportation. It is recommended that instances where clients are unable to attend structured and/or clinical activities due to attending outside appointments, be documented.

Sample: Residential Daily Note

SAMPLE

Residential Daily Note

Client: Bobby B. Blueberry

Date: 1/15/22

Location: 123 Residential Way, Santa Ana, CA 92701

Services Received: 9:01am – 9:30am Morning Meditation/House Huddle

9:45am – 10:48am Clinical Group Relapse Prevention

11:02am – 12:06pm Clinical Group Seeking Safety

1:01pm – 2:31pm Clinical Group CBT

3pm – 5:30pm Outing Off-site (Fun in Recovery)

7pm – 8:30pm AA/NA Meeting (off-site)

Narrative: Client received three clinical groups and two structured activities on this day. Client was reported to be reluctant to participate in the Morning Meditation/House Huddle and irritable in response to peers joining late. Group facilitator Stacy Strawberry indicated that client was withdrawn and seemed distracted, needing more prompting for participation in the Relapse Prevention group than is typical for this client (see Care Coordination progress note). Facilitator Strawberry intervened 1:1 at end of group to check in with client who reported that he was feeling restless/anxious and having a hard time concentrating/focusing due to not being able to get in contact with family. Facilitator Watermelon (Seeking Safety group) also noted that client seemed preoccupied and at times became agitated when encouraged to participate (see Care Coordination progress note). Counselor checked in with client after lunch, who reported that he was able to reach his brother and was scheduled for another phone call later that evening. Client appeared to be back to being calmer and positively engaged with peers and staff by the afternoon outing at Quail Hill Trail.

Plan: Counselor scheduled to have individual counseling on 1/18/22 with client. Plan is to follow up regarding impact of not being able to contact family on program participation and focus on treatment that has the potential for hindering client's overall recovery process. Client continues to be in the midst of working on coordinating next dental appointment to address possible need for oral surgery and will need follow up.

Total Clinical Hours: 217 minutes (3.6 hours)

Provider Name: Lyle Lemon, CADC

Signature: Lyle Lemon, CADC **Date:** 11/16/22

Services via Telehealth & Telephone

A telehealth session means office or outpatient visits via interactive synchronous audio-only or synchronous video telecommunication systems. This means that telehealth includes telephone as well as services that utilizes a video conferencing medium without the video camera on. Please refer to your program administrator for the specific platform that is used for the interactive audio

and video telecommunication system at your site. The ability to utilize telehealth and telephone 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, there are some important requirements to be aware of.

We must have the client's consent to provide services by telehealth or telephone. Please be sure that there is documentation of the client's consent. The telehealth or telephone consent may be a formal document signed by the client, such as a program's Telehealth Consent Form or a verbal consent obtained at least once prior to starting telehealth or telephone services. Providers must document that the following information was explained, and that the client's written or verbal acknowledgement was received:

1. The client's right to access covered services through an in-person, face-to-face visit;
2. Use of telehealth and telephone is voluntary, and consent may be withdrawn at any time without it affecting the client's ability to access covered Medi-Cal services in the future;
3. Availability of transportation services through Medi-Cal to in-person visits when other available resources have been reasonably exhausted;
4. Potential limitations or risks related to receiving services through telehealth and telephone as compared to an in-person visit.

Best practice for documenting in a progress note when services have been provided by telehealth or telephone include:

1. How the client's confidentiality was ensured;
2. Confirmation of the client's presence in California;
3. If there is a particular reason as to why the service was conducted via telehealth or telephone rather than in person, this should be documented (i.e., due to isolating/quarantine for COVID-19); and
4. Appropriateness of telehealth or telephone services to the client to demonstrate that the client will be receiving the same quality of services as he/she/they would in person.

Group counseling sessions/services can be conducted via telehealth if the provider obtains consent from all participants and takes the necessary security precautions. The group size limit of a minimum of two (2) and a maximum of twelve (12) clients is still applicable for groups conducted via telehealth.

Telehealth and Telephone at Residential Treatment Services
Services may be provided in person, by telehealth, or telephone, however, telehealth and telephone services cannot replace in-person services. The expectation is that most services in a residential setting will be provided in-person. Be sure to include documentation of the reason for the use of telehealth or telephone services instead of in person services.

Progress Note FAQ

1. ***Is templated content (or copy/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. The exception would be for group service documentation that

includes information about the content of the group since the same service will have been provided to all group attendees. Since the client's response is required in group progress note documentation, it is expected that each progress note will be individualized. There may also be times when the same intervention is conducted with a client over several individual counseling sessions, but there should be an explanation as to the purpose and intent of doing so. For groups, if the same type of group is regularly provided, such as relapse prevention or a process group, information described should be reflective of the topic for each session. It is expected that each individual and group session progress note documentation 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/her/their 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.

2. ***If all the groups at our site are 90 minutes and scheduled at the same time every week, do I still have to put the exact start and end time?*** It is recommended that start and end times continue to be indicated, but not required (except for Residential Treatment Services). 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 potentially going to be flagged by the State as needing review. Like templated content, it is important to make sure the duration and start and end times of a service are specific to each session/service.
3. ***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. The documentation needs to support the type of service that corresponds with the service billing code used and evidence medical necessity. It is also a record of what we are doing to help the client make progress in the current episode of care. Therefore, it must effectively show how the service is necessary to address the client's needs. Keeping this in mind will help focus the content of the progress notes and keep your notes clear and concise!
4. ***I forgot to sign the progress note, but it has now been 2 months…what should I do?*** At the point at which it is discovered that a progress note has not been signed by the rendering provider, the signature can be added with the statement, "late entry for (date when it should have been signed)" and the date of the correction. Documents should never be backdated!
5. ***Does the ICD-10 and CPT code need to be on the actual progress note?*** No. The ICD-10 and CPT code do not need to be within the body of the progress note. Many providers have become familiar with using what is called the Encounter Document. The Encounter Document is simply a place where information necessary for data entry by your program's billing specialist is compiled, that is attached to the progress note. It typically includes information such as the date of service, date of documentation, the total amount of service time claimed, the corresponding billing code, face-to-face versus non-face-to-face time, the location where the service was provided, etc. Use of the Encounter Document will continue

to be an appropriate way to ensure the ICD-10 and CPT code are captured. Providers may determine, based on the needs of each specific program, how best to clearly identify the ICD-10 and CPT code and making sure it is tied to the progress note.

~~6.~~ ***What about the weekly note at the Residential levels of care?*** The State has made it clear that the weekly summary is no longer required at the residential programs.

7. ***Can we bill for couples counseling? How should I document for a session provided to two DMC-ODS clients in a relationship who are attending the same program?*** There are a few ways that a service provided to two DMC-ODS clients, who are in a relationship and addressing issues pertaining to each of their substance use disorders, can be documented, and claimed. One way would be to claim the service using the Family Psychotherapy (w/ Pt present), 50 Mins (90847-1) or the SUD Family Counseling (70899-116) T1006 code, depending on the rendering provider's credentials. In this situation, the time can be split between the two clients and a progress note completed for each of the clients. Each progress note would need to emphasize how addressing the relationship dynamics is necessary for the client's treatment, meaning that each note would need to be written geared towards the respective client's problems and needs. Another way to document this would be to claim the total time using the Family Psychotherapy (w/ Pt present), 50 Mins (90847-1) or the SUD Family Counseling (70899-116) T1006 code (depending on the rendering provider's credentials) under one of the two clients. A "note to chart" or administrative note can be added for the other client so that there is documentation of the service being provided to both clients.
8. ***My client is only going to be out of the state for a few weeks, can I provide services via telehealth or telephone?*** The client 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.
9. ***What happens at the time of a clinical chart review when there is no progress note for the service that was provided?*** The billing of a service is contingent upon a corresponding progress note because there needs to be supporting documentation to justify the billing. Therefore, a service found to be billed without a corresponding progress note during a clinical chart review will result in disallowance and/or recoupment due to the appearance of fraud, waste, and/or abuse.

Time Components of a Progress Note

Face-to-Face Minutes

Time with the client, in person.
If the session or service was provided by telephone, there would be no face-to-face time.
Services provided via telehealth would be considered face-to-face time.

Non-Face-to-Face Minutes

Billable time spent on a service activity that does not include the physical presence of the client.

Examples:
- Telephone session/service
- Collateral sessions (sessions with significant individuals involved in the client's treatment) without client present
- Family Counseling/Therapy sessions without client present
- Working on pertinent assessment documents (i.e., developing Dimensions 1-6 of the ASAM Criteria, determining the risk ratings, formulating the rationales for the risk ratings, establishing clinical recommendations, diagnosing, conceptualizing the level of care determination justification) that do not include the client (i.e., outside of session with client)

It is possible that there may be non-billable, non-face-to-face time associated with a service. For example, if you have conducted the MAT referral assessment with a client and after the session, sent the appropriate Authorization to Disclose (ATD) and copy of the evidence-based MAT assessment to the MAT program via fax. This would be a non-billable, non-face-to-face activity. We cannot claim the amount of time that it took to complete this task, but if you wish to document this in the same service progress note where the encounter with the client was documented, be sure to make it clear that the administrative task provided after the session with the client was not included in the total service time.

Service Minutes

Billable face-to-face and/or non-face-to-face time. Non-billable face-to-face and/or non-face-to-face time, if using the non-billable code.

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 total service time would be 90 minutes (45 minutes of face-to-face time and 45 minutes of non-face-to-face time). For more information, see the Billing section.

Each type of service must have its own progress note to claim the time. However, if the same service type is provided to the same client on the same day by the same provider more than once, it should be submitted as one claim rather than two services. For example, if there was a care coordination session with the client in the morning and another contact for care coordination via telephone with the client later in the same day, by the same provider, one progress note should be completed to capture both encounters. This is possible because the two encounters were of the same service type (care coordination) provided on the same day by the same provider. Therefore, billing can be entered as one claim under one Financial Identification Number (FIN) in IRIS. The exception is for groups. Multiple groups provided by the same provider for the same client cannot be claimed together as one claim. Each group must be claimed separately.

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? This does not mean that every detail

of the activity needs to be described. For example, if you are billing non-face-to-face time for the time spent compiling the initial assessment, it is not necessary to include all the content included on the initial assessment into the progress note. In other words, do not copy and paste the initial assessment into the progress note! Provide a brief description or reference the parts of the assessment document that were addressed so that an outside reader can reasonably conclude that the time claimed is appropriate. Excessive service minutes for what is documented may be interpreted as fraud, waste, and/or abuse and result in recoupment.

Documentation Minutes

Time to complete the progress note is not billable. However, it should still be documented on the progress note and entered into IRIS for the purposes of data tracking. This data will be useful for making any potential fiscal adjustments in the future.

Travel Minutes

Time it takes to travel from one location to another to meet with the client to provide a billable service is not billable. It is recommended that if there is travel time associated with a billable service, the time is documented and entered in IRIS. Like documentation time, this information will be used to collect data for potential fiscal adjustments in the future.
Transporting a client from point A to point B, continues to be non-billable (Medi-Cal will not reimburse for us to simply drive a client places). This applies even in those situations where the transportation helps address problems on the client's problem list. However, if during the transport of 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 ***<u>without</u>*** a client and transportation time as time in the car ***<u>with</u>*** a client when there is no service being provided. This does not mean that 5 minutes of counseling provided during a 30-minute drive can be billed as 30 minutes of service! Only the time spent providing an actual service can be billed.

12. CODES & TYPES OF SERVICES

In this section, we will look at how the services provided are tied to billing. Activities are classified based on the type of service they fall under. Each service has its own billing code. The billing codes are attached to the amount of money that is reimbursable for that service, depending also on the rendering provider's credentials. To bill properly, we will first need to understand what activities are billable and what are not.

Billing

The services provided in the DMC-ODS are going to either be billable or non-billable. It is important to know what types of activities can be billed so that we can document them accordingly. We will also need to be clear on who (according to credentials/licenses/registrations/certifications) are eligible to use each of the billing codes.

Billable Services

Billable services are those that are deemed reimbursable by DMC-ODS standards. For a service to be billable, it must be medically necessary. The activity or service provided must reflect the standard of care for addressing the SUD. This means that other professionals in the field would agree that the activity or service was intended to address the client's needs in SUD treatment to ameliorate, reduce, and prevent use of alcohol and/or substances.
Billable services must also be within the scope of practice of the provider.

Assignment of Insurance Benefits (AOB) /Authorization to Disclose (ATD)

In addition to services being medically necessary to bill, there must be an AOB/ATD on file in the DMC-ODS client's chart. An AOB/ATD for the DMC-ODS is a combined document that captures both the AOB and ATD. The AOB portion is the agreement that transfers the insurance claims rights or benefits to a third party (or program/entity), which allows the program/entity to be reimbursed. The ATD portion of the document is what authorizes the disclosure of information necessary for reimbursement. Without the AOB/ATD, we cannot submit claims to the State for reimbursement.
An AOB/ATD document or form should be one of the items discussed, reviewed, and completed in the intake process. An AOB/ATD document is required for each insurance or health plan that is responsible for funding the client's services. For reimbursement of DMC-ODS services through Medi-Cal, the AOB/ATD must indicate "Medi-Cal" for the name of the insurance and the Client Index Number (CIN) for the client can be used as the policy number. The policy number is typically obtained once eligibility is verified or a copy of the client's insurance card is received. AOB/ATD documents without this information are invalid. The client's Medical Record Number (MRN) is recommended, but not required. Please be sure that clients are NOT signing a blank AOB/ATD form! Clients must provide their signature on an AOB/ATD, with the corresponding insurance information, for claims to be sent to the State for reimbursement. Electronic signatures are acceptable. However, verbal consent without the client's signature is not acceptable. Again, client charts without this document or form will not allow us to bill Medi-Cal. This means that in a clinical chart review, any charts without this on file or with forms that are not completed appropriately will be out of compliance and will result in disallowance and/or recoupment.

Non-Billable Services

Non-Billable services are defined as services that an outside third-party payer would NEVER reimburse.

Activities considered in the DMC-ODS to be services that are NOT billable can include, but are not limited to the following:

1. Completing an Authorization to Disclose (ATD)
2. Educational/Vocational services
3. Recreational/Socialization services
4. Search of client's belongings/property
5. Suspected Child Abuse and Dependent/Elder Abuse Reporting
6. Waiting time
7. Translating/Interpreting
8. Clerical Services:

    a. Emailing
    b. Faxing
    c. Scheduling/confirming appointments
    d. Photocopying
    e. Filing/organizing client records/chart
    f. Allowing the client to use program telephone, computer
9. Searching for a missing client
10. Checking or leaving voice messages
11. Providing transportation
12. Completion of bus pass application
13. Completing Shelter + Care application/activities
14. Completion of immigration form
15. Conducting internet searches
16. Most letter writing is not billable
17. 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
18. Any service while the client is in prison, jail/juvenile hall, psychiatric hospitalization, or any public institution
    a. Exceptions to this rule for outpatient only:
        1. Day of admission
        2. Day of discharge

Note: Although CalAIM has expanded what is permissible to bill for, keep in mind that each service or activity must still be based on medical necessity and done to support the client's SUD treatment. It is not enough to just document *what* was done, but also *why* it was done.

Clinical or administrative supervision are not activities that should be documented in a client's chart or entered in the billing system.

Disallowance or Recoupment of Services

A clinical chart review may uncover services that would normally be reimbursable but because something is wrong with the chart, we are not authorized to submit the services for billing. Such services deemed to not be reimbursable by DMC-ODS standards may be disallowed and/or recouped. A disallowance is an issue that is found to be out of compliance and needs to be corrected, that may or may not result in recoupment of a service(s). Recoupment is the repayment, or "giving back," of funds claimed. Typically, this will involve making the service non-billable by changing the billable code to a non-billable code for the progress note and corresponding billing entry in the billing system. This prevents the service from being submitted to the State for reimbursement.

A chart can be deemed "out of compliance" for several reasons. With the implementation of CalAIM in July 2022, disallowances and recoupments are based on services or billing considered as fraud, waste, and/or abuse. A few areas that can result in a disallowance and/or recoupment of services include, but are not limited to, the following:

1. Missing or invalid Assignment of Insurance Benefits / Authorization to Disclose (AOB/ATD)
2. Services provided out of scope of practice
3. Services provided by a non-DMC certified and credentialed provider
4. Services provided under a lapsed/expired license/credential/registration
5. Assessment services provided without the completion of required trainings (i.e., ASAM A and B)
6. Missing appropriate documentation of clinical supervision
7. No medical necessity established
8. Level of care determination not substantiated
9. A pattern or egregious instance of there being no initial assessment completed to justify the access criteria
10. A pattern or egregious instance of there being no problem list (or treatment plan, if applicable) when it is clinically appropriate and reasonable to expect that it be completed
11. No progress note for the date of service claimed
12. A pattern of templated documentation
13. Patterns in billing without appropriate substantiation (either of time or interventions provided)

Note: Aside from the patterns that may indicate fraud, waste, and/or abuse, it may be possible that a single instance of non-compliance could result in disallowance or recoupment, depending on the scale of the issue. For the County's clinical chart review process, each instance or observation of potential patterns will be considered on a case-by-case basis.

Billing and Coding FAQ

1. ***What is the minimum amount of time that can be claimed for a service?*** With Payment Reform, some codes will have specific time restrictions. For example, some codes will have a time range (i.e., 5-14 minutes, 15-29 minutes, etc.), which requires that you use those specific codes for total service minutes that reach at least the lower bound of the range. There are also other codes that do not indicate any time in the Charge Description or is followed with, "per 15 minutes." One billing unit is equivalent to 15 minutes and the minimum number of minutes necessary to bill for a service will be when the service reaches the midpoint (or 8 minutes for a "per 15 minute" service). If a service is less than the midpoint required for that code, the State will not reimburse for those claims. The non-billable code must be used for such services.
   For more specific information on billing codes, refer to the [DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24]
2. ***Can we bill for travel time?*** Travel time or the time it takes for a provider to go from the provider site to another location to provide a billable service, is not billable.
3. ***Can we bill for completing the* Notice of Adverse Benefit Determination *(NOABD)?*** No, billing for the time spent to research the client's chart to complete the NOABD letter is not a billable activity.
4. ***What is a "blended" note?*** A "blended" note is a progress note that includes activities of different service types. For example, if a progress note includes both care coordination and individual counseling interventions or both billable and non-billable activities. We

can only bill one service type per progress note and the documentation needs to support the billing code used.

5. ***What happens if a progress note is "blended?"*** There may be some instances where the non-billable activity (or whatever other activity that does not fit the code used for billing), as documented, is incidental to the overall service. This means that based on the documentation, it is reasonable to determine that the activity was a very brief piece of the entirety of the service. In these cases, it may be permissible to allow for the billing without any corrective action. However, if it appears that the service claimed contains a significant amount of time spent on the other service type or activity that does not align with the service code used for billing, there is a greater risk of the appearance of fraud, waste, and/or abuse and may result in disallowance and/or recoupment.
6. ***If the time spent with my client includes both billable and non-billable activities, how do I document? How do I bill?*** You can use the billable code and document what was provided to the client. Be clear in the documentation that a non-billable activity was provided, in addition to the billable activity, and that the time claimed does not include the time spent for the non-billable activity. For example, if you would like to document that you completed a referral form and faxed it, the documentation could look something like, "Treatment Authorization Request form completed and faxed to the County (time not billed)." The total number of minutes claimed for the service can only include the time spent for the billable activity.
   For County EHR only: If the non-billable and billable activity are of the same service type (i.e., both are care coordination), one Financial Identification Number (FIN) may be used where both the non-billable and the billable time can be accounted for.
7. ***I coded the progress note as care coordination, but it should have been billed as individual counseling. Do I have to make it non-billable?*** This depends on the level of care. At the outpatient levels of care, where services are claimed separately, it is acceptable to correct the billing code to the appropriate service type according to the interventions provided. The service can continue to be billed and does not need to be made non-billable. If this is a service that has been inputted into the billing system by your program's billing staff, please have them correct it in the billing system to match the progress note and/or the encounter document where the billing information is contained. At the Residential and Withdrawal Management levels of care, it is advised that those services that were claimed as care coordination that should have been included as part of the daily bundle, be made non-billable. This kind of situation means that a service was billed in addition to the treatment day. In a County clinical chart review, such services may be open to disallowance and/or recoupment due to the potential for the appearance of fraud, waste, and/or abuse. Each instance will be looked at on a case-by-case basis as it is dependent on the content of the documentation and severity of the issue.

Types of Services

To bill under the DMC-ODS, each progress note needs to describe what was provided in the service/session that supports the service type and the corresponding billing code that is selected.

Service types are categories under which the billing codes fall. With Payment Reform under CalAIM, the State has specified the following service types:

1. Assessment
2. Crisis Intervention
3. Treatment Planning
4. Individual Counseling
5. Family Therapy
6. Group Counseling
7. Care Coordination
8. Discharge
9. Recovery Services
10. Medication Services
11. Mobile Crisis
12. Peer Support Services

Collateral

What are collateral activities?

Collateral can be provided within the context of and billed as assessment, individual counseling, or family therapy/counseling. Collateral services can be provided with or without the presence of the client.

The following is a billable collateral activity:

- Sessions or contact with significant people in the client's life in relation to the client's treatment.

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 those needs.

Billing Codes for Collateral (*NOTE - there are no specific codes for collateral as it is intended to be provided within the context of an assessment, individual, or family service. The content of the documentation will need to make it clear that the collateral activity was part of the service):*

Charge Description	CPT/HCPCS Code	Billable CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Psych Diagnostic Eval, 60 min	90791	90791-1	Non Billable SUD Assessment	70899-300
Assessment Substitute	T2024	TBD	TBD	TBD
Psychological Testing Eval, First Hour	96130	96130-1	Non Billable SUD Assessment	70899-300
Psychological Testing Eval, Each Add'l Hour	96131	96131-1	Non Billable SUD Assessment	70899-300

Telephone Assmt and Mgmt Service, 5-10 Min	98966	98966-1	Non Billable SUD Assessment	70899-300
Telephone Assmt and Mgmt Service, 11-20 Min	98967	98967-1	Non Billable SUD Assessment	70899-300
Telephone Assmt and Mgmt Service, 21-30 Min	98968	98968-1	Non Billable SUD Assessment	70899-300
SUD Structured Assmt, 15-30 Min	G0396	70899-100	Non Billable SUD Assessment	70899-300
SUD Structured Assmt, 30+ Min	G0397	70899-101	Non Billable SUD Assessment	70899-300
SUD Structured Assmt, 5-14 Min	G2011	70899-102	Non Billable SUD Assessment	70899-300
SUD Assmt	H0001	70899-103	Non Billable SUD Assessment	70899-300
SUD Screening	H0049	70899-105	Non Billable SUD Assessment	70899-300
SUD Brief Intervention, 15 Min	H0050	70899-117	Non Billable SUD Individual Counseling	70899-309
Skills Training and Dev, Indv, per 15 Min	H2014	70899-113	Non Billable SUD Treatment Planning	70899-303
Psychoeducational Svc, per 15 Min	H2027	70899-115	Non Billable SUD Treatment Planning	70899-303
SUD Family Counseling	T1006	70899-116	Non Billable SUD Individual Counseling	70899-309
Family Psychotherapy (w/o Pt Present), 50 Min	90846	90846-1	Non Billable SUD Family Therapy	70899-307
Family Psychotherapy (w/ Pt Present), 50 Min	90847	90847-1	Non Billable SUD Family Therapy	70899-307
Multiple-Family Group Psychotherapy, 84 Min	90849	90849-1	Non Billable SUD Family Therapy	70899-307
Therapy Substitute	T2021	TBD	TBD	TBD
SUD Individual Counseling, 15 Min	H0004	70899-130	Non Billable SUD Individual Counseling	70899-309
SUD Treatment Plan Development/Modification	T1007	70899-125	Non Billable SUD Discharge Svcs	70899-306

Note: The Non-Billable Code Charge Description reflects the State's categorization of the codes.

For more specific information on billing codes, refer to the [DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24]

Who can provide a collateral service?

Collateral services may be provided by a non-LPHA or LPHA.

How can a collateral service be provided?

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

Where can a collateral service be provided?

Collateral activities may be performed anywhere in the community or the home. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

For Residential levels of care: Collateral within assessment, individual counseling and/or family therapy/counseling, is part of the daily bundled rate. It cannot be claimed as a standalone service in addition to the treatment day*. Time spent providing collateral services that includes the client can be counted towards the required number of clinical hours needed each week. 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.

For Withdrawal Management levels of care: Collateral within assessment, individual counseling and/or family therapy/counseling, is part of the daily bundled rate. It cannot be claimed as a standalone service in addition to the treatment day*.

*The treatment day may be claimed even if the bed day is not. In other words, the treatment day can be billed even if the client does not stay overnight. However, there must be at least one qualifying service that justifies the billing of the treatment day. A qualifying service is an assessment, individual/group counseling, family therapy, medication service, patient education, or SUD crisis intervention. There must be documentation (e.g., progress note) in the client's chart to evidence that a qualifying service has been provided to justify the billing of the treatment day.

For situations where the client is entering into a 24-hour facility (i.e., inpatient, hospital stay for medical issue, etc.), we must be mindful of admit and discharge dates. For example, if the client is going to the hospital for a known period time where the client is expected to return to the program in a few days and the case will remain open, the treatment day cannot be claimed on the date of the client's admission to the other 24-hour facility. If, on the other hand, the client is discharging from your program to admit to the hospital as it is unknown when or if the client will be able to return, the treatment day can be claimed on the date of discharge if there is at least one qualifying service that was provided and documented.

Collateral FAQ

1. ***How do I know which code to use for billing a collateral session?*** The billing code will depend primarily on the content of the session and its intended purpose. If the nature of the interaction with the client's family, for example, was for the purpose of gathering background information needed to obtain a thorough assessment or gain further understanding of the client's functioning to determine the degree of impairment related to the substance use, an assessment code should be used. Which assessment code depends on the particular type of assessment that is conducted. A session that is mostly for screening a client is going to necessitate a different billing code than a more focused service directed to

the ASAM-based assessment. For more information, see the *DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24*

2. ***Why aren't care coordination billing codes included for collateral services?*** It's important to remember that collateral involves individuals that have a significant, personal relationship with the client. Care coordination is for work that may be done with professional organizations or individuals. Although you may be providing community resources to a client's parent that will be for the benefit of the client, the service would be considered a collateral session because it involves the client's parent. Another example would be coordinating discharge planning with the client's wife, such as ways that the wife can continue to support the client's recovery or setting up after-care appointments for services that were established while the client was in the care of a treatment program. Since the activity involves the client's wife, it is considered a collateral service. At the Residential and Withdrawal Management levels of care, collateral services are part of the daily bundle of services and there is no separate billing in addition to the treatment day.

Assessment

What are assessment activities?

The following are billable assessment activities:

- Gathering psychosocial information for assessment (the County's SUD Assessment form or some other initial assessment document)
- Interviewing the client about his/her/their substance use and its impact on functioning (i.e., Dimensions 1-6 of ASAM Criteria)
- Enlisting the support of the client's family members or other significant individuals in the client's life (collateral service) to obtain information needed to determine access criteria and treatment needs
- Formulating a DSM-5-TR diagnosis
- Determining the appropriate level of care
- Applicable for County's SUD Re-Assessment form or some other re-assessment document or activity)

For Residential levels of care: Assessment services are part of the daily bundled rates. It cannot be claimed as a standalone service on top of the treatment day. However, assessment services can count towards the required number of clinical hours needed each week when it involves the client's presence. 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. An assessment service is a qualifying service that allows for the treatment day to be claimed, if there is documentation to support that this took place.

For Withdrawal Management levels of care: Assessment services are part of the daily bundled rates. It cannot be claimed as a standalone service on top of the treatment day rate.

Assessment Billing Codes:

Charge Description	CPT/HCPCS Code	Billable CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Psych Diagnostic Eval, 60 min	90791	90791-1	Non Billable SUD Assessment	70899-300
Assessment Substitute	T2024	TBD	TBD	TBD
Psych Eval of Hospital Record, 60 Min	90885	90885-1	Non Billable SUD Assessment	70899-300
Psychological Testing Eval, First Hour	96130	96130-1	Non Billable SUD Assessment	70899-300
Psychological Testing Eval, Each Add'l Hour	96131	96131-1	Non Billable SUD Assessment	70899-300
Telephone Assmt and Mgmt Service, 5-10 Min	98966	98966-1	Non Billable SUD Assessment	70899-300
Telephone Assmt and Mgmt Service, 11-20 Min	98967	98967-1	Non Billable SUD Assessment	70899-300
Telephone Assmt and Mgmt Service, 21-30 Min	98968	98968-1	Non Billable SUD Assessment	70899-300
SUD Structured Assmt, 15-30 Min	G0396	70899-100	Non Billable SUD Assessment	70899-300
SUD Structured Assmt, 30+ Min	G0397	70899-101	Non Billable SUD Assessment	70899-300
SUD Structured Assmt, 5-14 Min	G2011	70899-102	Non Billable SUD Assessment	70899-300
SUD Assmt	H0001	70899-103	Non Billable SUD Assessment	70899-300
SUD Screening	H0049	70899-105	Non Billable SUD Assessment	70899-300
SUD Drug Testing POC Tests	H0048	70899-104	Non Billable SUD Assessment	70899-300

For more specific information on billing codes, refer to the [DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24]

Who can provide an assessment service?

Assessment activities can be performed by an LPHA or non-LPHA (within scope of practice). Please be mindful that there are restrictions on the type of assessment activities that can be provided and claimed for by Licensed/Clinical Trainee Pharmacists, Medical Assistants, Licensed/Clinical Trainee Occupational Therapists, Registered/Clinical Trainee Nurses, Licensed/Clinical Trainee Vocational Nurses, and Licensed/Clinical Trainee Psychiatric Technicians. Please refer to the *DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24* for more information.

Both ASAM A and B trainings must be completed prior to provision of assessment services.

How can an assessment service be provided?

Assessment services can be provided in-person, by telehealth, and telephone.

For NTP only: The medical evaluation for methadone treatment (medical history, laboratory tests, and a physical exam) must be conducted in-person.

Where can an assessment service be provided?

Assessment activities may be performed anywhere in the community or the home. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

How do we bill for an assessment service that is provided?

Intake session/service (Outpatient Drug Free (ODF) and Intensive Outpatient Treatment (IOT) levels of care):

- The **SUD Screening (70899-105) H0049** code may be used to claim the time spent conducting an intake session/service where there is a brief screening for the purposes of admission to treatment, but the significant portion of the time is utilized towards reviewing and signing intake paperwork. The modified ASAM provided by the ART team would fall under this category as it is considered a screening to direct the client to the appropriate level of care. The SUD Screening code cannot be used by a Licensed/Clinical Trainee Occupational Therapist.
- In cases where the intake session/service solely involves review of intake paperwork and obtaining the necessary signatures (no screening or assessment activities), the **Targeted Case Management (70899-120) T1017** code may be used.
- In cases where the intake session/service also involves a significant portion devoted to the ASAM-based assessment, the **SUD Assessment (70899-103) H0001** code may be used instead.
- For "open/close" or admit and discharge on the same day due to the client presenting to an intake or assessment session/service and deciding that they do not wish to stay/participate, the **SUD Screening (70899-105) H0049** code may be used. The SUD Screening code cannot be used by a Licensed/Clinical Trainee Occupational Therapist.

Intake session/service (Residential and Withdrawal Management levels of care):

- For "open/close" or admit and discharge on the same day due to the client presenting to an intake or assessment session/service and deciding that they do not wish to stay/participate, the treatment day may be claimed. The assessment session/service conducted will count as the minimum of one qualifying service needed to claim a treatment day at the residential programs. Documentation in the client's chart must clearly demonstrate that this service was provided.

Assessment sessions/services conducted by an LPHA* (ODF and IOT):

- The **Psychiatric Diagnostic Evaluation, 60 min (90791-1)** code should be used when the ASAM-based assessment or re-assessment is being conducted by the LPHA. It may only be used once per day. Although the LPHA is permitted to use the SUD Assessment (70899-

103) H0001 code, the more appropriate code for the level of decision-making and clinical evaluation involved by an LPHA is the Psychiatric Diagnostic Evaluation code. All subsequent assessment services/sessions after the initial service/session should be coded as SUD Assessment (70899-103) H0001.

- The minimum number of minutes required to use the Psychiatric Diagnostic Evaluation, 60 min (90791-1) code is 31 minutes. If the service/session is 30 minutes or less, the SUD Assessment (70899-103) H0001 code should be used. For services/sessions that are 68 minutes or more, there is an Assessment Substitute T2024 (CDM code TBD) code that will be available once it is built in the billing system. Until the build is complete, services/sessions 68 minutes or more should be claimed using the SUD Assessment (70899-103) H0001 code.

  *Assessment activities by Pharmacists, Registered Nurses, Licensed Vocational Nurses, Licensed Psychiatric Technicians, and Licensed Occupational Therapists are limited even though the State considers these disciplines as LPHA. This is due to the scope of practice for these disciplines. Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees can conduct assessment services/sessions and claim the SUD Assessment (70899-103) H0001 code to gather information, just as an AOD Counselor or non-LPHA can. However, they cannot diagnose or make the level of care determination. They cannot use the Psychiatric Diagnostic Evaluation, 60 min (90791-1) code. Information that is collected will need to be presented to a qualified LPHA for establishment of the SUD diagnosis and level of care placement determination.

Assessment sessions/services conducted by a non-LPHA *after* intake (ODF and IOT):

- The **SUD Assessment (70899-103) H0001** code should be used to account for the time spent by non-LPHA on the ASAM-based assessment or re-assessment. Time can be face-to-face or non-face-to-face. Non-face-to-face time includes using the gathered information to determine the appropriate risk ratings for each of the six dimensions of the ASAM Criteria, developing the rationales for the severity in the client's functioning for each of the six dimensions, and making any clinical recommendations to be discussed with the LPHA in the required consultation.
- There is no limit or maximum number of assessment services/sessions. Remember that each service/session claimed must demonstrate medical necessity. Therefore, each assessment service/session that is claimed must be justified by the documentation.

Assessment sessions/services *after* intake (Residential and Withdrawal Management levels of care):

- Assessment services are considered part of the "bundle" of services included in a treatment day. Therefore, there is no separate billing for assessment on top of the treatment day. All

services provided that justify the billing of the treatment day need to be properly documented.

Narcotic Treatment Program (NTP):

- In cases where there is *no dosing service provided on the same day,* the Medical Doctor, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee conducting a physical evaluation to determine the admission of a patient can be billed as **Psychiatric Diagnostic Evaluation with Medical Services, 60 Min (90792-1).** The non-LPHA completing the ASAM-based assessment can use the SUD Assessment (70899-103) H0001 to bill for the session/service. The appropriate corresponding documentation in a progress note would be required for each "unbundled" service claimed. If a dosing service is provided, the intake, physical evaluation, and ASAM-based assessment are included and cannot be claimed separately.

Recovery Services:

- The **Psychosocial Rehabilitation, Individual, per 15 Min (70899-122) H2017** code can be used to bill for time spent by the non-LPHA or LPHA conducting assessment activities at this level of care.

How do we bill for the time spent working on the Case Formulation?

Only qualified LPHA can complete the Case Formulation (or required write-up) and bill for the time. LPHA who are Registered Nurses, Vocational Nurses, Psychiatric Technicians, Occupational Therapists, and Pharmacists (and their respective Clinical Trainees) are not eligible.

Intensive Outpatient and Outpatient Drug Free: The LPHA's time spent conceptualizing the Case Formulation or the LPHA's write-up portion of the assessment that establishes the access criteria and level of care determination can be billed using the **Psychiatric Diagnostic Evaluation, 60 Min (90791-1)** code, if this code has not already been used for an assessment service/session by another provider on the same day. If the amount of time spent diagnosing or developing the Case Formulation is 68 minutes or more, the Assessment Substitute T2024 (CDM code TBD) code may be used instead to account for the total service minutes. This code has not yet been built in IRIS. As a work-around, it is permissible for the LPHA to use the SUD Assessment (70899-103) H0001 code for services that are 68 minutes or more. Service minutes that do not reach the midpoint (30 minutes or less) should also be coded using the SUD Assessment (70899-103) H0001 code.

Residential Treatment: The LPHA spending time to create the required write-up or narrative that justifies the access criteria, and the level of care placement determination is part of the day rate. There is no additional billing permitted in addition to the treatment day.

Withdrawal Management: The LPHA spending time to create the required write-up or narrative that justifies the access criteria, and the level of care placement determination is part of the day rate. There is no additional billing permitted in addition to the treatment day.

Narcotic Treatment Program (NTP): If the Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee completes the narrative or write-up to justify the patient's need for the NTP level of care on a day that does not involve a dosing service, the **Psychiatric Diagnostic Evaluation with Medical Services, 60 Min (90792-1)** code may be used to claim this time. For services that are 30 minutes or less, the SUD Assessment (70899-103) H0001 code should be used. There is an Assessment Substitute T2024 (CDM code TBD) code that may be used instead for services that are 68 minutes or more, however this code is yet to be built in IRIS. As a work-around until the build is complete, it is permissible for the LPHA to use the SUD Assessment (70899-103) H0001 code in these cases. If, the narrative or write-up is completed on the same day as a dosing service, the time is included and there is no additional billing permitted.

Recovery Services: The LPHA should use the **Psychosocial Rehabilitation, Individual, per 15 Min (70899-122) H2017** code for claiming this time.

How is the time spent on a Re-Assessment billed?

Intensive Outpatient and Outpatient Drug Free: The **SUD Assessment (70899-103) H0001** code can be used. LPHAs conducting re-assessments may use the **Psychiatric Diagnostic Evaluation, 60 min (90791-1)** code. If the amount of time by the LPHA is 68 minutes or more, the Assessment Substitute T2024 (CDM code TBD) code may be used instead of the Psychiatric Diagnostic Evaluation, 60 min (90791-1) code to account for the total service minutes. This code has not yet been built in IRIS. As a work-around, it is permissible for the LPHA to use the SUD Assessment (70899-103) H0001 code for services that are 68 minutes or more. Service minutes that do not reach the midpoint (30 minutes or less) should also be coded using the SUD Assessment (70899-103) H0001 code.

Residential Treatment: Any time spent for re-assessing a client's level of care placement needs is part of the day rate. There is no additional billing permitted in addition to the treatment day. However, all direct client service minutes related to re-assessment can be counted towards the required five (5) clinical hours in the week if there is corresponding documentation to support that this took place.

Withdrawal Management: Sessions/services with the client to complete the re-assessment or screening for readiness to transition out of this level of care is considered part of the bundle of services that are included in the day rate at this level of care. There is no additional billing that is permitted in addition to the treatment day.

Narcotic Treatment Program (NTP): The non-LPHA conducting sessions/services for the purposes of re-assessing a patient's level of care determination needs, such as for the Annual Justification, can use the SUD Assessment (70899-103) H0001 code to bill for the session/service if a dosing service is not provided on the same day. The appropriate corresponding documentation in a progress note would be required for each "unbundled" service claimed. Dosing services include assessment and re-assessment.

If the Licensed Physician conducts an updated physical evaluation or re-assessment, such as for the Annual Justification, the Psychiatric Diagnostic Evaluation with Medical Services, 15 Min

(90792-1) code may be used to claim the time if a dosing service is not provided on the same day. In such instances, the Licensed Physician's time spent on the required narrative portion to attest to the patient's diagnosis and/or continued need for NTP may also be included in the total service minutes for this code. This code may only be used one time per day. If the amount of time spent is 68 minutes or more, the Assessment Substitute T2024 (CDM code TBD) code may be used instead to account for the total service minutes. This code has not yet been built in IRIS. As a work-around, it is permissible for the LPHA to use the SUD Assessment (70899-103) H0001 code for services that are 68 minutes or more. Service minutes that do not reach the midpoint (30 minutes or less) should also be coded using the SUD Assessment (70899-103) H0001 code. The appropriate corresponding documentation in a progress note would be required for each "unbundled" service claimed.

Recovery Services: The Psychosocial Rehabilitation, Individual, per 15 Min (70899-122) H2017 can be used to bill for time spent by the non-LPHA or LPHA to complete re-assessments at this level of care.

Assessment FAQ

1. ***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. See above for more information on billing codes for the intake at outpatient levels of care. 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 is not necessary to list all documents, however, be explicit about the client's consent to treatment by clearly indicating that the informed consent was reviewed, and the signature was obtained. It should also include some assessment of the client's appropriateness for treatment services (i.e., substance use history, referral source and reason, etc.) to support any problems or issues (i.e., ICD-10 Z55-Z65 codes) that may be necessary to bill for the intake service and begin the problem list. Additionally, now that we must also assess all clients for the need of a MAT referral within the first twenty-four (24) hours of a client's admission to treatment, be sure to document the completion of this in the intake note if this was part of the intake service. If the client is already receiving MAT services at your program or elsewhere, this should be clearly documented. There is no expectation that an evidence-based MAT assessment is conducted for existing MAT clients.
2. ***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 progress note using the billable SUD Assessment (70899-103) H0001 code. 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 progress note with face-to-face time of 45 minutes and non-face-to-face time of 60 minutes.

3. ***Can we bill for the assessment at the Residential level of care?*** Since assessment 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 cannot be counted towards the required number of clinical hours for the week. Only activities that directly involve the client should be counted.
4. ***My client has a lot of paperwork from other agencies that I need to review. Can I bill for my time?*** If you are an LPHA at the outpatient levels of care and the review of paperwork is centered around determining, confirming, and/or changing the client's diagnosis, the time may be claimed using the Psychiatric Evaluation of Hospital Record, 60 mins code (90885-1) code. The Psychiatric Evaluation of Hospital Record code can only be used once on any given day. This code may also be used to claim 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. LPHA who are a Pharmacist, RN, LVN, LPT, and LOT (and their respective Clinical Trainees) are not eligible to provide and claim for this service.
5. ***I worked on the assessment over multiple sessions. Is this billable?*** Time spent working on analyzing and developing parts of an assessment document are billable. However, be mindful of the potential for the appearance of fraud, waste, and/or abuse with billing multiple instances of assessment. Each time that assessment is claimed, the documentation needs to clearly show that you are billing for an activity that is different from what was previously claimed.
   Here is where the initials and date on each page of the County's SUD Assessment form becomes important, if using a paper copy or timestamps, if using an Electronic Health Record (EHR) system. This is to help corroborate what the counselor is claiming to bill for the activity and what is done. Information does not need to be repeated between the assessment document and the progress notes. One way to differentiate between numerous assessment services might be to document the ASAM dimension that was addressed in that encounter. For example, "Counselor gathered information from client related to psychiatric history, current symptoms, and traumatic experiences (Dimension 3) for the ASAM assessment."
6. ***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. 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 risk assessment is completed, follow your agency's protocol for addressing situations involving DTS, DTO, or GD.

Crisis Intervention

What is 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. For example, a client who discloses thoughts of self-harm perhaps through overdose during a regularly scheduled individual counseling session would constitute a crisis if it were 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. It would now require the counselor to stop what he/she/they 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 prevent ongoing use in the immediate situation that is centered around preventing further escalation would be considered crisis intervention activities.

Crisis intervention progress notes must be completed within twenty-four (24) hours of the service. However, the billable code should continue to be used even if the progress note is not able to be documented within the timeframe. Please keep in mind that patterns of instances with any one provider or across an agency/organization, where crisis intervention is documented outside of the twenty-four (24) hour timeline will be looked at for potential fraud, waste, and/or abuse and may result in disallowance and/or recoupment.

For Residential levels of care: Crisis intervention is part of the daily bundled rate and not billable on top of the treatment day. However, time spent providing crisis intervention services that include the client can count towards the required number of clinical hours needed for the week. 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. Crisis intervention is a qualifying service to be able to claim the treatment day.

For Withdrawal Management levels of care: Crisis intervention is part of the daily bundled rate. It cannot be claimed as a standalone service in addition to the treatment day.

Crisis Billing Code:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
SUD Crisis Intervention (OutPt)	H0007	70899-107	Non Billable SUD Crisis Intervention	70899-301

For more specific information on billing codes, refer to the DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24

Who can provide Crisis Intervention?

Crisis intervention services can be provided by a non-LPHA or LPHA. Pharmacists, Pharmacist Clinical Trainees, and Medical Assistants are not eligible to provide and claim for this service.

How can Crisis Intervention be provided?

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

Where can Crisis Intervention be provided?

Crisis intervention activities may be performed anywhere in the community or the home. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

Crisis Intervention FAQ

1. ***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 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 self or others based on assessment, your agency's 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 completely unrelated to substance use or does not constitute a potential relapse (perhaps because it is 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.
2. ***I went to the client's house because his mom said he was relapsing, but when I got there, he was not experiencing a relapse. 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 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 as crisis intervention 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 may be an individual counseling or family

counseling/therapy session). A progress note for each type of service would be necessary to support the billing code used to claim the time.

Treatment Planning

What are treatment planning activities?

The State uses the terms "treatment planning" and "treatment plan" to describe general activities associated with planning the course of treatment for a client. Thus, treatment planning activities can involve more than just developing and updating treatment plans and/or problem lists to address the client's needs. It can include the work that leads to the development and/or update of actual treatment plans or problem lists. Treatment planning should be a collaborative process involving the client and any significant individuals that the client elects to include. As such, the conceptualization, building, and maintaining of the treatment plan and/or problem list should take place with the client present. This interactive discussion should be made evident in the documentation of sessions in the progress notes utilizing the treatment planning billing code for the outpatient levels of care. It can be a discussion about potential interventions that may be used (i.e., type of services and the frequency needed or clinical modalities most appropriate to address the client's particular issues), the client's desired outcomes for treatment, measures to be taken to monitor for treatment progress, etc.

Remember that there are no set timelines or frequencies with which a treatment plan and/or problem list needs to be created or updated. It is intended to be reviewed on a continuous basis and modified, as needed. Time spent with the client conducting periodic discussions regarding their treatment progress with the goal of determining any potential changes that may be needed for the treatment plan and/or problem list can be coded using the treatment planning billing code. Due to the State's emphasis on billing for services that are "direct client care," it is important to only claim the time that is spent with the client on these activities. This means that the time to complete a treatment plan and/or problem list outside of the session (i.e., without the client present) is not billable.

Keep in mind that for those programs that must continue to fulfill the requirement for a treatment plan, a standalone treatment plan is not required. However, the State requires that providers be able to produce and communicate the contents of a client's care plan to other providers, the client, and other systems of care involved in the client's treatment. See more information in the Problem List section above.

For Residential levels of care: Treatment planning is part of the daily bundled rate and not billable on top of the treatment day. However, time spent providing treatment planning services that include the client can count towards the required number of clinical hours needed each week. 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.

For Withdrawal Management levels of care: Treatment planning is part of the daily bundled rate. It cannot be claimed as a standalone service in addition to the treatment day.

Treatment Planning Billing Code:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
SUD Treatment Plan Development/Modification	T1007	70899-125	Non Billable SUD Discharge Svcs	70899-306

Note: The Non-Billable Code Charge Description reflects the State's categorization of this code.

For more specific information on billing codes, refer to the DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24

Who can provide treatment planning?

Treatment planning can be provided by a non-LPHA or LPHA. Pharmacists, Pharmacist Clinical Trainees, and Medical Assistants cannot provide and claim for treatment planning services.

How can treatment planning be provided?

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

Where can treatment planning be provided?

Treatment planning activities may be performed anywhere in the community or the home. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

How do we bill for the time spent on developing or modifying the Problem List?

At the outpatient levels of care, the SUD Treatment Plan Development/Modification (70899-125) T1007 can be used by a non-LPHA or LPHA (except Medical Assistants, Pharmacists, and Pharmacist Clinical Trainees) to claim for time spent working on creating or changing the problem list with the client present. Due to the State's emphasis on "direct client care," only the time spent with the client conducting this activity can be claimed.

Recommendation: If, during an individual counseling service/session, there is discussion that leads to an update or change in the client's course of treatment (i.e., resulting in a change to the treatment plan or problem list), the code used for that service/session should be the SUD Treatment Plan Development/Modification (70899-125) T1007 code.

Individual Counseling

What are individual counseling activities?

Individual counseling consists of contacts with the client. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the client and support for his/her/their recovery efforts.

Some examples of billable individual counseling activities:

- Working with the client on skill-building for the purposes of maintaining sobriety and relapse prevention

- Discussing 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
- Contact with family members or other significant individuals in the client's life (collateral services) if participation is focused on the needs of the client and how the family/individual can support the client towards achieving treatment progress.

Interventions provided in an individual counseling session must be within the scope of practice of the individual providing the service. If Evidence-Based Practices (EBPs) are referenced, it should be clear how it is addressing the client's treatment needs. Documented interventions should show individualization to the specific needs of the client.

Individual counseling is to be billed for the respective level of care that the client is receiving (i.e., ODF, IOT, etc.).

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 when it involves the client's presence. 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. Individual counseling is a qualifying service to be able to claim the treatment day.

For Withdrawal Management levels of care: Individual counseling services are part of the daily bundled rates and cannot be claimed as an additional service.

Individual Counseling Billing Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
SUD Brief Intervention, 15 Min	H0050	70899-117	Non Billable SUD Individual Counseling	70899-309
SUD Individual Counseling, 15 Min	H0004	70899-130	Non Billable SUD Individual Counseling	70899-309
Skills Training and Dev, Indv, per 15 Min	H2014	70899-113	Non Billable SUD Treatment Planning	70899-303
Psychoeducational Svc, per 15 Min	H2027	70899-115	Non Billable SUD Treatment Planning	70899-303

Note: The Non-Billable Code Charge Description reflects the State's categorization of this code.

For more specific information on billing codes, refer to the [DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24]

Psychoeducational Services – In the past, psychoeducation activities were billed using the individual counseling service code, however, there is now a separate billing code for this. If the session/service predominantly consists of psychoeducation, the Psychoeducational Service (70899-115) H2027 code should be used. Pharmacists, Pharmacist Clinical Trainees, and Registered Nurse Clinical Trainees cannot provide and claim for psychoeducational services.

Patient Education in a one-on-one, individual session/service – The Skills Training and Development, Individual (70899-113) H2014 code should be used to capture the time for this. For example, a Patient Education group content provided to a client in an individual session because no other group members arrived. Pharmacists, Pharmacist Clinical Trainees, and Psychologist Clinical Trainees cannot provide and claim for individual patient education services.

Who can provide an individual counseling service?

Individual counseling can be provided by a non-LPHA or LPHA. Interventions must be within the scope of practice of the provider. Pharmacists, Pharmacist Clinical Trainees, and Medical Assistants cannot provide and claim for individual counseling services.

How can an individual counseling service be provided?

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

Where can an individual counseling service be provided?

Individual counseling activities may be performed anywhere in the community or the home. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

Sample: Individual Counseling Progress Note

SAMPLE

PROGRESS NOTE

Client Name: Ava Avatar **Location:** Really Helpful Services **Type of Service:** Individual Counseling

Date of Service: 11/11/22 **Start Time:** 10:01am **End Time:** 10:56am **Total Service Time:** 55 minutes

Doc Start Time: 1:34pm **Doc End Time:** 1:41pm **Total Documentation Time:** 7 minutes

Narrative: Client seen today at the clinic to address her SUD and how it interferes with her day-to-day functioning. Writer processed with client about ways to cope with her feeling "on edge" and restlessness due to triggers of being in social situations and large crowds of people. Client was able to discuss possible coping skills with some prompting. As the session progressed, she became more at ease and showed reduced psychomotor agitation (stopped tapping foot). Writer helped client to role play situations in which client manages triggers using visualization and relaxation techniques of deep breathing and grounding. She seemed to enjoy the role play and stated that she likes noticing "feeling lighter" after using the relaxation techniques. Writer 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. 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. Plan for next session is 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 agrees to continue to practice coping skills 2 times per day. Client seems to be improving her ability to track her triggers and note how she is feeling as a result. Client continues to need interventions to process triggering events and use of adaptive coping skills in order to progress towards increasing time in sobriety.

Provider Name: Erin Example, LMFT **Provider Signature:** *Erin Example, LMFT* **Date:** 11/13/22

Family Services

What are Family Services?

Family services include family therapy and family counseling. There are some key differences between family therapy and family counseling.

Family therapy (can only be conducted by LPHA within scope of practice) brings the family into the treatment process to identify unhealthy family dynamics that enable the addiction to continue. It is considered a rehabilitative service where, 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 client, however, is for the direct benefit of the client. Family members can provide

social support and help with motivating the client to remain in treatment. Family therapy services can be provided with or without the presence of the client.

Family counseling (can be conducted by non-LPHA and LPHA within scope of practice) is more general in the scope of addressing family issues and consists primarily of providing education to help the client and families understand the impact of substance use on the family. The focus of the service is to directly benefit the client, even though family counseling can be provided with or without the presence of the client.

Multiple-Family Group Psychotherapy (can only be conducted by LPHA within scope of practice) is a service that involves multiple families, interacting together to address themes and common experiences related to substance use. A non-LPHA conducting a group involving multiple families, within scope of practice, can claim services using the SUD Family Counseling code.

For Residential levels of care: Family services (therapy and counseling) are part of the daily bundled rate and cannot be billed on top of the treatment day. However, time spent providing family therapy services that include the client can count towards the required number of clinical hours needed each week. 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 is a qualifying service to be able to claim the treatment day.

For Withdrawal Management levels of care: Family services (therapy and counseling) part of the daily bundled rate. It cannot be claimed as a standalone service in addition to the billing of the treatment day.

Family Services Billing Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
SUD Family Counseling	T1006	70899-116	Non Billable SUD Individual Counseling	70899-309
Family Psychotherapy (w/o Pt Present), 50 Min	90846	90846-1	Non Billable SUD Family Therapy	70899-307
Family Psychotherapy (w/ Pt Present), 50 Min	90847	90847-1	Non Billable SUD Family Therapy	70899-307
Multiple-Family Group Psychotherapy, 84 Min	90849	90849-1	Non Billable SUD Family Therapy	70899-307
Therapy Substitute	T2021	TBD		

Note: The Non-Billable Code Charge Description reflects the State's categorization of this code.

For more specific information on billing codes, refer to the [DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24]

Who can provide a family service?

Only an LPHA working in their scope of practice can provide family therapy. Pharmacists, RNs, LVNs, LPTs, and LOTs (and their respective Clinical Trainees) cannot provide and claim for family therapy services.

Family counseling may be provided by an LPHA or non-LPHA, within their scope of practice. Pharmacists, LVNs, LPTs, LOTs (and their respective Clinical Trainees), and Medical Assistants cannot provide and claim for family counseling services.

How can a family service be provided?

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

Where can a family service be provided?

Family services activities may be performed anywhere in the community or the home. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

Family Services FAQ

1. ***What is the difference between collateral sessions and family therapy?*** Depending on the nature of the contact or content of the session/service, collateral services may be part of an assessment, individual counseling, or family therapy/counseling service. In general, collateral sessions can include a variety of activities, whereas family therapy is more specific. Collateral sessions involve counselors meeting with a client's family or significant others that can support their treatment needs, focusing on the treatment needs of the client and how loved ones can support the client in his/her/their recovery process. These services may be educational or for information gathering. Collateral services may also include coordination of care activities that involve the family or significant individuals in the client's life. Family therapy, on the other hand, is specific to the 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.

Group Counseling

What is Group Counseling?

Group counseling is contact with multiple clients at the same time, where the focus is on the needs of the participants. Groups are held in a structured setting that allows for interactions with peers as an effective way to engage and promote behavioral and cognitive change in individuals with a SUD.

Groups claimed must have a minimum of two (2) and a maximum of twelve (12) clients present. One of those clients must be a Medi-Cal beneficiary for the group to be billed to Medi-Cal.

To claim the time for the provision of a group counseling service, there must be a corresponding progress note with the appropriate service billing code and participant list. For more information, see the Progress Notes section.

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.

Due to the need for each service claim to be tied to a provider's National Provider Identification (NPI) number, if more than one provider conducts a group service, each provider will need to do his/her/their own progress note documentation and billing. Each provider will need to document interventions that demonstrate specific involvement, and the specific amount of time involved in the group activity.

For Residential levels of care: Group counseling services are part of the daily bundled rates and cannot be billed in addition to the treatment day. Group counseling can count towards the required number of clinical hours needed each week when no more than twelve (12) clients are present in the group and the content is clinical in nature. There must be documentation on file to support that this service was provided. Group counseling is a qualifying service to be able to claim the treatment day.

For Withdrawal Management levels of care: Group counseling services are part of the daily bundled rate. It cannot be claimed as a standalone service in addition to the billing of the treatment day.

List of Participants for Groups

Each group provided must have a corresponding participant list that includes the names of all attendees for the group. It is recommended that the group topic or name, date, time, and rendering provider's name be noted so that it can be matched up with the respective progress note. The provider's signature is also not required but recommended to demonstrate that the provider conducted the group session as documented. As it is with other documents, a provider's signature should be accompanied by the provider's printed name, credentials, and date of signature. The need for participant lists applies to all groups claimed, regardless of level of care.

Group Counseling Billing Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Skills training and dev, Group, per 15 Min	H2014	70899-114	Non Billable SUD Group Counseling	70899-310
SUD Group Counseling	H0005	70899-131	Non Billable SUD Group Counseling	70899-310

For more specific information on billing codes, refer to the DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24

Who can provide Group Counseling?

Groups can be provided by a non-LPHA or LPHA. Interventions must be within the scope of practice of the provider. Pharmacists and their respective Clinical Trainees cannot provide and claim for patient education services.

How can Group Counseling be provided?

Group counseling services must be provided face-to-face or by telehealth. For groups conducted by telehealth, consent from all participants must be obtained and necessary security precautions

must be taken regarding Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2.

Where can Group Counseling be provided?

Groups can be provided anywhere in the community. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

Patient Education

What is Patient Education?

According to the State, it means "providing 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.

A few examples of Patient Education Groups…

- Providing information about health risks for intravenous drug users, such as HIV
- Presentation on the neurobiological effects of substance use
- Differences in gender-specific physiological effects of long-term substance use based on research

Patient Education Groups may be claimed even if the number of participants exceeds twelve (12) for the Intensive Outpatient Treatment (IOT) and Outpatient Drug Free (ODF) levels of care. The Skills Training and Development, Group (70899-114) H2014 code must be used to claim Patient Education Groups.

For Residential levels of care: Patient Education Groups are part of the daily bundled rate. There is no additional billing in addition to the treatment day. Group size can exceed twelve (12) and can count as a qualifying service to be able to claim the treatment day. Be sure there is documentation on file to support that this service was provided.

Sample: Group Counseling Progress Note

SAMPLE

GROUP COUNSELING SERVICE PROGRESS NOTE

Client Name: Patrick Star

MRN: 1000-12-3456

Date of Service: 11/01/22

Service Start Time: 1:34pm
Service End Time: 2:31pm
Total Service Time: 57 mins

Doc Start Time: 8:07am
Doc End Time: 8:12am
Total Documentation Time: 5 mins

Narrative: Writer conducted group, "Honesty in Recovery," 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. This writer explored with the group the importance of honesty in recovery. Client was more withdrawn in this session than usual, but participated with prompting. The group was encouraged to give input on what honesty in recovery means for them. Client seemed to be listening and reflecting on what his peers shared. 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. Client was able to share that he continues to feel guilty for lying to his family during his use. In closing, this writer had group members identify what new opportunities and positive outcomes have come about from embracing honesty in their recovery journey. 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. Plan is 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 enhancing communication to express his needs so that he does not bottle up emotions, which is a prominent trigger for him to use.

Provider Name: Max Model, RADT-I
Provider Signature: Max Model, RADT-I
Date: 11/03/22
Place of Service: Bikini Bottom Treatment Center

Group Counseling FAQ

1. ***Are all types of groups billable?*** To claim a service, there must be medical necessity. Hence, whether a group is billable will depend 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 make progress in his/her/their recovery. It is helpful to focus on what the intention of the activity is and ask, "how is this relevant to the client's substance use treatment?" or "how might this be beneficial for the client's recovery?" Additionally, be sure the documentation makes clear what the result or benefit of the client participating in this activity is.

The level of care must also be considered. At the residential levels of care, groups such as house meeting would not be considered "clinical" groups. 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. Structured activities that are solely about independent living skills or healthy recreational activities are not "clinical." If the purpose is to build skills necessary to prepare for reintegration back into the larger community and clinical interventions were provided to do so, the time spent may count towards the daily required number of hours. It must be clear in the documentation that such activities are intended to build skills and not simply to occupy the client's time.

2. ***What happens if there are more than twelve (12) clients in the group?*** Groups will be limited to twelve (12) participants only to bill. 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 two (2) groups. Alternatively, one client can be seen individually for a one-on-one session. 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 there is a pattern across any one provider or the agency/organization, where groups exceeding the maximum of twelve (12) clients are found during reviews, the services may be disallowed and result in recoupment due to the potential for fraud, waste, and/or abuse.
3. ***What if there is no corresponding group participant list for the group progress note?*** A single instance where a group progress note documented does not have a matching group participant list may not result in disallowance and/or recoupment. However, a pattern across any one provider or the agency/organization would be examined further for the potential of fraud, waste, and/or abuse.

Discharge Planning

What are discharge planning activities?

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

There is no specific billing code for discharge services. Billing for the time spent providing discharge planning services will be dependent on the nature of the session or service. If the session involves collaborating on the contents or development of a discharge plan, this may fall under individual counseling. Another example would be if, in preparation for discharge, the session/service revolved around the discussion of ways to utilize the relapse prevention skills learned while the client is at home, this would be individual counseling.

If the nature of the discussion is predominantly about what resources or linkages might be needed upon discharge, this may be claimed as care coordination.

For Residential levels of care: Discharge planning that is not centered around referrals and linkages is part of the daily bundled rates. However, the time spent on such activities, if it

involves the client's presence, can count towards the required number of clinical hours needed each week. For the time spent on discharge planning 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 is primarily to discuss potential resources or referrals that are needed upon discharge, this would be considered care coordination and may be claimed as such.

For Withdrawal Management levels of care: Discharge planning that is not centered around referrals and linkages is part of the daily bundled rates. It cannot be claimed as a standalone service in addition to the treatment day. If the service with the client is primarily to discuss potential resources or referrals that are needed upon discharge, this would be considered care coordination and may be claimed as such.

Who can provide a discharge planning service?

Discharge planning services may be provided by a non-LPHA or LPHA (within scope of practice).

How can a discharge planning service be provided?

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

Where can a discharge planning service be provided?

Discharge planning activities may be performed anywhere in the community or the home. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

Care Coordination

What is Care Coordination?

The following are billable care coordination activities:

- Coordinating with medical and/or mental health care providers to monitor and support comorbid health conditions
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups

The focus of care coordination is on treating the whole person, to integrate primary care and other systems of care that impact the client's SUD treatment. For example, our clients with a chronic substance use disorder who are involved with the criminal justice system are likely going to need greater care coordination services.

Keep in mind that the care coordination needs must be related to the substance use for the service to be billable to Medi-Cal. This will need to be clearly documented in the progress note.

Care coordination services can be provided with or without the client present.

For Residential levels of care: Care coordination is a standalone, billable service. There must be documentation on file to support the billing of this service. Since it is a separate billable service, care coordination cannot count towards the required number of clinical hours for the week. Due to licensing and certification requirements, be sure to include the start and end time of the service and the topic of the session/service on the progress note documentation for the care coordination activity.

For Withdrawal Management levels of care: Care coordination is a standalone, billable service. There must be documentation on file to support the billing of this service.

Care Coordination Billing Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Environmental Intervention for Med Mgmt Purposes	90882	90882-1	Non Billable SUD Care Coordination	70899-304
Preparation of Report of Pt's Psych Status	90889	90889-1	Non Billable SUD Care Coordination	70899-304
Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-1	Non Billable SUD Care Coordination	70899-304
Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-1	Non Billable SUD Care Coordination	70899-304
Prenatal Care, At Risk Assmt	H1000	70899-119	Non Billable SUD Care Coordination	70899-304
Targeted Case Management, Each 15 Min	T1017	70899-120	Non Billable SUD Care Coordination	70899-304

For more specific information on billing codes, refer to the DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24

Who can provide Care Coordination?

Care coordination can be provided by a non-LPHA or LPHA (within scope of practice).

How can Care Coordination be provided?

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

Where can Care Coordination be provided?

Care coordination services can be provided anywhere in the community or the home. However, outside of the provider site, be sure to document how the clients' confidentiality is ensured.

Same Day Billing

Transitioning clients from one level of care to another

Care coordination 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 care coordination 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 care coordination. This period of transition should be substantiated by documentation justifying each of the care coordination services provided.

For the Residential levels of care, clients will be able to stay for a short period of time (room and board only) after no longer meeting medical necessity for that level of care if 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 care coordination services during the additional days.

Lockouts between outpatient and inpatient/24-hour services do not apply for the date of admission or discharge. This means that there are no longer concerns about same-day billing for those clients transitioning between the two levels of care for the date of admission or discharge. For example, when a client is transitioning from an outpatient program to enter a residential program, the outpatient program can claim discharge services even if the client is admitting and staying overnight at the residential program on the same day.

In situations where the client is leaving the residential program to enter an outpatient program, the residential program may claim the treatment day (if applicable) even when the outpatient program claims the intake/assessment service/session. However, it is important to remember that the residential program can only claim the treatment day when all requirements are met for claiming a treatment day and the documentation supports this.

Review of Documents

Review of documents is not billable, except in the case of the LPHA when it is related to a client's diagnosis.

Examples of situations where an LPHA may bill for the review of documents:

- Review of the non-LPHA's ASAM-based assessment document for the purpose of establishing or confirming the client's diagnosis
- Review of an ASAM-based assessment document received from another provider to confirm and/or modify the client's diagnosis
- Review of other documents for determining, clarifying, and/or updating the client's diagnosis

These activities can be claimed by the LPHA using the Psychiatric Evaluation of Hospital Records (90885-1) code. Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees cannot provide and claim for review of documents.

The progress note documentation should clearly indicate how the activity is tied to diagnosing the client.

Non-LPHAs cannot claim any time for solely reviewing documents regardless of the purpose. It is permissible to review documents with the client in a session/service if it is relevant to the treatment of the client's SUD. The focus of the session/service is not the review of the document itself, but on the reason for the need to do so with the client (i.e., resulting discussion, need for explanation or clarification for the client to be properly informed, how the information may be used for further tailoring the client's treatment) and the progress note for the session/service should reflect this.

The following activities are not billable:

- Review of the physical exam
- Review of clinical chart records (i.e., last session progress note, treatment plan to prepare for next session, etc.)
- Completing the discharge summary for unplanned discharges

Consultations

In addition to being able to bill for the consultation between a non-LPHA and LPHA for the purposes of establishing a 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/her/their 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. Other situations might be for the transfer of clients from one primary counselor to another. In such instances, if the consultation is a necessary activity that is relevant to the client's treatment, it can be billed as care coordination. As with other consultations discussed earlier, it can be billed by both parties involved. There may be instances where a consultation needs to take place with a non-clinical staff member, who is not authorized to bill. For example, at the Residential programs a counselor may need to consult with a non-DMC certified support staff who is assigned the night shift at the home and had a noteworthy encounter with the client. In such cases, only the certified DMC provider may claim for the time. 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. This also includes group supervision or weekly treatment team meetings. If the nature of what is discussed is primarily an update on the client's status, it is not billable. If, during a regularly held treatment team meeting, there is a need for input regarding the client's course of treatment that results in a change in interventions or services that are needed, the time where this was discussed can be claimed, not the entirety of the duration of the team meeting.

Sample: Care Coordination Progress Note

PROGRESS NOTE

Client Name: Bart Simpson **Location:** Springfield Recovery Center **Type of Service:** Care Coordination

Date of Service: 11/22/22 **Start Time:** 2:36pm **End Time:** 2:52pm **Total Service Time:** 16 minutes

Doc Start Time: 5:09pm **Doc End Time:** 5:15pm **Total Documentation Time:** 6 minutes

Narrative: Counselor met with the client's sober living manager (see ATD on file) 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. Client was not present for this service. Counselor 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. 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. Next steps include follow up with sober living manager over the next few weeks in order to monitor 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. Ongoing coordination of care needed to help support client in reducing interpersonal conflicts that perpetuate behaviors associated with use and impact ability to maintain housing.

Provider Name: Sam Sample, RADT-I **Provider Signature:** *Sam Sample, RADT-I* **Date:** 11/23/22

Care Coordination FAQ

1. ***What is the difference between collateral and care coordination?*** Collateral involves the client's family or significant individuals in the client's life who may be part of their treatment. Although we may be collaborating with these individuals, this activity is separate from care coordination. Care coordination is specific to professionals or those of other systems of care involved in the client's treatment, such as law enforcement, court, social services, education, medical/physical health care, mental health services, etc.

2. ***I must transport the client to their psychiatrist appointment. Can I bill this as care coordination?*** No. Even though we provide care coordination for mental health needs that may impact a client's SUD, this does not mean that we can bill for the transportation provided to access such services. Transportation is not billable under the DMC-ODS.
3. ***My client has a telehealth appointment with their medical specialist. Can I bill care coordination for facilitating this?*** No. If, by "facilitating," this is to provide the client with access to a confidential space where a computer can be utilized for a telehealth service, then this is not a clinical service that is billable. If you must be involved in the meeting with the outside provider in a clinical manner, it may be billable depending on the medical necessity for the activity.

Clinician Consultation

Previously known as Physician Consultation

What is Clinician Consultation?

DMC-ODS LPHAs consulting with other LPHAs (non-MD) to support the client's care.

"Other LPHAs" may be either within or outside of the network. Consultations with licensed individuals outside of one's agency is permitted, given that the outside clinicians are also Drug Medi-Cal Organized Delivery System (DMC-ODS) providers.

The client is not present and involved in this service.

How is this different from consultations under care coordination?
Clinician consultation is intended for use in special circumstances where there is a complex case that may need to be discussed to address issues such as level of care considerations. It is designed to allow DMC-ODS clinicians the ability to seek expert advice on treatment needs specific to DMC-ODS clients.

Clinician consultations must be face-to-face and involve, at minimum, three (3) qualified LPHA from different specialties or disciplines (each of whom provide direct care to the client). The consultation is intended to involve development, revision, coordination, and implementation of health care services needed by the client.

Clinician Consultation Billing Code:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-1	Non Billable SUD Care Coordination	70899-304

For more specific information on billing codes, refer to the DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24

Who can provide Clinician Consultation?

Only non-MD LPHAs. Physicians, Medical Students in Clerkship, LVNs, LOTs, and LPTs (and their respective Clinical Trainees) cannot provide and claim for Clinician Consultation services.

How is Clinician Consultation billed?

Only the rendering provider can bill. The rendering provider must have performed a face-to-face encounter with the client within the previous sixty (60) days. Only the rendering provider connected to the client being consulted about may claim for the service. If all three providers are DMC-ODS providers, it is advised that the provider initiating the need for the consultation claim for the service.
Please be aware that this is different from consultations under care coordination where both providers can bill.

Physician Consultation

This is limited to only the Physician (MD/DO) and Medical Students in Clerkship. Consultations between Physicians/Medical Students with other Physicians/Medical Students within or outside of the network. Other medical-related LPHA include addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists. Examples of issues needing consultation include medication selection, dosing, side effect management, adherence, and drug-drug interactions. Physician consultations must be face-to-face and involve, at minimum, three (3) qualified LPHA from different specialties or disciplines (each of whom provide direct care to the client). The consultation is intended to involve development, revision, coordination, and implementation of health care services needed by the client.

Only the rendering provider connected to the client being consulted about may claim for the service. If all three providers are DMC-ODS providers, it is advised that the provider initiating the need for the consultation claim for the service.
Physician consultations must be face-to-face and involve, at minimum, three (3) qualified LPHA from different specialties or disciplines (each of whom provide direct care to the client). The consultation is intended to involve development, revision, coordination, and implementation of health care services needed by the client.

Physician Consultation Billing Code:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-1	Non Billable SUD Care Coordination	70899-304

For more specific information on billing codes, refer to the DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24

13. DISCHARGE

A discharge plan and discharge summary document are not required under DMC-ODS. It is permissible to continue with the practice of completing a discharge plan and/or discharge summary if your program so chooses. Furthermore, if your program has other regulating authorities to abide by (such as AOD Certification Standards), a discharge plan and/or discharge summary may be required. For the DMC-ODS, care coordination activities include discharge

planning. Therefore, it is expected that clients continue to receive support for transitions between levels of care and to other recovery and community resources/services, based on individual need.

Discharge Summary

What if the discharge summary is used to close the case?

For some programs, the completion of the discharge summary is what triggers the process for closing out the episode of care (EOC). If so, the discharge summary will generally be the last piece of documentation completed for any given chart. Please remember that once the EOC is closed, there is to be no other documentation or billing.

Can we bill for completing the discharge summary?

No, with Payment Reform and the State's focus on "direct client care," there is no longer any billing permitted for the completion of the discharge summary.

14. OTHER LEVELS OF CARE

Residential Treatment Services

What are Residential Treatment Services?

A short-term residential program offered in a clearly established site where clients are considered a "short-term resident" of the facility. All facilities will be required to obtain an ASAM LOC Certification and/or DHCS LOC Designation for each level of care provided. Each client will live on the premises and be provided with individualized services that address the impairments based on the ASAM Criteria to help restore, maintain, and apply interpersonal and independent living skills and access community supports. There are three (3) levels:

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

A few key things to note about the Residential Treatment levels of care:

- It is the only level of care that requires prior authorization for clients to receive services.
- Services are billed by the day (except for care coordination, MAT, and Recovery Services).
- The State does not "cap" the length of stay, however, the goal is thirty (30) days.

Services that may be provided at the Residential Treatment levels of care:

- Assessment
- Care Coordination
- Individual and Group Counseling
- Family Therapy
- Medication Services

- MAT for Opioid Use Disorder, Alcohol Use Disorder, and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

Residential Treatment Services Billing Codes:

Residential (Billed by the day)		
Level of Care/Type of Service:	*Billable CDM Code:*	*Non-Billable CDM Code:*
Residential 3.5	90899-674	90899-675
Residential 3.5 Perinatal	90899-692	90899-693
Residential 3.3	90899-844	90899-845
Residential 3.3 Perinatal	90899-888	90899-889
Residential 3.1	90899-638	90899-639
Residential 3.1 Perinatal	90899-656	90899-657

Billing at the residential levels of care is by the day. The client is not required to stay the night to be able to claim for the day rate. However, the client must receive one of the following services to bill the day rate: assessment, individual or group counseling, family therapy, medication service, patient education, or SUD crisis intervention service. There must be documentation in the client's chart to evidence that the qualifying service was provided.

Who can provide Residential Treatment Services?

Residential Treatment Services may be provided by non-LPHA and LPHA, within scope of practice. It is permissible for non-credentialed staff (i.e., unlicensed, non-certified, non-registered) to provide general supervision activities and transportation, however, they cannot bill.

How can Residential Treatment Services be provided?

Residential Treatment Services may be provided in-person, by telehealth, or by telephone. However, the State emphasizes that all residential treatment services claimed should be provided on-site and in person. If circumstances necessitate services to be provided by telehealth or telephone, it is advised to clearly document the reason.

For more information on documentation specific to the Residential Treatment levels of care, see sections above.

Recovery Services (RS)

What is RS?

Recovery Services is a level of care designed to support recovery and prevent relapse. It is not considered treatment. The focus is on restoring the client to their best possible functional level and emphasizes the client's role in managing their health by using effective self-management support strategies.

We can utilize RS as an ancillary service to other treatment services to help supplement the clients' efforts towards relapse prevention and self-management of their recovery. According to the State, clients may receive RS while also receiving treatment services at another level of care, including NTP and MAT.

Clients can self-refer to RS. Providers may also refer based on assessment of relapse risk. With client self-assessment, we will want to explore and document the client's preference or desire to enroll in RS as well as our clinical impressions of how it could be helpful for the client's recovery based on our interactions with the client. An assessment using the ASAM Criteria is needed to demonstrate how the RS level of care is necessary for the client.

A few key things to note about Recovery Services (RS):

- RS are a covered service for all treatment levels of care (see below for more information).
- RS are available to clients during or after substance use disorder (SUD) treatment.
- Clients without an in-remission diagnosis may also receive RS and do not need to be abstinent from drugs for any specified period.
- Clients may receive RS immediately after incarceration regardless of whether they received SUD treatment during incarceration.

Services that may be provided at Recovery Services (RS):

- Assessment
- Care Coordination
- Individual and Group Counseling
- Family Therapy
- Recovery Monitoring (Includes recovery coaching and monitoring for maximum reduction of SUD).
- Relapse Prevention (Includes interventions designed to teach how to anticipate and cope with the potential for relapse).

RS may be offered as a standalone DMC-ODS service. This means that clients not actively enrolled in treatment at any level of care are eligible to receive RS. For example, a client who does not wish to engage in ODF services, may rather participate in RS instead.

Recovery Services (RS) Billing Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code

Community Support Svcs, per 15 Min	H2015	70899-121	Non Billable SUD Recovery Svcs	70899-305
Psychosocial Rehabilitation, Indv, per 15 Min	H2017	70899-122	Non Billable SUD Recovery Svcs	70899-305
Psychosocial Rehabilitation, Group, per 15 Min	H2017	70899-123	Non Billable SUD Recovery Svcs	70899-305
Recovery Svcs, 1 Hr	H2035	70899-124	Non Billable SUD Recovery Svcs	70899-305

For more specific information on billing codes, refer to the DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24

Who can provide RS?

RS may be provided by non-LPHA and LPHA. Pharmacists, Pharmacist Clinical Trainees, and Medical Assistants cannot provide and claim for Community Support Services.

How can RS be provided?

RS may be provided in-person, by telehealth, or by telephone.

Where can RS be provided?

RS may be provided in the home or anywhere in the community.

RS Scenarios

Since RS can now be provided on its own or while the client is in treatment at another level of care, there are a few scenarios in which a client may be enrolled:

1. A client may be receiving RS as a standalone service, meaning that he/she/they are only involved in RS and no other service.
2. A client may be in one program, receiving treatment (such as ODF, for example), and RS as part of that treatment. Such cases are rare.
3. A client may be enrolled in treatment at one provider while receiving RS at another provider. Such cases are rare.

The sections below will detail more on each scenario.

Recovery Services (RS) as a Standalone Service

As a standalone service, the client receives RS at one program and no other services. There will be only one Episode of Care (EOC) open for the client receiving RS.

For such a client, if his/her/their diagnosis is "active" (meaning, not "in remission") and demonstrates the need for a higher level of care, be sure to document the reason why the client is in RS only and how the provider will support the client's needs at this level of care. For example, the client may need more frequent individual and/or group counseling sessions than what may be typical for a RS program or there may be more significant care coordination needs.

CalOMS is not required for standalone RS.

Initial assessment reminders for Recovery Services (RS) as a standalone service:

- Initial assessments should be completed as soon as clinically appropriate from the date of the client's admission. It needs to clearly document the client's need for RS. Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) should be looked at closely for areas that may compromise a client's sobriety. Documentation in this area will help to highlight how RS can help lower the risk and address beneficial relapse prevention supports.
- Establish how the client meets criteria for the DSM-5-TR diagnosis/diagnoses.

Recovery Services (RS) Problem List

- RS problem list should be specific to the client's needs, such as those identified in the initial assessment. Be sure to consider areas related to the client's relapse risk and/or supports needed to prevent relapse and promotion of the use of effective self-management strategies.
- There is no definitive timeline and should be implemented when clinically relevant to coincide with the completion of the initial assessment.
- The expectation is that it be updated (problems added or resolved) as clinically appropriate.
- Like the other levels of care, the items on the problem list do not automatically become resolved at the time of discharge. Problems should only be identified as resolved if it is applicable.

*****Before having a RS client attend individual/group sessions at the Residential facility, verify with the Department of Health Care Services' (DHCS) licensing and certification to ensure it would be permitted for non-residents (i.e., Alumni) to be onsite at the same time as current clients/residents.***

RS Concurrently with Another Level of Care in Another Program (2 different providers)

This scenario is where two different providers (or entities) are involved. There will be two EOCs opened simultaneously. One EOC for treatment (i.e., ODF, Residential, etc.) and one EOC for the RS. Please note that a client receiving both SUD treatment and Recovery Services simultaneously is not a common scenario. Both providers must establish medical necessity for their corresponding treatment type. Clinical judgment should be used to determine the need for concurrent involvement and the documentation must reflect this.

The treatment provider would continue to provide treatment services, and the RS provider would follow the same process as a client enrolled in a standalone RS program (see above in the prior section). Both providers should coordinate care with each other to ensure duplicative services are not being offered and to offer the best care for the client. The treatment provider and the RS provider should be providing and documenting

different services. For coordination of care, both providers must secure a valid Authorization to Disclose (ATD).

RS and Treatment Provided at the Same Provider

For this scenario, the client is receiving RS and another treatment level of care within the same program or entity. This means that the client is receiving RS as an additional service within his/her/their treatment episode at the program. Therefore, there is only one EOC (for treatment). Again, like the scenario above, please note that a client receiving both SUD treatment and RS simultaneously is not a common scenario. The client must meet the access criteria and need for both levels of care. Clinical judgment should be used to determine the need for concurrent involvement and the documentation must reflect this.

If it is identified at the time of the initial assessment for treatment, that the client would also benefit from RS, this should be documented in the initial assessment document. Although the information can be included anywhere, a good place to discuss this need would be in Dimension 5. The LPHA should also note the client's need for RS in the Case Formulation section of the initial assessment.

If the client has been enrolled in treatment for some time and it is determined that the client would now benefit from the addition of RS, this should be documented in a progress note for the encounter with the client where this was discussed. The documentation should clearly indicate the client's need for RS at this time. Be sure to update the problem list accordingly.

*****Before having a RS client attend individual/group sessions at the Residential facility, verify with the Department of Health Care Services' (DHCS) licensing and certification to ensure it would be permitted for non-residents (i.e., Alumni) to be onsite at the same time as current clients/residents.***

For clients who are at the Residential levels of care, although RS is now allowable, please note that in most cases it is to be considered part of the treatment day. There should be no additional billing for RS on top of the treatment day. Such situations are going to be rare that a client receiving Residential Treatment services would also benefit from the addition of RS. There must be clinical justification for the need of both.

What about clients who are completing treatment, but remaining with the same provider to continue with Recovery Services (RS)?

All treatment closing activities must occur, including completing CalOMS discharge, discharge plan, discharge summary and/or any other documentation required. A new EOC for RS only must be opened. Timelines will be re-set to match the newly opened RS EOC. Please follow the requirements for RS as a standalone service in the section above. CalOMS is not required for standalone RS. An example would be a client who is discharged from Residential Treatment Services and wishes to participate in RS at the residential program.

Withdrawal Management (WM)

What is WM?

The focus at the WM level of care is on stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided.

Services that may be provided at WM:

1. Assessment
2. Care Coordination
3. Medication Services
4. MAT for Opioid Use Disorder, Alcohol Use Disorder, and other non-opioid SUDs
5. Observation
6. Recovery Services

It is permissible for Care Coordination, Medication Assisted Treatment (MAT), Peer Support Services, and Recovery Services (RS) to be provided simultaneously with the client's enrollment in WM.

Observations at WM

Personnel who have been trained in detoxification services must conduct face-to-face physical checks of each client. These close observations must occur at a frequency of at least once every thirty (30) minutes as well as the monitoring of vital signs at least once every six (6) hours for the first seventy-two (72) hours of a client's admission. The observations and checks must be recorded in the client's file along with the signature of the personnel providing the service.

The frequency of observations may be discontinued or reduced after 24 hours of a client's admission based upon determination by trained personnel. There must be documentation on file in the client's chart to support the need for modification of the frequency. This applies to both the physical checks and the vital signs.

Trained personnel in detoxification services

Specific to the 3.2 Withdrawal Management level of care, personnel must complete the following:

1. Completion of six (6) hours of orientation training that covers the needs of residents who receive WM (for all personnel providing WM services or monitoring/supervising such personnel)
    a. If there is a break in employment of more than 180 consecutive days, the personnel must repeat the orientation training within fourteen (14) days of return to work
2. Completion of eight (8) hours of training that covers the needs of residents who receive WM services on an annual basis.

Documentation of the trainings must be maintained in the personnel records.

<u>WM Billing Codes:</u>

Withdrawal Management (WM)		
Charge Description:	*Billable CDM Code:*	*Non-Billable CDM Code:*
WM Residential Withdrawal Management 3.2	90899-779	90899-780

Who can provide services at WM?

WM Services may be provided by non-LPHA and LPHA.

How can WM services be provided?

WM Services may be provided in-person, by telehealth, or by telephone. However, since clients are residing on the premises for the 3.2 level of care, the State's emphasis for how services are provided at residential programs would be applicable. For services to be claimed, all services should be provided on-site and in person. If there are special circumstances that warrant the need for services to be provided by telehealth or telephone, it is advised that this be clearly documented.

Assessments at WM

A full ASAM-based assessment is not required for a client's admission to WM. The County's Brief SUD Level of Care Screening is sufficient to use for this purpose. If the assessment or screening at WM was completed by a non-LPHA, a consultation needs to take place between the non-LPHA and LPHA, since the LPHA is the only provider who can diagnose and determine whether a client meets the access criteria. Following the consultation, the LPHA must document his/her/their clinical impressions regarding the client meeting the access criteria and appropriateness for WM within seventy-two (72) hours of the client's admission. Please be mindful that the consultation needs to take place after sufficient assessment information has been obtained by the non-LPHA so that the LPHA has all the relevant information.

Be sure to document that the consultation was completed. This is a billable care coordination activity, if documented in a progress note. It is sufficient for the LPHA to document that the consultation was completed in the LPHA's required write-up or narrative, however, the time cannot be claimed if there is no separate progress note.

To facilitate an appropriate care transition, a full ASAM-based assessment or brief screening/tool such as the Brief SUD Level of Care Screening to support referral to additional services is appropriate. Although not required, it is good clinical practice to have documentation on file to support the client's readiness for discharge by demonstrating how the client's functioning across the ASAM Criteria warrants the need for a different level of care.

Treatment plans are not required at WM for DMC-ODS. Problem lists are sufficient (see section above on Problem Lists for more information). Please be mindful of any other regulations your program may need to abide by.

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

What is NTP/OTP?

NTP/OTP is considered an outpatient program (not to be confused with the outpatient level of care) that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary.

Services that may be provided at the NTP/OTP levels of care:

1. Assessment
2. Care Coordination
3. Individual and Group Counseling
4. Family Therapy
5. Medical Psychotherapy
6. Medication Services
7. MAT for Opioid Use Disorder, Alcohol Use Disorder, and other non-opioid SUDs
8. Patient Education
9. Recovery Services
10. SUD Crisis Intervention Services

NTPs/OTPs are required to administer, dispense, or prescribe medications covered under the DMC-ODS formulary including methadone, buprenorphine, naltrexone, disulfiram, and naloxone.

In addition to medication services, the NTP/OTP offers clients a minimum of fifty (50) minutes of counseling services per calendar month. Counseling services may be provided in person, by telehealth, or by telephone.

NTPs/OTPs conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS. This must be conducted in-person with the client.

Medical Psychotherapy, a counseling service, may also be provided by the medical director of an NTP/OTP on a one-to-one basis with the client.

NTPs/OTPs may be provided in conjunction with any other level of care treatment.

<u>NTP/OTP Services Billing Codes (*part of the dosing service):</u>

NTP			
Level of Care/Type of Service:	*CPT/HCPCS Code:*	*CDM Billable Code:*	*CDM Non-Billable Code:*
Psych Diagnostic Eval w/ Med Svcs, 60 Min*	90792	90792-1	70899-300
Assessment Substitute*	T2024	TBD	TBD
SUD Assessment*	H0001	70899-103	70899-300
SUD Screening*	H0049	70899-105	70899-300

SUD Structured Assmt, 15-30 Min*	G0396	70899-100	70899-300
SUD Structured Assmt, 30+ Min*	G0397	70899-101	70899-300
SUD Structured Assmt, 5-14 Min*	G2011	70899-102	70899-300
Targeted Case Management, Each 15 Min	T1017	70899-120	70899-304
Environmental Intervention for Med Management Purposes	90882	90882-1	70899-304
Preparation of Report of Pt's Psych Status	90889	90889-1	70899-304
Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-1	70899-304
Prenatal Care, At Risk Assmt	H1000	70899-119	70899-304
Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-1	70899-304
Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-1	70899-304
Inter-Prof Phone/EHR Assmt-Consult. MD 5-30 Min	99451	99451-1	70899-304
SUD Individual Counseling, 15 Min	H0004	70899-130	70899-309
SUD Group Counseling	H0005	70899-131	70899-310
OTP/NTP Methadone Dosing	H0020	90899-632	90899-633
OTP/NTP Courtesy Methadone Dosing	H0020	90899-786	90899-787
OTP/NTP MAT Antabuse Administration	S5001	90899-719	90899-720
OTP/NTP MAT Narcan (2-pack Nasal Spray)	S5001	90899-722	90899-723
OTP/NTP MAT Suboxone Administration	S5001	90899-728	90899-729
OTP/NTP MAT Subutex Administration	S5001	90899-731	90899-732
OTP/NTP MAT Courtesy Subutex Administration	S5001	90899-838	90899-839
OTP/NTP MAT Suboxone (Film) Administration	S5001	90899-862	90899-863
OTP/NTP MAT Sublocade Injectable Administration	S5001	90899-865	90899-866
OTP/NTP MAT Vivitrol Injectable Administration	S5001	90899-868	90899-869
OTP/NTP MAT Disulfiram Administration	S5000	90899-635	90899-636

OTP/NTP MAT Buprenorphine (oral) Administration	S5000	90899-734	90899-735
OTP/NTP MAT Courtesy Buprenorphine (oral) Administration	S5000	90899-841	90899-842
OTP/NTP MAT Buprenorphine w/ Naloxone (oral) Administration	S5000	90899-737	90899-738
OTP/NTP MAT Naloxone (2-pack Nasal Spray)	S5000	90899-743	90899-744
OTP/NTP MAT Buprenorphine w/ Naloxone (Film) Administration	S5000	90899-871	90899-872
OTP/NTP MAT Buprenorphine Injectable Administration	S5000	90899-874	90899-875
OTP/NTP MAT Naltrexone Injectable Administration	S5000	90899-877	90899-878
OTP/NTP Perinatal Methadone Dosing	H0020	90899-804	90899-805
OTP/NTP Perinatal Courtesy Methadone Dosing	H0020	90899-808	90899-809
OTP/NTP Perinatal MAT Antabuse Administration	S5001	90899-811	90899-812
OTP/NTP Perinatal MAT Narcan (2-pack Nasal Spray)	S5001	90899-814	90899-815
OTP/NTP Perinatal MAT Suboxone Administration	S5001	90899-817	90899-818
OTP/NTP Perinatal MAT Subutex Administration	S5001	90899-820	90899-821
OTP/NTP Perinatal MAT Suboxone (Film) Administration	S5001	90899-880	90899-881
OTP/NTP Perinatal MAT Disulfiram Administration	S5000	90899-823	90899-824
OTP/NTP Perinatal MAT Buprenorphine (oral) Administration	S5000	90899-826	90899-827
OTP/NTP Perinatal MAT Buprenorphine w/ Naloxone (oral) Administration	S5000	90899-829	90899-830
OTP/NTP Perinatal MAT Naloxone (2-pack Nasal Spray)	S5000	90899-832	90899-833
OTP/NTP Perinatal MAT Buprenorphine w/ Naloxone (Film) Administration	S5000	90899-883	90899-884
OTP/NTP Peri MAT Sublocade Injectable Administration	S5001	90899-890	90899-891
OTP/NTP Peri MAT Vivitrol Injectable Administration	S5001	90899-892	90899-893
OTP/NTP Peri MAT Buprenorphine Injectable Administration	S5000	90899-894	90899-895
OTP/NTP Peri MAT Naltrexone Injectable Administration	S5000	90899-896	90899-897

For more specific information on billing codes, refer to the [DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24]

Who can provide NTP/OTP Services?

NTP/OTP services may be provided by non-LPHA and LPHA.

How can NTP/OTP be provided?

NTP/OTP counseling services may be provided in-person, by telehealth, or by telephone. To provide synchronous audio-only counseling services without video capability, an NTP must submit a letter of need to DHCS to request an exception to the Title 9 requirement.

For Methadone treatment, the medical evaluation (consisting of medical history, laboratory tests, physical exam) must be conducted in-person.

NTP/OTP and the ASAM Assessment

An ASAM-based assessment is required to determine placement into the appropriate level of care, which is also applicable to the NTP/OTP level. In addition to the physical history and exam completed by the physician that establishes medical necessity, the level of care determination is also required. Under CalAIM, the level of care determination is separate and distinct from determining medical necessity.

The ASAM-based assessment used to determine the client's need for the NTP/OTP level of care may be completed, in part, by a non-LPHA or non-medical LPHA. He/she/they may gather the necessary information for each of the six (6) ASAM Criteria dimensions and the severity of risk for each. The LPHA (medical or non-medical within scope of practice) is responsible for documenting how the information from the six (6) ASAM Criteria dimensions justifies the client's need for NTP/OTP. There are two methods in which this may be completed:

1. The LPHA (medical or non-medical within their scope of practice) conducts the ASAM-based assessment himself/herself/themselves by meeting with the client (in person, by telehealth, or telephone) for an assessment session(s) and documenting findings and observations in an assessment document, or
2. The LPHA (medical or non-medical within their scope of practice) needs to consult with the non-LPHA who conducted the assessment session with the client (in person, by telehealth, or telephone) prior to the LPHA documenting how the client is appropriate for the level of care. The consultation can be completed in person, by video conferencing, or by telephone. The LPHA (medical or non-medical within their scope of practice) must then complete separate documentation to explain his/her/their determination.

IMPORTANT: Assessment and re-assessment services are only billable as separate services when there is no dosing service provided on the same day. The appropriate corresponding documentation in a progress note would be required for each "unbundled" service claimed. Dosing services include the following activities in the bundled rate:

- physical exam
- drug screening

- intake assessment
- medical director supervision
- TB, syphilis, HIV and Hepatitis C tests
- dosing
- ingredient costs

See the Assessment section for more information.

If a consultation between the non-LPHA and LPHA is needed, this must be documented to evidence that it took place.

Once a consultation is completed, the LPHA (medical or non-medical within their scope of practice) will be required to document his/her/their conclusion, based on review of the six (6) ASAM Criteria dimensions, as to how the client is appropriate for the NTP/OTP level of care. This means that information about the client's functioning in the six (6) ASAM Criteria dimensions should be used to explain how the NTP/OTP is the most appropriate placement for the client. Please be careful that this documentation is not a template or a "copy and paste." Although many of the clients at the NTP/OTP may have similar presentations, the documentation must be specific to the individual to prevent the appearance of fraud, waste, and/or abuse.

NTP/OTP and the Treatment Plan

Treatment Plans are still required in accordance with Title 9.

Medications for Addiction Treatment or Medication Assisted Treatment (MAT)

What is MAT?

Addresses Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders and includes all FDA-approved drugs and services to treat AUD and other non-opioid SUDs.

MAT for AUD and non-opioid SUDs may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care.

Services at MAT primarily consists of prescribing and monitoring MAT for AUD and Other Non-Opioid Substance Use Disorders (prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT services for AUD and Other Non-Opioid Substance Use Disorders). Other services that are included:

- Assessment
- Care Coordination
- Individual and Group Counseling
- Family Therapy
- Medication Services
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

<u>Medication Services Billing Codes (Outpatient MAT ONLY):</u>

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Psych Diagnostic Eval w/ Med Svcs, 60 Min	90792	90792-1	Non Billable SUD Assessment	70899-300
Assessment Substitute	T2024	TBD	TBD	TBD
Oral Medication Admin, Direct Observation, 15 Min	H0033	70899-109	Non Billable SUD Medication Services	70899-302
Medication Training and Support-Indv per 15 Min	H0034	70899-110	Non Billable SUD Medication Services	70899-302
Medication Training and Support-Group per 15 Min	H0034	70899-111	Non Billable SUD Medication Services	70899-302
Office OutPt Visit of New Pt, 15-29 Min	99202	99202-1	Non Billable SUD Assessment	70899-300
Office OutPt Visit of a New Pt, 30- 44 Min	99203	99203-1	Non Billable SUD Assessment	70899-300
Office OutPt Visit of a New Pt, 45- 59 Min	99204	99204-1	Non Billable SUD Assessment	70899-300
Office OutPt Visit of a New Pt, 60- 74 Min	99205	99205-1	Non Billable SUD Assessment	70899-300
Office OutPt Visit of an Established Pt, 10-19 Min	99212	99212-1	Non Billable SUD Assessment	70899-300
Office OutPt Visit of an Established Pt, 20-29 Min	99213	99213-1	Non Billable SUD Assessment	70899-300
Office OutPt Visit of an Established Pt, 30-39 Min	99214	99214-1	Non Billable SUD Assessment	70899-300
Office OutPt Visit of an Established Pt, 40-54 Min	99215	99215-1	Non Billable SUD Assessment	70899-300
Prolonged Clinical Staff Service, first hour	99415	TBD	TBD	TBD

Prolonged Clinical Staff Service, additional 30 min	99416	TBD	TBD	TBD
Home Visit of a New Pt, 15-29 Min	99341	99341-1	Non Billable SUD Assessment	70899-300
Home Visit of a New Pt, 30-59 Min	99342	99342-1	Non Billable SUD Assessment	70899-300
Home Visit of a New Pt, 60-74 Min	99344	99344-1	Non Billable SUD Assessment	70899-300
Home Visit of a New Pt, 75-89 Min	99345	99345-1	Non Billable SUD Assessment	70899-300
Home Visit of an Established Pt, 20-29 Min	99347	99347-1	Non Billable SUD Assessment	70899-300
Home Visit of an Established Pt, 30-39 Min	99348	99348-1	Non Billable SUD Assessment	70899-300
Home Visit of an Established Pt, 40-59 Min	99349	99349-1	Non Billable SUD Assessment	70899-300
Home Visit of an Established Pt, 60-74 Min	99350	99350-1	Non Billable SUD Assessment	70899-300
Prolonged Outpatient E&M, each 15 Min	99417	TBD	TBD	TBD
Telephone E&M Service, 5-10 Min	99441	99441-1	Non Billable SUD Assessment	70899-300
Telephone E&M Service, 11-20 Min	99442	99442-1	Non Billable SUD Assessment	70899-300
Telephone E&M Service, 21-30 Min	99443	99443-1	Non Billable SUD Assessment	70899-300
Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-1	Non Billable SUD Care Coordination	70899-304
Transitional Care Mgmt Svcs: Comm. w/in 14 days	99495	99495-1	Non Billable SUD Discharge Svcs	70899-306
Transitional Care Mgmt Svcs: Comm. w/in 7 days	99496	99496-1	Non Billable SUD Discharge Svcs	70899-306

Inter-Prof Phone/EHR Assmt-Consult. MD 5-30 Min	99451	99451-1	Non Billable SUD Care Coordination	70899-304

For more specific information on billing codes, refer to the [*DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24*]()

<u>Medication Services Billing Codes (MAT at Residential and Withdrawal Management ONLY):</u>

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Oral Medication Admin, Direct Observation, 15 Min	H0033	70899-109	Non Billable SUD Medication Services	70899-302
Medication Training and Support-Indv per 15 Min	H0034	70899-110	Non Billable SUD Medication Services	70899-302

For more specific information on billing codes, refer to the DMC-ODS Payment Reform 2024 CPT Guide v2 6.26.24

Who can provide MAT services?

MAT services can only be provided by LPHA Physician (Medical Doctor or Doctor of Osteopathy), Medical Student in Clerkship, LPHA Physician Extender (Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee), or LPHA Non-Physician (Pharmacist, Pharmacist Clinical Trainee, Registered Nurse, Registered Nurse Clinical Trainee, Licensed Vocational Nurse, Vocational Nurse Clinical Trainee, Licensed Psychiatric Technician, Psychiatric Technician Clinical Trainee). Medical Assistants may provide Oral Medication Administration and Medication Training and Support services. Licensed Occupational Therapists and Occupational Therapist Trainees may provide Oral Medication Administration.

MAT and the Treatment Plan

For those clients who receive MAT services within another program or level of care, there are some specific requirements as it pertains to the MAT treatment plan:

1. MAT must be determined to be medically necessary by an LPHA within his/her/their scope of practice. Due to the scope of practice restrictions, only the physician or MD (or physician extender) can make this determination.
2. A non-LPHA or non-MD LPHA is limited to referring the client for a MAT evaluation using an evidence-based assessment for MAT. The non-LPHA and non-MD LPHA cannot authorize MAT or state that the client needs MAT. This must be done by the physician or physician extender.

3. If MAT services are offered by the same provider (such as MAT in a Withdrawal Management program, for example), the MD or physician extender should review the evidence-based assessment completed by the non-LPHA or non-MD LPHA to indicate concurrence of the need for the client to be medically evaluated for MAT. If the MD determines that the client is appropriate for MAT services, he /she/they must clearly document how the client meets medical necessity for MAT and what the plan will be for administering the medication as it relates to the specific individual (i.e., MAT specific treatment plan). This would include information such as medication name, dosage, frequency, etc. A MAT assessment by the MAT provider to demonstrate the client's medical necessity for MAT services must be completed and medications prescribed within forty-eight (48) hours of a client's admission to the initial referring program (if coming to MAT from another provider).

For information specific to documentation within a MAT program, please refer to the MAT Documentation Manual accessible at: MAT Documentation Manual 2024

Peer Support Services

What are Peer Support Services?

Peer Support Services are culturally competent individual and group coaching services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate clients and their families about their conditions and the process of recovery.

Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the client by supporting the achievement of the client's treatment goals.

Peer support services are based on an approved plan of care (which means that there must be a treatment plan) and can be delivered and claimed as a standalone service.

Peer Support Services are available to all clients and may be provided concurrently with other DMC-ODS services.

Peer Support Services include the following service components:

- Educational Groups: a supportive environment in which clients and their families learn coping mechanisms and problem-solving skills for achieving desired outcomes. These groups promote skill building in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement: Peer Support Specialist led activities and coaching to encourage and support clients to participate in behavioral health treatment, which may include

supporting clients in their transitions between levels of care and in developing their own recovery goals and processes.

- Therapeutic Activity: a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the client's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the client, promotion of self-advocacy, resource navigation, and collaboration with the clients and others providing care or support to the client, family members, or significant support persons.

Peer Support Services Billing Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
Behavioral Health Prevention Education, Group	H0025	70899-128	Non Billable SUD Peer Support Svcs	70899-308
Self-Help/Peer Svcs, Individual, per 15 Min	H0038	70899-129	Non Billable SUD Peer Support Svcs	70899-308

Who can provide Peer Support Services?

Only a Peer Support Specialist who has obtained a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and meet ongoing education requirements may claim for services in a Peer Support Services Program. The following are the required qualifications to be a Peer Support Specialist:

1. Be at least 18 years of age;
2. Possess a high school diploma or equivalent degree;
3. Be self-identified as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver, or family member of a consumer;
4. Be willing to share their experience;
5. Have a strong dedication to recovery;
6. Agree, in writing, to adhere to a code of ethics;
7. Successfully complete the curriculum and training requirements for a Medi-Cal Peer Support Specialist; and
8. Pass a Medi-Cal Peer Support Specialist certification examination provided by a DHCS-approved certification program.

Medi-Cal Peer Support Specialists must provide services under the direction of a Behavioral Health Professional.

Where can Peer Support Services be provided?

Peer support services may be provided in a clinical or non-clinical setting.

Recovery Incentives (RI) Program (Contingency Management)

What is RI?

California is the first state in the country to receive Medicaid funding to offer Contingency Management. The County has elected, and the State has approved to pilot this new benefit for eligible DMC-ODS clients through the Recovery Incentives (RI) Program. Involvement in this pilot will provide the State with information to assess the effectiveness of such a benefit before determining whether it should be made available statewide. The pilot period will be through December 2026.

Only non-residential DMC-ODS provider sites that have been approved by DHCS for the pilot phase will be participating in the RI Program. As of January 2023, this is only the County operated outpatient clinics.

Contingency Management (CM) is an evidence-based treatment for SUD that utilizes motivational incentives to reinforce positive behavior change for an individual to reduce the use of substances. Through the RI Program, the focus will be specifically on stimulant use, where eligible clients may participate in a structured 24-week outpatient CM program. The first twelve (12) weeks consists of a series of incentives for abstinence from stimulants (verified by urine drug tests negative for stimulant drugs). Low-denomination gift cards will be used as the motivational incentive. Upon completion, clients may receive six or more months of additional recovery support services without incentives.

It is expected that CM be offered as complementary to other therapeutic interventions like cognitive behavioral therapy and motivational interviewing.

RI Program services include activities, such as administering point-of-care urine drug tests, informing clients of the results of the evidence/urine drug test, entering the results into the mobile or web-based application, providing educational information, and distributing motivational incentives.

To mitigate the risk of fraud, waste or abuse associated with the motivational incentive:

- Providers have no discretion to determine the size or distribution of motivational incentives, which will be determined by the State.
- Motivational incentives may be managed and disbursed through a mobile or web-based incentive management software program that includes strict safeguards against fraud and abuse.
- To calculate and generate the motivational incentives, providers will enter the evidence of the Medi-Cal client receiving the CM benefit into a mobile or web-based incentive management software program.

RI Program Services Billing Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Corresponding Non-Billable Charge Description	Non-Billable CDM Code
SUD Recovery Incentives, 15 Min	H0050	70899-118	Non Billable SUD Individual Counseling	70899-309

Who can provide RI Program services?

RI Program services may be provided by:

- Licensed Practitioner of the Healing Arts (LPHAs);
- SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies;
- Certified peer support specialists; and
- Other trained staff under supervision of an LPHA.

Medical Assistants cannot provide and claim using the SUD Recovery Incentives billing code.

Eligibility Criteria for RI Programs

DMC-ODS clients must meet the following criteria to participate in the RI Program:

1. Be a Medi-Cal beneficiary residing in Orange County (Medi-Cal eligibility should be checked monthly or per provider policy);
2. Demonstrate meeting the DSM-5-TR criteria for moderate or severe stimulant use disorder (the presence of additional substance use disorders and/or diagnoses does not impact the client's qualification for RI;
3. Based on the ASAM Criteria, determined to be appropriate for treatment at the outpatient level of care (clients transitioning to/from other levels of care may access RI, including on the date of admission/discharge without implications for multiple service billing*); and
4. Demonstrate that CM is medically necessary and appropriate.

*Clients at the Residential Treatment Services levels of care are not eligible for the RI Program until the day of discharge when they are transitioned to the outpatient level of care. RI Programs are responsible for confirming that admitted clients are not actively receiving Residential Treatment Services.

Clients may participate in RI, in addition to MAT. There is no minimum age limit so long as they meet the above criteria. Clients under the age of 21 are covered under the Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations. The RI program is open to pregnant and parenting individuals with stimulant use disorder who meet the above criteria.

CM should not be offered as a standalone treatment. However, clients needing CM cannot be denied participation in the RI program, even if they decline to participate in any other aspect of SUD treatment (e.g., ODF). Clients cannot be required to participate in any other SUD treatment

as a condition of receiving CM. Be sure to clearly document in the session/service progress note that the client was informed of the benefit of utilizing CM to complement the client's overall treatment program and the reason for decline if the client is only going to be receiving CM.

Treatment Schedule at RI Programs

There will be two phases that consist of the CM treatment phase (phase 1) and the CM continuing care phase (phase 2).

Phase 1 is a twenty-four (24) week outpatient program, which is split into two parts: weeks 1-12 will be the escalation/reset/recovery period while weeks 13-24 will be the stabilizing period.

Clients will be required to make two treatment visits per week for weeks 1-12. There must be at least seventy-two (72) hours in between each visit (e.g., Monday and Thursday or Tuesday and Friday). This is to minimize the chance that drug metabolites from the same drug use episode will be detected in more than one UDT. Each visit where the UDT indicates a negative sample for stimulants allows the client to earn an incentive. This is the "escalation" period as the initial value of the incentive is $10 and for each week (which is two consecutive UDTs negative for stimulants) the client demonstrates non-use of stimulants, the value increases by $1.50 (maximum total during this period is $438). Each encounter with the client where the UDT results are discussed, incentive is distributed, and any education is provided should be documented in a session/service progress note.

A "reset" is when the client tests positive for a stimulant or has an unexcused absence. The next time they submit a stimulant-negative sample, the incentive value will return to the initial $10 amount.

A "recovery" of the pre-reset value will occur after two consecutive stimulant-negative UDT sample. This means that the incentive value will return to the client's previously earned incentive level without having to restart the process no matter when the stimulant use occurs during the program. There is no penalty for positive samples, even if there are multiple positive UDTs in a row or even if the sample contains other substances. If the client is unable to achieve two consecutive simulant-negative samples within the phase 1 period, there should be a discussion between the provider and the client as to the appropriateness of CM as a clinical intervention and modify the course of treatment if needed. This should be clearly documented in the session/service progress notes and reflected through updates to the problem list.

In the stabilizing period (weeks 13-24), clients are expected to present for a treatment visit once a week. For weeks 13-18, clients are eligible to receive $15 per stimulant-negative UDT. For weeks 19-23, $10 per stimulant-negative UDT. On week 24, if the client's sample is stimulant negative, the client may receive $21 (maximum total during this period is $161). Each encounter with the client where the UDT results are discussed, incentive is distributed, and any education is provided should be documented in a session/service progress note.

Readmission

A client is considered a readmission if they leave the RI program for more than thirty (30) days. For readmission, a client will need a new ASAM based assessment. A client who has completed

their 24-week CM treatment episode and is re-admitting for a second treatment episode will not need a new ASAM based assessment. Also, if the client has been engaged in other services and only absent from the RI program, it is sufficient to update the most recent ASAM assessment. If the assessment determines that the client is clinically appropriate to receive CM, the incentive structure would restart at week 1 (maximum total may not exceed $599 per year inclusive of all incentives earned that year, which includes previous RI program participation).

If the client leaves the RI program, but returns within thirty (30) days, they can return to the schedule of incentives as if there was no break in service, if the maximum total does not exceed $599 per year inclusive of all incentives earned that year, which includes previous RI program participation.

Reaching the limit for incentives earned does not mean that the client must be discharged automatically. All other clinically appropriate treatment services and/or recovery supports should continue as determined appropriate for their individualized course of treatment.

Phase 2 begins upon completion of the initial twenty-four (24) weeks of CM. The client may receive CM continuing care for six (6) months of more with treatment services and recovery-oriented support from DMC-ODS providers to support their recovery. It is permissible for clients to receive Recovery Services during this period.

Documentation at RI Programs

Assessments should be completed as timely as possible and must clearly substantiate the client's diagnosis for a moderate or severe stimulant use disorder, justification for the client's appropriateness for treatment at the outpatient level of care, and medical necessity for CM. For information on the ASAM based assessment, see the Initial Assessment section. For clients assessed to have a co-occurring Alcohol or Opioid Use Disorder, be sure to conduct an evidence-based assessment for MAT to determine the need for a referral. See the section MAT Referral Assessment above for more information.

The client's stimulant use disorder diagnosis must be indicated on the problem list. For more information, see the Problem List section.

There must be a corresponding progress note for each claim associated with the use of CM. For more information, see the Progress Notes section. The following sections provide information on what should be included in the content of a progress note, depending on the type of encounter.

Orientation session/service

All clients participating in the RI program must consent to participation and receive an orientation or education session/service that clearly explains the program components and requirements. Additionally, clients must sign a RI program specific agreement. The orientation session/service should be documented to evidence that it was provided and may be part of the intake visit. The following areas to cover include:

- Clients must visit the site twice weekly during weeks 1-12 and once weekly during weeks 13-24.
- The process of readmission in the event of a lapse or relapse.

- Urine Drug Test (UDT) procedures as well as discussion of the medications/substances that could result in a false-positive.
- Rules related to when an incentive will be provided that includes –
    - Incentives being contingent on the absence of the evidence of any stimulant use (e.g., cocaine, amphetamine, methamphetamine) based on UDT results
    - An explanation that opioid testing will be done in addition to testing for stimulant use due to safety concerns in association with overdose deaths and how this will not impact the receipt of an incentive
    - All stimulant-positive tests will be treated the same, even if it is the result of use of medications/substances known to provide false-positive UDT results
- An explanation of how incentives will be delivered as well as how and where they can be redeemed/used. Incentives cannot be used to purchase alcohol, cannabis, tobacco, lottery tickets, or for any form of gambling.
- The amount of the initial incentive and how the value will increase with consecutive stimulant-free UDTs. The value will be re-set to a lower value in the case of a positive test or unexcused absence. Increases will be reinstated after repeated negative UDTs. The maximum incentive value per year is $599.

Documentation of visits

The rendering provider (also referred as the CM coordinator by the State) for the treatment visits of clients in the RI program will need to document the services provided. Be sure to document any "No show" or "excused/unexcused absences," as applicable. The following are the aspects of a treatment visit that should be reflected in the documentation as appropriate:

- Administration of the UDT
- Entering/logging the results of the UDT into the Incentive Manager program, a secure incentive distribution database designed to safeguard against fraud and abuse based on a set algorithm. The Incentive Manager will disburse incentives and track information on all incentives including the rendering provider, the format of the incentive provided, the date of distribution, and the amount.
    - If the UDT result entered is negative for stimulants, the Incentive Manager will disburse the incentive generated.
    - If the UDT result entered is positive for stimulants, the Incentive Manager will not disburse an incentive.
- Immediate delivery of the incentive amount set by the Incentive Manager in the format of an e-mail, hard copy, refillable gift card, or other mechanism approved by DHCS.
- Discussing the results of the UDT –
    - If tested positive for stimulants:
        - intervention to keep in mind is responding with **EASE**
            - **E**ncourage by using a non-judgmental and matter-of-fact approach
            - **A**pplaud their efforts to coming to the visit
            - **S**pecify that their next opportunity is very soon (discuss next visit)
            - **E**mpower by asking if there's anything you can do to support them, as appropriate

        - Communicate that they will not receive an incentive for the visit and remind them that they have another opportunity to earn an incentive in just a few days.
        - Review concepts of "reset" and "recovery"
    - <u>If tested positive for opioids,</u> there should also be documentation of a discussion to reinforce the risk of overdose, risk of exposure to fentanyl, harm reduction safety strategies (i.e., use of fentanyl test strips), ensure the client has naloxone, offer other treatment services, including MAT, as appropriate (positive test for opioids and oxycodone does not impact the ability to receive an incentive).
    - <u>If tested negative for stimulants:</u>
        - intervention to keep in mind is to respond with **JOY**
            - **J**oin them in celebration!
            - **O**ffer encouragement to keep up the good work
            - **Y**ield positivity by reminding them that they can earn even more with continued stimulant-negative test results
        - Communicate the incentive amount earned for the visit
        - Utilize Incentive Manager Portal to generate and disburse incentive. Be sure to clearly document that the incentive was given because of the negative UDT result for stimulants and the exact amount that was given.
    - If a client contests a positive test for stimulants, remain non-confrontational yet firm to relay that receipt of the incentive is contingent upon the objective evidence (i.e., UDT) and utilize EASE noted above.
- Review of the client's progress in the program
- Offering of other services if/as appropriate such as motivational interviewing, encouragement, and education (within scope of practice of provider)
- Encouraging client's engagement with other services (meeting with their counselor or LPHA)
- Plan for the next appointment

For billing, the stimulant use disorder diagnosis should be primary. The following codes may be used as a secondary diagnosis:

R82.998: positive UDT for stimulants

Z71.51: negative UDT for stimulants

Recovery Incentives FAQ

1. ***If an individual completes the program but has struggled to stay abstinent from stimulants and earned, for example, $300 in incentives, could that individual be enrolled for another 24-week treatment episode in the Recovery Incentives Program?***
   Yes, they can be enrolled for another 24-week treatment episode without any kind of waiting period if they have not earned more than the $599 limit in that calendar year. The CM Coordinator/Supervisor must be able to demonstrate that the client still meets all eligibility criteria including medical necessity, i.e., that they still have a current moderate

to severe stimulant use disorder. A new ASAM based assessment is not required. It is recommended that the UCLA Training and Technical Assistance team be contacted/consulted for these situations.

2. ***If the CM Coordinator spends more than 15 minutes with a client for a CM session, how should this be documented and billed?*** If the CM session itself requires more than 15 minutes and extends at least 8 minutes past the initial 15 minutes, you can bill for two 15-minute sessions using the H0050 billing code. There is no maximum number of minutes that can be claimed for this service. As with all other services, the amount of time claimed must be substantiated in the documentation. If the discussion and content of the CM session becomes more of a general counseling session, for instance talking about recent substance use and identifying a trigger and coping strategy, you can include the time spent addressing this into the CM service, using the H0050 billing code. A separate progress note is not necessary.

Protocol for Naloxone

Each RI program must have a protocol in place for prescribing naloxone to all clients with an opioid, sedative and/or stimulant use disorder as well as a protocol for naloxone distribution for those clients who do not obtain a prescription for naloxone. Clients are to be provided with education regarding the following:

- Risks associated with fentanyl, including its presence in other substances
- Harm reduction safety strategies (i.e., use of fentanyl test strips, harm reduction agencies that distribute test strips for home use from the California Department of Public Health)
- Education on the use of naloxone to reverse an opioid overdose

15. APPENDIX

Appendix A: Breakdown of the ICD-10 Codes of Z55-Z65

Breakdown of the ICD-10 codes of Z55-Z65

(From ICD-10-CM Section Z55-Z65)

The headings in RED and underlined are the ICD-10 headers and NOT actual diagnoses. The headers should not be used for progress notes, and they are NOT BILLABLE.

Z Codes that are highlighted in BLUE have been identified as the Department of Health Care Services' (DHCS) Priority Social Determinants of Health (SDOH) Codes.

Problems related to education and literacy

Z55.0 Illiteracy and low-level literacy
Z55.1 Schooling unavailable and unattainable
Z55.2 Failed school examinations
Z55.3 Underachievement in school
Z55.4 Educational maladjustment and discord with teachers and classmates
Z55.8 Other problems related to education and literacy
Z55.9 Problems related to education and literacy, unspecified

Problems related to employment and unemployment

Z56.0 Unemployment, unspecified
Z56.1 Change of job
Z56.2 Threat of job loss
Z56.3 Stressful work schedule
Z56.4 Discord with boss and workmates
Z56.5 Uncongenial work environment
Z56.6 Other physical and mental strain related to work
Z56.8 Other problems related to employment
  Z56.81 Sexual harassment on the job
  Z56.82 Military deployment status
  Z56.89 Other problems related to employment
Z56.9 Unspecified problems related to employment

Occupational exposure to risk factors

Z57.0 Occupational exposure to noise
Z57.1 Occupational exposure to radiation
Z57.2 Occupational exposure to dust
Z57.3 Occupational exposure to other air contaminants
  Z57.31 Occupational exposure to environmental tobacco smoke
  Z57.39 Occupational exposure to other air contaminants
Z57.4 Occupational exposure to toxic agents in agriculture

Z57.5 Occupational exposure to toxic agents in other industries
Z57.6 Occupational exposure to extreme temperatures
Z57.7 Occupational exposure to vibration
Z57.8 Occupational exposure to other risk factors
Z57.9 Occupational exposure to unspecified risk factors

Problem related to physical environment

Z58.6 Inadequate drinking water supply

Problems related to housing and economic circumstances

Z59.0 Homelessness
- **Z59.00** Homelessness unspecified
- **Z59.01** Sheltered homelessness
- **Z59.02** Unsheltered homelessness

Z59.1 Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.2 Discord with neighbors, lodgers, and landlord
Z59.3 Problems related to the living in residential institution
Z59.4 Lack of adequate food
- **Z59.41** Food insecurity
- **Z59.48** Other specified lack of adequate food

Z59.5 Extreme poverty
Z59.6 Low income
Z59.7 Insufficient social insurance and welfare support
Z59.8 Other problems related to housing and economic circumstances
- **Z59.81** Housing instability, housed
  - **Z59.811** Housing instability, housed, with risk of homelessness
  - **Z59.812** Housing instability, housed, homelessness in past 12 months
  - **Z59.819** Housing instability, housed unspecified
- **Z59.89** Other problems related to housing and economic circumstances

Z59.9 Problem related to housing and economic circumstances, unspecified

Problems related to the social environment

Z60.0 Problems of adjustment to life-cycle transitions
Z60.2 Problems related to living alone
Z60.3 Acculturation difficulty
Z60.4 Social exclusion and rejection (physical appearance, illness, or behavior)
Z60.5 Target of (perceived) adverse discrimination and persecution
Z60.8 Other problems related to social environment
Z60.9 Problem related to social environment, unspecified

Problems related to negative life events in childhood

Problems related to upbringing

Z62.0 Inadequate parental supervision and control
Z62.1 Parental overprotection
Z62.2 Upbringing away from parents
Z62.21 Child in welfare custody
Z62.22 Institutional upbringing
Z62.29 Other upbringing away from parents
Z62.3 Hostility towards and scapegoating of child
Z62.6 Inappropriate (excessive) parental pressure
Z62.8 Other specified problems related to upbringing
Z62.81 Personal history of abuse in childhood
Z62.810 Personal history of physical and sexual abuse in childhood
Z62.811 Personal history of psychological abuse in childhood
Z62.812 Personal history of neglect in childhood
Z62.813 Personal history of forced labor or sexual exploitation in childhood
Z62.819 Personal history of unspecified abuse in childhood
Z62.82 Parent-child conflict
Z62.820 Parent-biological child conflict
Z62.821 Parent-adopted child conflict
Z62.822 Parent-foster child conflict
Z62.89 Other specified problems related to upbringing
Z62.890 Parent-child estrangement NEC
Z62.891 Sibling rivalry
Z62.898 Other specified problems related to upbringing
Z62.9 Problems related to upbringing, unspecified

Other problems related to primary support group, including family circumstances

Z63.0 Problems in relationship with spouse or partner
Z63.1 Problems in relationship with in-laws
Z63.3 Absence of family member
Z63.31 Absence of family member due to military deployment
Z63.32 Other absence of family member
Z63.4 Disappearance and death of family member (assumed death, bereavement)
Z63.5 Disruption of family by separation and divorce (marital estrangement)
Z63.6 Dependent relative needing care at home
Z63.7 Other stressful life events affecting family and household
Z63.71 Stress on family due to return of family member from military deployment
Z63.72 Alcoholism and drug addiction in family
Z63.79 Other stressful life events affecting family and household
Z63.8 Other specified problems related to primary support group
Z63.9 Problem related to primary support group, unspecified

Problems related to certain psychosocial circumstances

Z64.0 Problems related to unwanted pregnancy
Z64.1 Problems related to multiparity
Z64.4 Discord with counselors

Problems related to other psychosocial circumstances

Z65.0 Conviction in civil and criminal proceedings without imprisonment

Z65.1 Imprisonment and other incarceration

Z65.2 Problems related to release from prison

Z65.3 Problems related to other legal circumstances

Z65.4 Victim of crime and terrorism

Z65.5 Exposure to disaster, war, and other hostilities

Z65.8 Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Z65.9 Problem related to unspecified psychosocial circumstances

Appendix B: Substance Use Disorder Diagnoses DSM-5-TR Criteria Guide

According to the DSM-5-TR, 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 there are repeated problems socially or in relationships because of use
			7. Less or stopped involvement in social, work, or pleasurable activities
			8. Continuing to use even though there have been instances of it being physically dangerous
			9. Knowing that the use is causing physical or psychological problems, but continuing anyway
			10. Signs of tolerance – needing more than you used to in order to get the same feeling OR using the same amount you used to does not achieve the effect it used to
			11. Signs of withdrawal – specific to substance or substance is taken to avoid withdrawal

TOTAL:

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

Appendix C: DMC-ODS Covered Diagnoses List For Residential & Withdrawal Management Levels of Care

ICD-10 CODE	CODE DESCRIPTION
F10.10	Alcohol abuse, uncomplicated
F10.11	Alcohol abuse, in remission
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.130	Alcohol abuse with withdrawal, uncomplicated
F10.131	Alcohol abuse with withdrawal delirium
F10.132	Alcohol abuse with withdrawal with perceptual disturbance
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F11.10	Opioid use, uncomplicated
F11.11	Opioid use, in remission
F11.120	Opioid use with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.13	Opioid abuse with withdrawal
F11.14	Opioid abuse with opioid-induced mood disorder
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission

F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder
F12.10	Cannabis abuse, uncomplicated
F12.11	Cannabis abuse, in remission
F12.120	Cannabis abuse with intoxication, uncomplicated
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.13	Cannabis abuse with withdrawal
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.23	Cannabis dependence with withdrawal
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.11	Sedative, hypnotic or anxiolytic abuse, in remission
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.130	Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated
F13.131	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium
F13.132	Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced mood disorder
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced sexual dysfunction

F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic, or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.11	Cocaine abuse, in remission
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.13	Cocaine abuse, unspecified with withdrawal
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.21	Cocaine dependence, in remission
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.11	Other stimulant abuse, in remission
F15.120	Other stimulant abuse with intoxication, uncomplicated
F15.121	Other stimulant abuse with intoxication delirium

F15.13	Other stimulant abuse with withdrawal
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.11	Hallucinogen abuse, in remission
F16.120	Hallucinogen abuse with intoxication, uncomplicated
F16.121	Hallucinogen abuse with intoxication with delirium
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.11	Inhalant abuse, in remission
F18.120	Inhalant abuse with intoxication, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.14	Inhalant abuse with inhalant-induced mood disorder

F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.17	Inhalant abuse with inhalant-induced dementia
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.188	Inhalant abuse with other inhalant-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.27	Inhalant dependence with inhalant-induced dementia
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.99	Inhalant use, unspecified with unspecified inhalant-induced disorder
F19.10	Other psychoactive substance abuse, uncomplicated
F19.11	Other psychoactive substance abuse, in remission
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.130	Other psychoactive substance abuse with withdrawal, uncomplicated
F19.131	Other psychoactive substance abuse with withdrawal delirium
F19.132	Other psychoactive substance abuse with withdrawal with perceptual disturbance
F19.14	Other psychoactive substance abuse with psychoactive substance-induced disorder
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance abuse-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium

F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder

ATTESTATION

I acknowledge that I have read the DMC-ODS Documentation Manual.

Printed Name: ________________________ Title: _______________________

Signature: ___________________________ Date: ____________

Program/Agency: ____