Clinical Provider Documentation Manual
Substance Use Treatment Services

2019

Santa Clara County
Behavioral Health Services Department,
Substance Use Treatment,
Quality Improvement Division

Project Manager:
Nancy Taylor, MFT, QIC
# Table of Contents

**CHAPTER 1: INTRODUCTION** ........................................................................................................... 7

- Overview and Purpose .................................................................................................................... 7
- Philosophy of Care ......................................................................................................................... 7
- Vision ............................................................................................................................................ 8
- Mission .......................................................................................................................................... 8
- Values ........................................................................................................................................... 8
- Strategic Priorities ....................................................................................................................... 9
- Determining Location of Treatment ............................................................................................. 9
- Treatment Modalities Covered by Manual .................................................................................. 9

**CHAPTER 2: PROGRAM OVERSIGHT** ......................................................................................... 11

- The 1115 Waiver .......................................................................................................................... 11
  - System Performance .................................................................................................................... 11
  - The Client Feedback Survey (CFS): .......................................................................................... 12
  - Out of County Clients ............................................................................................................... 12
- Client Records ............................................................................................................................. 13
  - Client Record Retention Requirements ..................................................................................... 13
  - Chart Order & Other Required Documentation: ....................................................................... 14
- Protected Health Information (PHI) ............................................................................................ 14
- Audits ........................................................................................................................................... 14
- Peer Utilization Reviews (UR) & Counselor Self-Checks: ............................................................ 14
  - Counselor self-checks: .............................................................................................................. 15
- Supervision Standards: ................................................................................................................ 15
- Signature Requirements: ............................................................................................................. 15
  - Provider Signature .................................................................................................................... 15
  - Client Signature on Treatment Plan .......................................................................................... 16

**CHAPTER 3: SCOPE OF PRACTICE** ............................................................................................ 16

- DHCS Regulations: ....................................................................................................................... 16
- Definitions: ..................................................................................................................................... 17
  - Certified or Credentialed: .......................................................................................................... 18
  - Pre-Certified/Credentialed: ....................................................................................................... 18
  - Community Workers and Peer Mentors: .................................................................................. 18

**CHAPTER 4: SCREENING, ADMISSION & TREATMENT** ....................................................... 18

- Screening: ..................................................................................................................................... 18
  - Adult Services ........................................................................................................................... 19
  - Youth General Referrals: .......................................................................................................... 19
    - Custodial Youth Referrals: ..................................................................................................... 19
    - Transition Age Youth (TAY): .................................................................................................. 20

**TIMELINES AND TREATMENT REQUIREMENTS** ...................................................................... 20
CHAPTER 5: ASSESSMENT STANDARDS

LEVEL OF CARE ASSESSMENT USING THE ASAM MODEL

Assessment for Residential Treatment

Assessment of Imminent Danger

STRENGTH BASED ASSESSMENT:

REQUERED ELEMENTS OF ALL ASSESSMENTS

CASE MANAGEMENT: ASSESSMENT & SERVICES

CHAPTER 6: DIAGNOSIS, MEDICAL AND CLINICAL NECESSITY

DIAGNOSIS AND MEDICAL NECESSITY

Diagnosis

Medical Necessity Determinates

Role of Physicians

DHCS Requirement of Face to Face Review for Registered Counselors

Clinical Necessity

Client no longer meets Medical Necessity for current Level of Care

CHAPTER 7: TREATMENT PLANNING

Strength Based Treatment Plan Development

Identifying Treatment Plan Priorities

The Treatment Plan shall include:

Problem Statements

Goals

Action steps

Target dates:

CHAPTER 8: PROTECTED HEALTH INFORMATION

Standard Authorizations, Acknowledgements, and Advisements:

Additional Advisement and/or Authorization forms:

Clients in Dependency Court

Clients in Methadone Treatment

Youth Services clients

Status Report Form (TSR and CSR):

Utilization of Encrypted Email Services
CHAPTER 11: SERVICE TYPES AND CHARGING REQUIREMENTS

DRUG MEDICAL ORGANIZED DELIVERY SYSTEM: ................................................. 57
TRAVEL TIME: ................................................................................................. 57
CLINICAL SERVICES AND CHARGING ............................................................... 58
Outpatient Services (ASAM Level 1) ................................................................. 58
Group Treatment Services................................................................. 58
Intensive Outpatient Services (ASAM Level 2.1) .............................................. 59
Partial Hospitalization Services (ASAM Level 2.5) * ........................................ 59
Case Management .................................................................................. 59

Residential Treatment (ASAM Level 3.1)* .................................................. 60
Withdrawal Management Services (ASAM Level 3.2-WM) .............................. 60
OTP/NTP (Opioid Treatment Program Services) (ASAM Level 1) * ................. 60
Additional Medical Treatment Services (MAT) ( Multiple levels of care) ............ 61
Recovery Services ................................................................................. 61
Outpatient Case Management Services: ..................................................... 62

SERVICE DEFINITIONS .................................................................................. 63
Individual Treatment Services .................................................................... 63
Intake ....................................................................................................... 63
Individual Treatment .............................................................................. 64
Treatment Planning .................................................................................. 64
Crisis Intervention .................................................................................... 64
Discharge Planning .................................................................................. 64
Family Treatment ..................................................................................... 65
Collateral Services ................................................................................... 65
Group Treatment Services: ................................................................. 65
Case Management (CM) ......................................................................... 66

RECOVERY SERVICES (RS) ........................................................................ 66
BILLING (SAME DAY-SECOND SERVICE) .............................................. 67
RESOURCES ............................................................................................... 67

CHAPTER 12: CLIENT PROBLEM RESOLUTION PROCESS ............................. 68
Notice of Adverse Benefit Determination (NOABD) ....................................... 68
Grievances, Appeals and Expedited Appeals ............................................... 70

CHAPTER 13: CALOMS DATA REVIEW .......................................................... 71

APPENDIX A: REFERENCE TABLES ............................................................. 72

Table 1: 4 Quadrant model ....................................................................... 73
Table 2: Steps to Engagement and Successful Treatment .............................. 74
Table 3: Service-Related Scope of Practice Crosswalk .................................. 76
Table 4: Timelines Overview ...................................................................... 77
Table 5: Residential ASAM Levels of Care1,2 ................................................. 77
Table 6: Levels of Care Placement Overview 1 .............................................. 78
  Levels 0.5 through 2.5 .......................................................................... 78
  Levels 3.1 Through 41 ......................................................................... 79
  Levels 3.1 through 4 -Continued 1 .......................................................... 80
  Withdrawal Management1,2 ................................................................ 81

Table 7: SUTS Transfer Grid ................................................................. 82
Table 8: Title 22 & Title 9 DMC Services Crosswalk .................................. 84
Overview and Purpose
This Clinical Documentation Manual is to be used by counselors as a reference guide and should be used along with SUTS and your agency’s Policies and Procedures and in consultation with your Program Manager to understand chart documentation requirements. Additional reference documents include SUTS issued Alerts, the Beneficiary Handbook, the Access to Treatment Handbook and the Business Operations Handbook. These are the standards for the documentation of clinical records used within the Substance Use Treatment Services’ provider network. These are the minimum requirements. Your agency may have other specific requirements or expectations. This manual includes information based on the following sources: The Intergovernmental Agreement, the California Code of Regulations, Department of Health Care Services (DHCS) guidelines, the Santa Clara County BHSD Substance Use Treatment Services policies & procedures, FAQs; contractual agreements and the Quality Improvement Program’s interpretation and determination of documentation standards. The manual applies to Santa Clara County contracted and county treatment providers for SUTS Behavioral Health Services.
While this version of the documentation manual has been modified in accordance with the ODS 1115 Waiver Pilot, documentation requirements apply to all SUTS clients, regardless of payor source. It is the official documentation guide for counselors, associates, supervisors, managers, trainers and SUTS Quality Assurance auditors.
Program and modality-specific documentation requirements have been included where possible. If there are any questions/concerns about which standard applies, please consult with your Program Manager.

Philosophy of Care
SUTS has developed a philosophy of client-centered and client-directed care that focuses on providing services, which are individualized to clients’ needs and directed by clients’ choices so...
they can have healthy and meaningful lives in their communities. These services are tailored for the client based on the American Society of Addiction Medicine (ASAM) model. The ASAM model supports and promotes a collaborative, participatory process of assessment and service planning where services are matched to each client’s unique multidimensional needs.

SUTS believes that Substance use disorders are chronic conditions that require a disease management approach throughout the recovery process - beginning with treatment and continuing beyond discharge from active treatment.

### Vision

The SUTS Continuum of Care is designed to ensure that individuals in need of Substance Use Treatment services are:

- Treated as individuals deserving of respect, regardless of their personal stage of readiness to change.
- Treated with an understanding of the whole person, their cultural perspective and beliefs, and with a focus inclusive of their current substance use issues and their mental health, physical health, living situation and social support network.
- Provided services at the appropriate level of intensity.
- Provided services in their preferred language and translation services must be available for beneficiaries, as needed.
- Linked to services in a timely manner including access to walk-in services where possible.

### Mission

The SUTS mission is dedicated to improving the health and well-being of individuals in our community who are affected by substance use disorders and to helping to achieve their hopes, dreams, and quality of life goals. To accomplish this, SUTS strives to deliver services in a manner that is non-stigmatizing, easily accessible and focused on whole person care. Services are offered within a trauma-informed, culturally and linguistically competent, and coordinated system of care. Services also take into consideration a person’s gender identification and sexual orientation.

### Values

- To deliver a state-of-the-art Organized Delivery System for Substance Use Treatment.
- To collaborate with our Providers to provide excellent customer service.
- To develop our Clinical workforce to provide services at the highest level of Best Practices in the Behavioral Health field.
- To work as a learning community, engaging providers, clients and the system in expansion and changes in service delivery.
❖ To meet the client “where they are at” using Stage of Readiness to Change principles.
❖ To meet CSCHS Triple Aims: Improved Outcomes & Customer Experience, and Reduced Costs.

Strategic Priorities

Behavioral Health focus is on improving clients’ experience of care, improving and maintaining optimal quality care for the diverse population of the County through a seamless Continuum of Care, and increasing health care value through cost-effective measures.

Determining Location of Treatment

It is common to find co-occurring Mental Health conditions in individuals with Substance Use Disorders, as well co-occurring physical illness. As SUTS and MH move forward to be one BHS Department, we will increase collaboration and cross referral with Mental Health as well as expand services with the County of Santa Clara Health System (CSCHS) medical providers. We may use the four-quadrant model (Ries, 1993 Minkoff K, Cline CA. 2002 & 2009 and Mauer BJ. 2009) to recommend the location of treatment for clients with different combinations of severity of mental health, physical health and substance use disorders. The graphic below only shows Mental Health/Substance use integration, while the more recent and complex “Clinical Integration Model” can be found in: Appendix A. Table1-4QuadrantModel

![Four-Quadrant Model](image)

(NASMHPD, NASADAD, 1998; NY State; Ries, 1993; SAMHSA Report to Congress, 2002)

Treatment Modalities Covered by Manual

The SUTS-BHSD Manual covers the following modalities:
❖ Outpatient Drug Free (OS)
❖ Intensive Outpatient Treatment Services (IOS)
While required data elements for intake/assessment and Treatment Plans are standard across Substance Use Treatment programs, the type and frequency of required client services differ by modality.

Our goal with this manual is to increase an understanding of documentation requirements with a focus on client engagement and Federal, State and County requirements for billing. To maintain simplicity and brevity, readers should refer to other documents for more details, including; the 1115 ODS Waiver Pilot, the DHCS, ODS Intergovernmental Agreement (IA), Exhibit A, Attachment 1 A, Title 22, Title 9 and other State & Federal guidelines. Counselors should also familiarize themselves with the new Beneficiary Handbook, the Business Operations Manual and new Grievance procedures. The SUTS P&P is currently being revised to reflect the changes due to the waiver implementation.

We request your patience as we all work to fully understand and implement the State, Federal and the 1115 ODS Waiver requirements into our P&P. Current SUTS P&P are still applicable until further notice.

For a deeper understanding of why documentation is required as outlined in the manual, we encourage you, the counselor, to refer to these resources as needed for clarification as well as consult with your clinic’s Clinical Supervisor, Program and Quality Assurance managers. Questions that are specific to your clinic or program modality, and that are not able to be answered at that level, should be directed to the SUTS Clinical Standards Coordinators and/or Adult and Youth Directors.

We also encourage you to utilize the many trainings offered through the Learning Partnership. Link: sccLearn Agency personnel should also consult with your supervisor for agency specific trainings.


**Steps to Engagement & Successful Treatment:** You will see the step symbol throughout the manual. This refers to critical clinical and outcome guidelines. See Table2.

⭐ Please Note: throughout the Manual, there are embedded Bookmarks and Hyperlinks primarily in blue. When you hover your mouse over these links, in the electronic copy, you will see the actual link. Press and hold your “Ctrl” button and then left-mouse click. This will take you directly to the location in the manual or the internet link of the item selected.

⭐ Definitions: A good reference for the terms used within the Intergovernmental Agreement with DHCS, please see the IA Agreement, § Exhibit A, Attachment A1, Section IV.

⭐ You will find the Table of Contents link TOC at the bottom of most pages for your quick access.

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**Chapter 2: Program Oversight**

The Department of Health Care Services (DHCS) has contracted with the Behavioral Health Services Department (BHSD) to provide Substance Use Treatment Services (SUTS) with Santa Clara County. SUTS must ensure Federal and State regulations are met under the contract. SUTS obligation is to monitor all provider agencies to ensure they are appropriately licensed and credentialed, follow all regulatory standards, monitor provider billing, process claims for reimbursement, conduct compliance audits, and offer training, quality improvement and technical assistance to the treatment providers.

**The 1115 Waiver**

The Medi-Cal DMC-ODS 1115 Waiver expands services and has added additional regulations on how those services are to be provided and monitored. SUTS services now fall under the Federal guidelines of; 42 CFR Part 438-Managed Care. SUTS now shifts to formally managing substance use treatments services for Medi-Cal beneficiaries and unsponsored clients as a Managed Care Plan. Clients are “beneficiaries” with a specific set of entitlements and rights of access to substance use treatment services. BHSD P&P for 42CFR 438 can be found here: BHSD 438 P&P

**System Performance:**

DMC-ODS requires specific performance metrics in areas such as network adequacy, timely access to care, appropriate placement, client engagement, authorization for Residential services, and quality of care, cost effectiveness, and client satisfaction. Multiple data measures will be
collected and reported to DHCS including but not limited to:

a. **Timeliness to Treatment Services**: The following metrics are tracked: time from initial screening/referral to 1st appointment, timely appointments, no-shows and other measures.

b. **Quality of Care Standards**: SUTS will ensure providers operate within their scope of practice, have documented evidence of fidelity to the ASAM model and medical necessity as well as requiring authorization for Residential Treatment services. SUTS will measure clinical and/or functional outcomes of clients along with other measures.

c. **Engagement**: Outpatient providers shall provide 4 client contacts within the first 30 days of treatment.

d. **Use of**: Evidenced Based treatment and practice guidelines.

The Client Feedback Survey (CFS):
This survey is to be offered a minimum of 2 times during client’s course of treatment. Please see graph below for frequency and time of delivery based on modality.

Also see ROM System Alert: 8/21/18 for more information. [ClientSurvey](#)

<table>
<thead>
<tr>
<th>OUTPATIENT AND RECOVERY SERVICES</th>
<th>NARCOTICS TREATMENT PROGRAM (NTP)</th>
<th>RESIDENTIAL</th>
<th>Withdrawal Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fourth (4th) treatment session</td>
<td>Fourth (4th) counseling session</td>
<td>Tenth (10th) day of the stay</td>
<td>Within seventy-two (72) hours from admittance</td>
</tr>
<tr>
<td>At or Near discharge</td>
<td>At or Near discharge</td>
<td>At or Near discharge</td>
<td>At or Near discharge</td>
</tr>
</tbody>
</table>

Out of County Clients

*Please Refer to DHCS Information Notice 17-036 as of July 28, 2017.* [DHCS IN 17-036](#)

All out of county Medi-Cal beneficiaries will be referred to their County of origin except:

1. *If a client is homeless or out of county but in transition of moving to Santa Clara County, the client may be admitted to treatment.*

2. *The provider will work with the client to ensure that they are working with SCC SSA to obtain or transfer Medi-Cal benefits. The counselor will document the client’s attempts to complete the Medi-Cal package and request verification of submission to SSA.*
3. Those clients who are already in the process of transferring Medi-Cal to SCC should present verification that the Medi-Cal package is in process with SSA.

4. When Medi-Cal eligibility is in dispute, then SUTS agencies should accept the client into treatment as an “unsponsored” client.

Client Records

All SUTS providers, regardless of DMC certification status, must establish, maintain, and update as necessary an individual client record for each client admitted to treatment and receiving services. This includes, but is not limited to: *(IA Agreement, § Exhibit A, Attachment A1, Section III, 00., 9.)*

- A client identifier
- Client date of birth
- Client gender
- Client’s emergency contact and if none, so indicate
- Referral source and reason for referral
- Appropriate Advisements, Authorizations and Acknowledgement of Receipts
- Client race/ethnicity
- Client address & phone number
- Client Authorization for treatment
- Date of admission; and Type of admission (LOC)
- Primary Counselor identified on TX plan

In addition, providers are required to include, in each client’s individual patient record, all activities, assessments and services. This may include but is not limited to:

- Intake and admission data, CalOMS, Health Screening Questionnaire (HSQ) and physical examination, where applicable
- Evidence of:
  - Compliance with minimum client contact requirements
  - Compliance with specific treatment modality requirements
- Care coordination with Mental Health and/or Primary Care
- Treatment Plans
- Discharge Plan
- Clinical Discharge Summary
- Continuing Services Justifications
- Proof of parental contact for minors
- Laboratory test orders and results
- Medication Dosage
- For pregnant and postpartum women, medical documentation must substantiate a client’s pregnancy & the last day of pregnancy. (*22 Cal. Code Regs., div. 3, subdiv. 1, Ch. 3, part 4, § 51341.1(c)*)

Client Record Retention Requirements

All SUTS providers must maintain the above documentation in the individual client record for a minimum of ten (10) years from the date of the last face-to-face contact with the client, in alignment with Health & Hospital requirements. Minor client records will be retained at least until the minor attains the age of 20 years, and in any case, for no less than ten (10) years following the minor’s
date of discharge or client care visit. (See VMC P&P: #321.8, dated 7/16/15)

**Chart Order & Other Required Documentation:**

All paper charts must contain a Chart Order sheet at the front of each chart, documenting left and right side for Audit review.

Required items that must be in the chart records include:

- Documentation of Medi-Cal eligibility status for each month in treatment. (This may be kept in a separate binder.)
- Identification of Primary Counselor on Treatment Plan.

Each site must all maintain a separate record of Group sign in sheets.

*(I A, § Exhibit A, Attachment A1, Section III., OO., 13.)*

**Protected Health Information (PHI)**

There are specific state and federal required confidentiality laws for all Clinical records that contain protected health information (PHI). All providers, both at the program and at the individual level, are required to safeguard the record against loss, defacement, tampering, or use by any unauthorized persons. Records must be stored in a double locked location and if transported, must always be maintained in a locked unit. All electronic devices containing PHI must also be secured.

Please refer to 45 CFR for complete details. [https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html](https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html)

**Audits**

SUTS QI is responsible for performing regular clinical audits. Audits conform to Federal and State regulations as applied within the Intergovernmental agreement (IA) for the ODS 1115 Waiver, as well as SUTS contract performance measures. SUTS Administration also conducts fiscal and administrative audits annually. The audits identify areas of compliance and deficiencies that may affect reimbursement. Please note that requirements may be subject to changes and revisions by DHCS and other contracting entities. Clinical standards will also be reviewed as part of the SUTS Administrative and DMC-ODS regulatory audit. The Waiver requires each modality to demonstrate that they are providing a minimum of two out the following five Evidenced Based Practices (EBPs): Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Trauma Informed Treatment, Relapse Prevention (Gorski Model) and Psychoeducation. Additional EBPs may be used but providers need to implement at least two of the above. EBPs interventions shall be incorporated into progress notes. Link to SUTS Quality Improvement: [SUTS QI](#)

**Peer Utilization Reviews (UR) & Counselor Self-Checks:**

Internal Peer Utilization Reviews (UR) must be conducted every quarter, reviewing a minimum 5% of all charts following contractual and standard DMC-ODS compliance and regulatory statutes.
Documentation of the UR per SUTS standards must be kept in the client chart. Each agency must document their review process and findings and submit regulatory disallowances to SUTS QI and to PBS billing for DMC recoupment of funds. Peer reviews allow the counselor and/or agency to catch patterns of errors and take corrective actions, request training, and improve outcomes.

**Counselor self-checks:**
All counselors should check their work in your agency’s EHR and/or via the County EHR to catch documentation and service errors. Remember, when signing a progress note, the counselor is attesting that they performed the selected service for a specified amount of time. Incorrect entries could result in problems with charging to the State. Deliberate fraudulent entries would have consequences that are more serious.

### Supervision Standards:
Clinical Supervision is critical in the substance abuse treatment field to improve client care, develop the professionalism of counselors, to maintain ethical standards and for the effectiveness as a SUD treatment program. It is expected that the providers will provide consistent, scheduled and structured clinical supervision. Providers will also establish policy and procedures regarding clinical supervision and utilize the requisites of the BBS and other credentialing bodies in providing and documenting clinical supervision hours.


### Signature Requirements:

**Provider Signature**
Signatures and corresponding dates are an integral part of the documentation process. The signature and date are a person’s attestation of the documentation, confirming the person completing the paperwork has all the qualifications to perform in that role. The signature and date signify the person is the one responsible for that information and its truthfulness. A signed and dated document in the medical / behavioral health record is officially a legal document. All documents must contain signatures in **black** ink or have a valid Electronic Signature and include the following:

**All recorded services, assessments, and plans must include:**

- The signature and printed name of the person providing the service (or electronic equivalent)
• The person’s type of licensure or certification and number adjacent to the signature.
• Date
All staff persons providing services for a client, throughout a treatment episode, must sign their own respective documentation.

Client Signature on Treatment Plan

If a client refuses to sign or is unavailable to sign the Treatment Plan, a progress note must document the refusal or lack of availability to sign. In order for an updated Treatment Plan to proceed without a client signature, the counselor must note in the progress notes the client involvement in the development of the Plan and document efforts to have the client sign the updated plan. The client must sign and date the Treatment Plan to signify that the Treatment Plan was collaboratively developed.

For additional information, about laws and regulations please refer to:
1. DHCS link to Federal, State and DHCS laws and regulations
2. DHCS Supplement 3 TN No. 13-038 : DHCS SUD Services
4. BHSD 42 CFR 438 Managed Care Polices: BHSD 438 P&P
5. 

Chapter 3: Scope of Practice

The Scope of Practice for a credentialed or licensed provider as defined by State, Federal and County regulations and ensures that counselors and ancillary staff are performing within the scope of their training and competence. Clinical services, for both substance use disorders and Mental Health disorders, are provided by Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (MFT), Licensed Professional Clinical Counselors (LPCC), Licensed Psychologists (Ph.D.) and registered Associates within those license types. Certified and pre-certified Rehabilitation Counselors may provide substance use treatment services. All staff must complete online ASAM trainings prior to providing services.

New staff should also attend the following trainings within the first 6 months of employment:
1) “Understanding SUTS System of Care, ASAM model and Clinical Standards”,
2) “Documenting to meet Medical Necessity for LOC Authorization in SUTS (ALOC)” and
3) “Stage of Change and Treatment Planning for SUTS Clinicians”

DHCS Regulations:
If a staff person is not registered or does not have a valid license or credential, as verified on the
appropriate licensing body’s website, she/he will not be able to provide direct services. Please refer to Business Operations manual, Chapter 2, Section 2.8. If a counselor allows their license or credential to lapse, they must immediately stop providing direct services and inform SUTS of this change.

Clinical staff must also obtain a National Provider Identifier (NPI) prior to offering services. See: NPPES Website and work with your Program Manager to obtain your NPI and submit our credentialing form to SUTS credentialing manager.

The type of services provided must also be in line with one’s abilities and experience, including specialized training, certification, and licensure. Your individual clinic and/or modality of treatment may have additional restrictions and/or requirements that would require co-signatures on your work.

**Definitions:**

**LPHA:** A Licensed Practitioner of the Healing Arts includes Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, and Licensed PhDs who have completed the licensing process and are current with their license with their governing board, either the Board of Behavioral Science or Board of Psychology. Registered ASWs, AMFTs, APCCs and pre-licensed psychologists who are _license eligible_ and working under the supervision of licensed clinicians are also considered LPHAs. They must be receiving the level of supervision required by their specific licensing board in order to function as an LPHA. *(See DHCS FAQ: LPHA Definition)*

TOC

LPHAs may determine diagnoses, validate medical necessity, and review, approve and sign treatment plans. This means that they do not require co-signatures for their own notes, treatment plans, etc., _except_ as required by their specific agency. County OTP/NTP programs operate under the supervision of a Medical Doctor with more conservative requirements.

**Note:** SCC SUTS policy is that pre-licensed LPHA’s may not sign off on treatment plans, medical necessity, and diagnosis for (pre)Credentialed, (pre)Certified counselors _unless_ they have completed all their required practicum hours and are preparing to take their final licensing test.

Also, see: [http://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx)

**Note:** All Counselors are responsible for keeping their licenses and credentials current and must provide copies of their license renewals to their manager. Managers are required to update SUTS with license updates and changes in staffing via the SUTS credentialing form.
Certified or Credentialed:
These terms are used interchangeably and refer to those counselors who have completed training specific to Substance Use Disorder Treatment and have passed credentialing process by their governing boards. (CCAPP, CADTP) Please note that CAADE (CA Association for Alcohol/Drug Educators) was reinstated as a certifying body commencing 3/11/19.  

Pre-Certified/Credentialed:
Refers to counselors who have registered with their governing boards, including Registered Alcohol and Drug Trainees.

Community Workers and Peer Mentors:
Currently do not require licensing but must complete all SUTS mandatory trainings. Please note that Credentialed or Pre-Credentialed providers may no longer apply a SUD diagnosis. This information will be covered under Chapter 6


See: Appendix A: Table 3 for Crosswalk for Services Scope of Practice Crosswalk-Table3SOS

Chapter 4: Screening, Admission & Treatment

Screening:

**Referrals for service are made in four different ways:**

1. Appointment–based
2. Pre-Authorization sites
3. Care Coordination referrals determined by the Quality Improvement Coordinators (QICs)
4. Same day walk-in or intake (“open access”)

Clients entering through Gateway (1.800.488.9919) or any Pre-Authorization sites are screened using the Gateway Referral for Services (GRS). Pre-Authorization sites also must complete the Authorization for Level of Care form (ALOC). The ALOC is used to indicate which TX modality and intensity of services will best serve the client’s needs and Stage of Change. All Providers must document the rationale for level of care placement. LPHA’s will document (verify) medical necessity using the ASAM assessment and DSM 5 criteria. (See Chapter 6)
Placement decisions may be made at the initial Screening (for example, client calls Gateway and requests Withdrawal Management) or during an Assessment or at any time during Treatment based on the client’s needs. **Note:** Effective 7/1/19, the GRS is only valid for 30 days and a new screening required if client has not been admitted within 30 days. There are exceptions to this rule. Please refer to the Alert issued 9/24/19. The ALOC continues to be valid for 30 days. An ALOC is required for every new opening of an episode in SUTS, when there has been a gap between referral and placement or if client has significant change in status. An ALOC for Residential placement authorization is not the same as a “admit ALOC” to a SUTS program. **GRS Alert**

➤ Please refer to Table 5, ASAM Residential Levels of Care: [Table5ResAsam](#). An additional resource for placement decision is the Minnesota Risk and Treatment Planning Matrices. **MATRIX**

**Adult Services**

- Gateway: Fills out Section A of the GRS which includes Client Demographic Information, Client Payor information, Criminal Justice Status, Referral Source, and Section B Screening Questions
- Medical-Homes use the ALOC for level of care placement.
- Methadone Screenings vary greatly based on referral source and admission type. They will, complete the ALOC. Please refer to the OTP/NTP P & P for specifics on these screening/intakes.
- Providers cannot refuse to admit a client/beneficiary based on a blanket restriction of an admission type (i.e., the diagnosis, type of illness or condition of the beneficiary).

**Youth General Referrals:**

Referrals from Juvenile Probation, the Department of Family and Children Services, community-based organizations, families and others are through the Youth Alexian Clinic, which is the Gateway referral site for youth. The contact for youth referrals is the Referral Coordinator at (408) 272-6594. Youth referrals for screening and assessment from Probation are entered into the Juvenile Automation System (JAS) using the Universal Referral Form (URF). The URF is valid for 60 days. The Referral Coordinator will “open” the client in the County EHR (Unicare/Profiler). If there is no prior admission, the Referral Coordinator will complete the GRS screening, and the case is assigned to a provider.

**Custodial Youth Referrals:**

In-Custody youth referrals are handled directly by the BHSD staff in Juvenile Hall. They will utilize
the ALOC for referral to Residential treatment and act as a Pre-Auth site. In-Custody youth needing Outpatient treatment are referred to the Youth Referral Coordinator.

**Transition Age Youth (TAY):**

Young adults who are 18-21 years old may be eligible for either the Adult or Youth systems of care dependent upon the ALOC assessment determination for the most developmentally appropriate placement. TAY clients may also be referred to Adult Withdrawal Management, Recovery Residences, or Residential when age and developmentally appropriate in consultation with QI.

**Documentation Tip:**

Document in the progress notes all forms and consents completed with the client at intake, including registration forms, health screening questionnaires, ALOC, acknowledgements, and parental involvement. Counselors should also document in the progress notes: the date the referral received, date of first contact with client, reasons for denial of parental involvement, and any other third party contacts that were made, provided the client had consented in writing to third party contacts (e.g. informing probation officer of receipt of referral and start of services). Note: CalOMS admission form completion should also be documented, which may not be at intake.

**Note:** If the intake and ALOC are completed and the client opened in your Cost Center, meeting medical necessity, you may charge for Intake. When a client is referred directly from one level of care to a higher or equal level of care the 2nd provider cannot charge a service on that same day at this time. For a Timelines Overview, please refer to Table 4: Table4Timelines

**Timelines and Treatment Requirements**

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Timelines</th>
<th>Process</th>
</tr>
</thead>
</table>
| **Intake**     | First Face to Face contact must be within ten business days of receipt of the referral | • Review all acknowledgements, advisements and consents.  
• HSQ must be reviewed with client and obtain client signature at admission.  
• Complete ALOC to determine/confirm LOC  
• Document Intake summary with description of symptomology, nature of impairment or distress and specific criteria indicating LOC.  
• Document your attempts to contact client. |
| Other Admission Procedures | Due within first 30 days | • HSQ must be reviewed & signed by MD within 30 days and prior to completion of TX plan.  
✓ HSQ includes determination of medical eligibility to participate in treatment by the M.D. within 30 days of admit.  
• Determine whether client had physical examination within last 12 months and obtain documentation of exam or document no exam and referral made for physical exam.  
• Diagnoses based on DSM criteria must be confirmed within 30 days of admit by LPHA with written documentation of face to face with non LPHA counselor. Non-LPHA will document diagnostic impressions.  
• Minors: Counselor must document attempts to involve client’s parents and seek parental consent and ongoing attempts to involve the family in treatment quarterly.  
• Complete full Biopsychosocial Assessment. |
| --- | --- | --- |
| Treatment Engagement | 4 clinical contacts in 1st 30 days | • All Outpatient clients should receive a minimum of 4 counseling sessions within first 30 days and as determined by individual need.  
• Client Feedback Survey to be completed by 4th visit. |
| ALOC | Admission, Discharge, Transfers, Authorization | • The ALOC form must be completed at Admit and at Discharge, for transfers and for residential authorization.  
• The 6 Dimensions should be regularly reviewed with the client, documented within progress notes and be reflected in the TX Plan. |
| Initial Treatment Plan | Within 30 days of admission for OS and IOS  
Within 10 days of admission for PHS | • Must be completed, signed and dated within 30 days of admission and client by primary counselor.  
• Must be reviewed by LPHA, if primary counselor is not a LPHA, within 15 days if OS, and must be signed and dated.  
• If counselor is unable to obtain client’s signature within 30 days, then this must be documented within the progress notes including reason for not obtaining the signature and the plan to obtain it.  
• Frequency, duration, and type of treatment (i.e. Individual, Group, and Case Management) must be documented on the TX Plan. |
| Encounter Type | Timelines | (OS/IOS/PHS continued)  
Process |
| Continuing Services Justification (CSJ) 6 months | Between 5th and 6th month of Treatment | This must be reviewed by the LPHA and signed and dated by the date CSJ is due when the primary counselor is credentialed or certified. LPHA’s may sign and date their own CSJ. Diagnosis and treatment LOC must be justified.  
*(See: IA Agreement, § Exhibit A, Attachment A1, Section III,0O.)* |
|---|---|---|
| Continuing Services Justification Annual | Between 11th and 12th month of Treatment | This must be reviewed by the LPHA and signed and dated by the date CSJ is due when the primary counselor is credentialed or certified. LPHA’s may sign and date their own CSJ.  
*(See: IA Agreement, § Exhibit A, Attachment A1, Section III,0O.,15.,1.)* |
| Discharge Plan | Developed during treatment & completed by discharge date | The Discharge Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources.  
Must be signed and dated by the counselor and the client with a *copy offered to the client and placed in the client record.* |
| Discharge | Within 30 days of last face-to-face or clinical telephone contact with client.  
*See Note* | Written clinical discharge summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary and discharge prognosis.  
Complete CalOMS Discharge Questionnaire.  
Use the CalOMS Administrative Discharge if client has left treatment and cannot be interviewed.  
ALOC & Client Feedback Survey completed at Discharge  
*Note: All documentation is required within 48 hours of date of service, thus when a client successfully completes treatment, the completion of DC should also be done at that time. The 30-day timeline is appropriately used for clients who stop attending treatment and it is unclear whether they are returning. DHCS allows for 30 days.* |
| Treatment Requirements | IOS Adult | Treatment must be a minimum of 9 and a maximum of 19 hours of structured programming weekly. |
| Treatment Requirements | IOS Youth | Treatment must be a minimum of 6 and a maximum of 19 hours of structured programming weekly. |
| Treatment Requirements | PHS Adult | Treatment must be a minimum of 20 hours of structured programming weekly. |

**Admission Criteria**

- Clients must be pregnant or with children 5 years or under. *(Note that PSAP provides treatment for non-pregnant women w children but that is separate from Perinatal services.)*  
- For pregnant and postpartum women, medical documentation that substantiates the client’s pregnancy and the last day of pregnancy.  
- Client must complete standard Lab tests, Vitals, UA and TB test.  
- Admit date is the first date the client meets with the Counselor.  

**Treatment**

- Treatment may include individual & group counseling, but must include parenting classes, pregnancy education, health, and nutrition counseling, co-ordination of care with OB-GYN, smoking cessation program, and
childcare is provided as able. Transportation and Case Management services are also offered.

| Treatment Plan | • Treatment Plan must reference Pre-Natal or Post-Partum issues. |
| Urine Testing | • UA’s are done randomly for all PSAP clients and weekly for pregnant women. |

### Outpatient Perinatal Specific Treatment Requirements

#### OTP/NTP Specific Requirements (Methadone)

| Intake | • Must conduct laboratory tests and certify fitness for treatment.  
|        | • Includes Physical Exam  
|        | • Client receives Narcan (Naloxone), education & completes receipt  
|        | • Treatment start date is the first day client receives medication. |
| Treatment Plan | • Initial Treatment Plan must be written within 28 days and must be signed by MD within 14 days.  
|        | • Subsequent Treatment Plans are required every 90 days from the date of admission.  
|        | • Step 27 Clients Treatment Plans are done annually |
| Discharge | • Discharge date is the last day of medication dosing.  
|          | • Clients must be discharged after missing 14 days of dosing while in Methadone Maintenance Treatment (MMT). |
| Frequency of Counseling | • Clients must receive a minimum of 50 minutes of counseling per calendar month except where the MD adjusts or waives said services. This must include a rationale for adjusting or waiving counseling services. The maximum reimbursable is 200 minutes per calendar month unless justified by MD in writing, in the client record.  
|          | • Clients with Step 27 require a minimum of one 50-minute counseling session per quarter  
|          | • Progress notes are documented in 10-minute intervals. |
| Consent for Methadone TX | • Federal consent must be signed at admission & re-signed within 30 days. |

### Residential Specific Requirements (ASAM Levels 3.1, 3.3 and 3.5)

| Encounter Type | Timelines | Process |
### Intake
First Face to Face contact with the client & starts clock for all Timelines requirements

| First face to face contact by counselor within 24 hours of admission | • Review all acknowledgements, advisements and consents.  
• HSQ must be reviewed with client and obtain client signature at admission.  
• Complete ALOC to determine/confirm LOC  
• Document Intake summary with description of symptomology, nature of impairment or distress and specific criteria indicating LOC. |

### Other Admission Procedures
Due within 10 calendar days

| • HSQ must be reviewed & signed by MD within 10 days and prior to completion of TX plan.  
• HSQ includes determination of medical eligibility to participate in treatment by the M.D. within 10 days of admit.  
• If client had physical examination within last 12 months, obtain documentation of exam or document no exam and referral made. Include on TX plan if needed.  
• Complete full Biopsychosocial Assessment.  
• Diagnoses based on DSM criteria must be confirmed within 10 days of admit by LPHA with written documentation of a face to face with non LPHA counselor. Non-LPHA will document diagnostic impressions.  
• Complete CalOMS admission form by 10th day. |

### ALOC
Admission, Discharge, Transfers, Authorizations

| • The ALOC form should be completed at Admission and Discharge for Transfers and Authorizations with authorization for Residential TX by SUTS QI.  
• The 6 Dimensions should be regularly reviewed with the client, are documented within progress notes, and be reflected in the Treatment Plan. |

### Initial Treatment Plan
Due within 10 calendar days

| • Must be completed, signed, and dated within 10 days of client's admission to treatment.  
• Must be reviewed and signed by LPHA within 10 days of admission if primary counselor is not a LPHA, |

### Updated Treatment Plans
As needed

| • Subsequent Treatment Plans are completed when a change in problem identification or focus of treatment occurs.  
• Must be reviewed and signed by LPHA by due date of updated TX plan if primary counselor is not a LPHA. |

### Discharge Plan
Completed by discharge date with client.

| • Addresses triggers for relapse, how to avoid/cope with them, and a support plan with referrals for ongoing care resources.  
• Must be signed and dated by the counselor and the client with a copy offered to the client & placed in the client record. |

### Discharge
Completed within 48 hours of last face to face or last clinical telephone contact with client.

| • Written clinical discharge summary of the treatment episode including duration of treatment, reason for discharge and discharge prognosis.  
• Complete CalOMS Discharge Questionnaire  
• Use the CalOMS Administrative Discharge if client has left treatment and cannot be interviewed  
• ALOC and Client Feedback Survey must be completed at Discharge |
<table>
<thead>
<tr>
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<th>Timelines</th>
<th>Process</th>
</tr>
</thead>
</table>
| **Intake** | First face to face contact by counselor within 24 hours of entry | • Review all acknowledgements, advisements and consents.  
• HSQ must be reviewed with client and obtain client signature at admission.  
• Complete ALOC to determine/confirm LOC. See note 1.  
• Document Intake summary with description of nature of impairment or distress and specific criteria indicating LOC.  
• Document Intake summary. |
| **Other Admission Procedures** | At admission | • Complete GRS if no not a Gateway referral. |
| **WM Care Plan, Diagnosis and Medical Necessity** | Within 48 hours of admit | • Diagnoses based on medical necessity criteria from DSM 5 must be confirmed within 48 hours by LPHA with written documentation of face to face with non LPHA counselor.  
• LPHA must document the criteria met specific to the substance use disorder diagnosis.  
• Complete Withdrawal Management Care Plan.  
• Care Plan must be completed, signed and dated by LPHA and client within 48 hours. |
| **Discharge Plan** | Completed by discharge date with client. | • The Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources.  
• Must be signed and dated by the counselor & the client with a copy offered to the client and placed in the client record. |
| **Discharge** | Completed within 48 hours of last face to face with client | • Written clinical discharge summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary and discharge prognosis.  
• Complete CalOMS Discharge Questionnaire  
• Use the CalOMS Administrative Discharge if client has left treatment and cannot be interviewed  
• Client Feedback Survey and ALOC is completed at Discharge |

1.ALOC from referring provider for WM may be used as intake ALOC if completed within 14 days of admission. If new ALOC is needed WM only may complete just Dim 1,2 & 3. For a complete review of all levels of WM please refer to Table 6, WM Table 6.

### Definition of Annual Period and Lengths of Stay

For the SUTS DMC-ODS the treatment year begins on July 1 and ends on June 30. This means that when tracking Residential Treatment episodes per year, we refer to the period between July 1 & June 30.

The length of Residential treatment services for adults ranges from 1-90 days with a 90-day maximum. The length of Residential treatment services for adolescents ranges from 1-30 days with a 30-day maximum. Per DHCS guidelines, perinatal clients may receive a length of stay for the duration of their pregnancy, plus 60 days postpartum, based on medical necessity.
Reimbursement through Medi-Cal allows for two non-continuous episodes of treatment in any one-year period. Adults and Youth may be authorized for one 30-day extension per annum. Additional treatment episodes may be authorized by QI, when medically necessary. These episodes cannot be charged to Medi-Cal and will be reimbursed through SUTS general funds.

Physical Examination Requirements

Each client in the Youth, Adult, Additional MAT and OTP/NTP systems of care, is to complete a Health Screening Questionnaire (HSQ) at admission, which must be signed & dated by the client. This HSQ is to be reviewed and signed by MD within 30 days of admission date in Outpatient. In Residential Treatment, the HSQ shall be reviewed and signed by the MD prior to the completion of the Treatment plan, which is due 10 days from admission date. In WM the HSQ shall be reviewed and signed by the MD within 24 hours of admit date (end of day). In all Modalities the MD must sign the HSQ prior to the signing of the Treatment Plan. In OTP/NTP and MAT, the client may have a Physical Exam upon admission. The MD is also providing the determination of medical eligibility for treatment services.

If the client *has* had a physical exam in the last 12 months, then the client is to obtain *written proof of completion* of that exam from the client’s Physician. This should include a summary of the exam, the MD Name, license number, signature date and contact information. The SUTS MD will review the exam paperwork and document that the client is appropriate for participation in SUD treatment services. This is documented on the HSQ, with the date of the exam, the date of the review by SUTS doctor with signature, license type, and number and date. Proof of the physical exam is kept in the Medical section of the client’s paper chart or most appropriate section in client’s EHR. Youth entering Residential treatment are required to complete a physical exam by the 30th day of treatment. (Community Care Licensing standard)

*Note: OTP/NTP and Additional MAT clients complete a more extensive version of the standard HSQ and have their intake physical at the clinic site.*

Clients who are unable to provide verification of a physical exam must have this as a goal on their Treatment Plan until the physical exam is completed. In addition, any identified medical issues are integrated into the client’s treatment plan under Dimension 2. This includes TB testing which is required for admission to Residential and Recovery Residences. It is the counselor’s responsibility to continue to encourage and assist the client in obtaining medical care and the exam throughout the treatment episode. (IA Agreement, § Exhibit A, Attachment A1, Section III,OO.,11. Physical Examination Requirements, i.-iii.)

*To review:*

Physical Exam:

a) Completed by MD/NLP/PA within 30 days of admit date in OS/IOS and 10 days in Residential or

b) Client provides proof of a Physical Exam done in last 12 months
If no exam:

c) Obtaining a Physical Exam is a Treatment Plan Goal until completed
d) If TB test need indicated by MD, OS/IOS/PHS counselor must assist client in obtaining.

Care Coordination

The *minimum* requirements for coordination with physical health (or mental health) involve:

a) Linking clients without a primary care physician to health services for immediate needs
b) Linking clients to a primary care physician/therapist if they do not have one at admission.
c) Linking clients without health insurance may involve providing case management to assist with linkage to health insurance benefits and a primary health provider.

This reflects an increased understanding of viewing the client as a “whole person” and recognizes that physical and mental health can play a significant role in substance use disorders.

**Documentation Tip:**

*If a client is unwilling to give a Release Of Information (ROI) consent to coordinate care with the Primary Care Physician, this must be documented in the progress notes, and notes should include evidence that the counselor made continuing efforts, using motivational enhancement interventions, to encourage the client to allow appropriate care coordination.*

**Documentation Tip:**

*The client’s Primary Care Physician and, if applicable, Psychiatrist, name and contact information should be documented in the chart both at the beginning of treatment and at discharge including a summary of care coordination efforts. All required consents should be completed and up to date.*

**Discharge Prognosis:**

It is required to include a written Prognosis in your discharge and to record the Discharge Diagnosis in your clinical discharge summary. This information should also be included on your progress note as well as an explanation as to why the counselor selected the prognosis.

Example: Prognosis may be identified as “Good, Fair or Poor”. ☐ Good  ☒ Fair  ☐ Poor

“Client has demonstrated understanding of his Relapse Triggers and developed strategies and new coping skills to support abstinence from alcohol use. Client has established support with parents who were previously distant and has started developing new friendships and support in AA. Client returns to live with his girlfriend who is still using Medical Marijuana.”

**Documentation Tip:**

*Residential discharges should be done in “real time” but no later than 48 hours from date of Discharge. This will meet the needs of Capacity management using electronic data transmission and will allow monitoring of capacity via Bed Census in BHSD EHR.*

(See: IA Agreement, § Exhibit A, Attachment A1, Section III,OO.,16.,i.-iii. for more information on discharges.)
Chapter 5: Assessment Standards

Assessment starts at the beginning of each episode of treatment and should include a thorough biopsychosocial evaluation, a risk assessment, the determination of SUD Diagnoses, determination of case management needs identified and summarized, and where applicable, and based on the counselor’s scope of practice, any mental health diagnosis. The complete assessment should also address and document client’s family and cultural issues, school and vocational issues, legal issues, preferred language and gender identity.

Assessment is an ongoing aspect of treatment and the counselor should evaluate the client’s progress and document areas of new concern at each contact. The State (DHCS) requires use of the American Society of Addiction Medicine (ASAM) criteria. ASAM structures multidimensional assessment around six dimensions, which represent different life areas that together impact assessment, service planning, and level of care placement decisions across addiction treatment, physical health, and mental health services. Each agency should determine what format (form) is used to complete the full biopsychosocial assessment.

Level of Care Assessment using the ASAM Model

Regular review of the client’s appropriate placement in the correct Level of Care is required to assure fidelity to the ASAM model. The confirmation of the appropriate level of care using the ALOC form is required at Intake, Transfers, and Authorization requests for Residential Treatment, requests for Recovery Residences and at Discharge. The form must be included in the client’s medical record. This review is to be clearly documented in the progress notes and should identify any increase or decrease in problem severity and risk rating for each Dimension. Regular review of the client’s treatment needs is important to gauge progress in treatment and to identify any new problem areas, goals, and action steps.

The ASAM model guides us to ensure the client is placed in the “least restrictive environment” for treatment; however, the criteria also direct the counselor to ensure the client is receiving the appropriate LOC for their needs.

The ALOC form (Assessment and Authorization Level of Care) must be completed whenever there is a change in the Level of Care needed for the client, whether to more intensive or less intensive services or to transfer to another clinic. The ALOC replaces the “Continuum of Care” form for transfers to same level of care and referrals to Recovery Residences (RR) (previously THU). The ASAM delineates a continuum of services with five levels of care, numbered Level 0.5 (early intervention) through Level 4 (medically managed intensive inpatient services). This is discussed
Whether you are required to complete a new ALOC determining factor is always whether the client’s severity rating or issues have changed since the ALOC in question at Intake or Discharge.

➔ Please refer to Table 5, ASAM Residential Levels of Care: Table5ResAsam.
➔ See Table 6 in Appendix A: Levels of Care Placement Overview: Table6LOC
➔ An additional resource is the Minnesota Risk and Treatment Planning Matrices. MATRIX

**Assessment for Residential Treatment**

When considering placement in Residential treatment the counselor should focus on risk of relapse, unsafe or high-risk living situation, and client’s inability to participate at a lower level of care. The counselor should determine if a client is sufficiently mentally stable to participate in treatment and does not have significant withdrawal needs that would require intensive Withdrawal Management services. The client must also be sufficiently medically stable in order to participate in treatment.

Adolescent criteria, while similar, focus on a client’s vulnerability to outside influences. (Please refer to “The ASAM Criteria”, third edition, Pages 90-104 for adolescent specific criteria.)

“All (ASAM) Level 3 programs serve individuals who, because of specific functional limitations, need safe and stable living environments and 24-hour care. This is needed to develop, practice and/or demonstrate the recovery skills necessary so that individuals do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care.”


Placement in Residential requires authorization by QI on the ALOC, with particular attention to assessment of risk or “imminent danger.” The provider must also assess what level of Residential care would best serve the client. Assessment of imminent danger requires determining the clients risk factors in the “Here and now,” with consideration of the clients History of risk in all 6 ASAM dimensions and the counselor’s degree of concern (How worried are you?). (“Three H’s”) (From The ASAM Criteria, 2013)

**Assessment of Imminent Danger**

Requires the presence of all the following three elements:

1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse)
2. The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated)
3. The likelihood that such adverse events will occur in the very near future.

Each dimension contains possibilities for imminent danger. Here are some examples:

1. Dimension 1
   a. Life threatening withdrawal symptoms.

2. Dimension 2:
   a. Severe physical health problems, when exacerbated by alcohol or drug use, result in the client needing urgent medical care, i.e. Emergency Room or hospitalization.

3. Dimension 3:
   a. Possibility of immediate danger to self or others due to exacerbation of mental health symptoms from intoxication, with prior recent events that substantiate this risk.

4. Dimension 4:
   a. Ambivalence or disinterest in change, especially in the light of potential high risks in other dimensions.

5. Dimension 5:
   a. Intoxication in the recent past has resulted in client engaging in severely risky behaviors, which have resulted in actual harm to the safety of self or others.

Examples of Dimension 6 issues that may contribute to risk are:

(From the ASAM Criteria, 2013, p.222-224):

- Living situation toxic to recovery: substance exposure, substance-infested environment, culture of substance-involved and antisocial behaviors
- Chaotic home situation
- Drug using family or significant others
- Lack of daily structured activity, such as school or work
- Patient’s functional deficits include greater than average susceptibility to peer or other influence

Remember that environmental exposure to alcohol and/or substance use does not, in and of itself, determine imminent danger. The environmental impact must be weighed against the client’s ability to withstand the influence of others in regard to substance use, both in the past and the present.

The concept of applying imminent danger is slightly different with adolescents in that we must add weight to the risk factors in Dimension 6 due to youth’s dependence on others for basic needs and external focus for motivation.

Strength Based Assessment:

It is important to include in your assessment the client’s strengths, protective factors and existing
social supports. Emphasizing strengths, in addition to deficits and problems, creates an opportunity to see possibilities, and options, and promotes change (Adams & Grieder 2005).

In your Assessment you should address the client’s:

1. Abilities, talents, prior and current accomplishments
2. Approaches that have worked well for them in the past in relation to achieve their goals.
3. Presences of active supports including family, friends, and relationships in the community.
4. Resiliency and an acknowledgment of the client’s capacity to meet their goals despite their current and past hardships and barriers, whether economic, emotional, or legal.
5. A recognition of their unique individual attributes, such as a sense of humor, physical abilities, vocational skills, tenacity intellect, etc.
6. Cultural and personal values and traditions, which are resources for emotional and social support and strength.

When you begin your interactions by identifying your client’s strengths, it improves client engagement and sets the groundwork for developing Strength Based Treatment Plans.

Required Elements of All Assessments

The following list includes those items required for a unified or integrated assessment to address co-occurring mental health and substance use treatment needs. SUTS expects that any assessment includes a comprehensive assessment of all 6 dimensions. These elements should be considered in any assessment and represent best clinical practice standards. A counselor must include all the items in an assessment that are relevant to their client and document what is not applicable and why. Each Dimension should have input, even if it is only “not applicable”.

Required elements for an assessment include:

1. Identifying information including emergency contact information
2. Primary counselor assigned to the client
3. Medical necessity indicating symptomology and functional impairment related to the client’s diagnosis. The description should include impairment in health, daily activities, social relationships, and living arrangements. (Dim 1-6)
4. A DSM/ICD diagnosis with primary SUD diagnosis (Dim 1 & 5)
5. A DSM/ICD Mental Health diagnosis where applicable and within counselor scope. (Dim 3)
6. Presenting & past alcohol or drug intoxication/withdrawal and pattern of use(Dim 1 & 5)
7. Current and past Biomedical/Physical Health Issues (Dim 2)
8. Developmental history (Dim 3 and possibly 2)
9. Presenting and past Mental Health issues, trauma and risk assessment (Dim 3)
10. Stage of Readiness to Change in all areas (Dim 1-6) (From Prochaska & Diclemente model of change)
11. Client Strengths (All)
12. Accommodations necessary to address language and other needs. (All)
13. Social, peer and community relationships (Dim 6)
14. Economic Status (Financial) (Dim 6)

15. Family & personal history, including substance use, ethnicity, immigration status, acculturation, preferred language(s), sexual orientation, spiritual beliefs and other practices that define the client’s personal and group identity (Dim 6)
16. Family or parent involvement both past and present, and family strengths. This should include family substance use and history (Dim 6)
17. Educational and/or vocational status and employment history (Dim 6)
18. Housing status and needs (Dim 6)
19. Legal issues and status past and present (Dim 6)
20. Clinical Summary and Recommendations for Level of Care and intensity of services (All)
21. Assessment summary has clinical descriptors, justification and diagnostic impression

(See: IA Agreement, § Exhibit A, Attachment A1, Section III, OO, 8, i, a.)

Case Management: Assessment & Services

Case Management includes a comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; transitions to higher or lower levels of SUD care; development and periodic revision of a client plan that includes service activities; communication, coordination, referral and related activities; monitoring service delivery to ensure member access to service and the service delivery system; monitoring the member’s progress; and, member advocacy, linkages to physical and mental health care, transportation and retention in primary care services.

**Case Management may include:**

a. Comprehensive assessment and periodic reassessment

b. Transition to a higher or lower level of care. Beneficiaries will be guided through the system of care, linkages will be made to ancillary services, and beneficiaries will be assisted in connecting the next needed level of care from detoxification through Recovery Services.

c. Development and periodic revision of a treatment plan that includes service activities.

d. Monitoring service delivery to ensure beneficiary access to service and the service delivery system. Providers may use case management services as an adjunct to outpatient and intensive outpatient treatment services to improve level of care from detoxification through Recovery Services.
e. Monitoring the beneficiary’s progress. Utilized as a method to provide thorough discharge planning that include access to ongoing Recovery Support Services, vocational rehabilitation, sober living housing, and access to childcare and parenting services to enhance the capacity of each beneficiary to achieve long-term recovery.

f. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services. The SUD counselor advocates for and monitors the beneficiaries progress of the linkages to physical and mental health care and other services, supporting including transitioning them to a higher or lower level of care, as needed.

Chapter 6: Diagnosis, Medical and Clinical Necessity

Diagnosis and Medical Necessity

Diagnosis
A Licensed or Pre-Licensed counselor, within their scope of practice, will determine a principle (primary) and, when appropriate, any additional Substance Use Disorder diagnosis. Credentialled and Pre-Credentialled counselors may give a diagnostic impression, but the actual diagnoses must be given by an LPHA after review of counselor’s assessment documenting all the critical issues of an individual’s symptomology, impairment, and distress. These diagnoses are determined through the assessment of the client and the LPHA review and based on medical necessity criteria from the DSM (5).

The LPHA must document the face to face (or phone) meeting with the counselor to review the assessment, confirm the Level of Care, provide the diagnoses, and include the justification for the diagnoses. Licensed or Pre-Licensed counselors may add a secondary Mental Health diagnosis. The purpose of the face-to-face consultation between the LPHA and the counselor is to confirm medical necessity. The counselor will bill this service as a CM consultation. The LPHA must document the service but may not bill for this service.

The diagnostic criteria always focus on functional impairment and distress. For youth this can include the potential risk of developing a SUD. The principal diagnosis must be a DSM Substance Use Disorder (SUD) diagnosis. For Drug Medi-Cal reimbursement, it must be a diagnosis included in the DHCS list of reimbursable diagnoses. Diagnosis may not be a deferred diagnosis. We use DSM 5 for medical necessity and ICD-10 for billing codes. Please refer to: Approved ICD 10 Codes

The diagnosis must be written with the ICD numeric code and the DSM written description.

Example: F10.20 (ICD) Alcohol Use Disorder, severe (DSM)

If the primary diagnosis changes during treatment, then the diagnosis in the client record must be revised and a new Treatment Plan must be created to reflect the new diagnosis. The Treatment Plan must then be reviewed by an LPHA to meet the criteria for establishing medical necessity for Substance Use Treatment Services, if the primary counselor is not a LPHA.

Substance use or mental health diagnosis reported by family members, spouse or others should
not be documented in the client record as a substantiated diagnosis. If there is collateral documentation of a diagnosis, it should be noted with reference to that document in your progress notes and/or assessment. Other documentation about self-report of a diagnosis from the client or others would state “client reports” or “as reported by …” Remember that if you include a mental health diagnosis that you as a LPHA determined through analysis of the diagnostic criteria you must also include planned treatment of said diagnosis in your Treatment Plan. Drug Medi-Cal requires providers to focus on medically necessary treatment with oversight by a LPHA and/or physician throughout all treatment episodes. Each client record must contain current documentation of “Medical Necessity Determinates” to justify both treatment, authorization and reimbursement.

Medical Necessity Determinates
Medical necessity is established with respect to current DMC Regulations [51341.1(a) & (h)], except in the case of MAT for which there are additional requirements. The following is a partial list of criteria used. **Note:** **DSM 5 diagnosis criteria are used to define the specific symptoms of the diagnosis and validate medical necessity specific to the substance(s) used.**

- Increased amounts of the drug
- Withdrawal Symptoms
- Preoccupation with the drug
- Increased frequency of use
- Unable to fulfill obligations
- Decreased personal functioning
- Symptoms of physiological dependence
- Unsuccessful effort to control use
- Diminished effect with same amount
- Social or interpersonal problems
- Persistent use in spite of negative consequences
- Recurrent physically hazardous situations

Please see the DHCS August 2016 Fact Sheet:
http://www.dhcs.ca.gov/services/adp/Documents/Title_22_Diagnosis_Medical_Necessity_DSM.pdf

The LPHA’s signature on the Treatment or Care Plan prescribes the type, frequency, and dosage of treatment. Medical necessity is therefore determined by the LPHA’s review of the Assessment, Treatment Plan, and the Diagnosis that is reached by applying the relevant DSM 5 and ICD 10 criteria.

**Role of Physicians**
Health issues and medical eligibility for the client to participate in treatment are determined via a
Health Screening Questionnaire (HSQ) and/or Physical Exam and the Assessment. The MD may determine specific recommendations for medical follow up, for example: “follow up with diabetes care, explore smoking cessation program, have a physical exam, etc.” These recommendations must be included on the client’s current Treatment Plan under Dimension Two. If the MD recommends Mental Health assessment or care than this must be documented under Dimension Three. MD’s must sign the HSQ and include their name, license, credential, and date. The Counselor must sign that they have reviewed the MD’s recommendations on the HSQ with their printed and signed name, license or credential and date. The counselor must actively assist the client in following up with recommended MH or Medical care and document those efforts within the client chart.

**DHCS Requirement of Face to Face Review for Registered Counselors**

The determination of Medical Necessity is described in the MHSUDS Information Notice No.: 16-044, 9/14/16. [Medical Necessity Notice](#)

“For clarity, counties must establish a process where there is a face-to-face interaction at the time the Medical Director, licensed physician, or LPHA are validating or verifying the determination of medical necessity. This face-to-face interaction must take place, at minimum, between the certified counselor who has completed the assessment for the client and the Medical Director, licensed physician, or LPHA. It would be allowable to include the client in this “face-to-face” interaction. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the client.”

*Note: This documentation is done by the primary counselor and the LPHA will document in a separate non billable note in the medical chart. The purpose of the face-to-face consultation between the LPHA and the counselor is to determine medical necessity and it can be billed as case management.*

Again, Medical Necessity, based on DSM Criteria are determined by an LPHA only.

**Clinical Necessity**

If the LPHA or doctor does not agree that the client meets SUD criteria for medical necessity, some bridge services should be provided to the client, but Drug Medi-Cal cannot be billed for these services. The counselor must communicate to their billing office that the services provided are not DMC billable. Clinically, the counselor should address the substance use issues and linkage to other services that may be indicated by the needs identified in the assessment.

**Client no longer meets Medical Necessity for current Level of Care**

When a client no longer meets medical necessity for their current LOC, they should be informed and moved to next less intensive level of care if they wish to continue in treatment. If this is not agreeable to the client for, whatever reason, they may request a second opinion. The current
provider should contact QI who will then assign the client to another provider for assessment. The first provider should ensure that the client is informed of the grievance procedures and provide the client with a “NOA” (Notice of Adverse Benefit determination).

*For example: A client has met all Treatment Plan goals, is abstinent and doing well. They would like to continue in Recovery Services and are transferred to that level of care.*

Or: A client has met all Treatment Plan goals, is abstinent and doing well. Their Probation officer insists they must remain in outpatient treatment or he/she will violate them. The counselor would contact the Probation officer (with appropriate consents signed) and help them understand that the client is doing well and no longer meets medical necessity for Outpatient LOC. The client is offered Recovery Services and agrees, case is transferred to that LOC.

**Chapter 7: Treatment Planning**

The provider shall prepare an individualized written Treatment or Care Plan in all modalities based upon information obtained in the intake and assessment process and in collaboration with the client. Recovery and Withdrawal Management Services require a “Care Plan”. The Treatment (or Care) Plan will be signed by the counselor and client within; 30 days of admission for Outpatient, Intensive Outpatient and Recovery Services (OS/IOS/RS), with 28 days for OTP/NTP, within 10 days for (Residential) and within 48 hours for Withdrawal Management.

The Treatment (or Care) Plan must be updated every subsequent 90 days in OS/IOS/PHS/RS (3 months for OTP/NTP), *unless* there is a change in treatment or significant event that requires a new Treatment Plan to be created. The Treatment Plan (including WM and RS Care Plans) acts as a “prescription” for the treatment services and should include the type and frequency of Individual, Group and Case Management Services. CM services may be indicated as a “range” such as: “CM: 1-3 x month” however individual and group services frequency must be specific to the client. The client’s strengths should be incorporated into every Treatment Plan along with incorporating the EBPs (Evidence Based Practices) to be utilized during treatment.

The WM Care Plan is to be completed by utilizing the three short-term strength-based objectives from the ALOC within 48 hours. Typical short-term Care Plan objectives might be; ‘Complete withdrawal from alcohol; Manage withdrawal symptoms asking for support from staff; transition to Outpatient (or Residential) Treatment.’

**Strength Based Treatment Plan Development:**

The biopsychosocial assessment identifies the client’s abilities, values, personal and social resources. The information gathered from the assessment is used to work collaboratively with the client to develop the Treatment Plan. The counselor will focus on what has worked well for the client in the past to determine future Action Steps. A counselor’s assessment of the client’s cultural
and personal values and traditions should be used to help the client reconnect with those values to establish their goals and identify family and community members who can assist them. Since change is an incremental process, it is important to remind the client of their past successes and to support resiliency.

**Identifying Treatment Plan Priorities**

The Treatment Plan should reflect the problems identified in the most recent biopsychosocial assessment. The client and counselor may prioritize 2 or 3 areas to be addressed on the Treatment Plan. All areas that are identified as areas of concern, however, should be documented in the progress notes and listed in the TX plan. Those problems that are not currently being addressed should be marked as Deferred and an explanation given in the progress notes.

For example:

A client may choose to focus only on immediate abstinence, dealing with cravings and developing a supportive recovery environment. The client may have also identified dental issues and depressive or anxiety symptoms during the assessment that will need to be addressed further along in treatment.

**The Treatment Plan shall include:**

**Problem Statements**

1. The Problem Statement identifies the client’s specific impairment or distress in life functioning that is related to the substance use diagnosis.
2. The Problem Statement should be correctly matched with the appropriate Dimension
3. The client’s Stage of Readiness to Change\(^1\) should be noted next to, and match, each Problem Statement on the Treatment Plan. (\(^1\) Prochaska & DiClemente, 1982; 1986)

**Goals**

1. Must be achievable, address the Problem Statements, and match the Stage of Readiness for Change for each problem.

**Action steps**

1. Developed collaboratively between the counselor and client. Action steps include counselor interventions and tasks the client has agreed to carry out
2. Action Steps help achieve the goal and are built upon the Client’s Strengths.
3. Action Steps must be **Specific**, **Measurable**, **Attainable**, **Relevant** and **Time-bound** (SMART)

**Target dates:** are agreed upon by the counselor and client for accomplishment of action steps and
Additional Treatment Plan Requirements:

1. The Treatment Plan must identify the current proposed type(s) of interventions and actions steps with **frequency and duration**, consistent with changes in Treatment focus.
2. The Treatment Plan must include a goal to obtain a physical exam if not done in last 12 months and when client has significant medical illness, a goal for the client to obtain appropriate treatment for that illness.
3. The Treatment Plan must be consistent with and indicate the **qualifying SUD diagnosis**.
4. If the client refuses to sign the treatment plan the provider shall document the reason for the refusal and the strategy to engage the client in treatment.
5. The plan shall include the designation of the Primary counselor.

6. The Treatment Plan must be cosigned by a (fully licensed) LPHA, if the primary counselor is credentialed, certified, or pre-credentialed.
   a. If the counselor preparing the Treatment Plan (or Care Plan) is a LPHA, it is not necessary for them to also sign in the additional signature line for Lead, Supervisor or MD (unless your clinic requires this).
   b. A review and signature by a MD may be required by individual agencies or clinics.
   c. Counselors should consult with their supervisor for specific instructions about agency or clinic-specific requirements.

7. Timelines for Treatment Plans and co-signature requirements are in Table 3: [Timelines](#).
8. The client should sign and *always* be offered a copy of the Treatment Plan and the counselor should document this in the progress Note.
9. The Treatment Plan **must** be offered in the client’s preferred language and in English.
10. The Treatment Plan must be current at time of discharge.

**Documentation Tip:**

*Progress notes should consistently reference the Treatment Plan and document client’s progress and barriers to accomplishing the Treatment Plan Goals and Action Steps within the correct Dimension. Group notes must also carry the thread of the TX Plan.*
What mental health and/or physical health services does the client need?

★ (For the complete list of TX Plan requirements see IA, § Exhibit A, Attachment A1, Section III, OO., 12.)

Chapter 8: Protected Health Information

Any verbal, written, recorded or electronic information that identifies or can identify a client is considered Protected Health Information (PHI). All counselors must complete mandated training that covers Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2 regulations upon employment and every year thereafter. HIPAA, 42 CFR Part 2, Title 22 and Title 9 and County P & P inform these Authorizations, advisements and acknowledgements. For information on required use of the BHSD “Authorization for Use or Disclosure of Protected Health Information” form, herein referred to as ROI form (Release of Information) please see SCVHHS Administrative P&P #585.12.

You will note that there are separate ROI for NTP, CDCR (Parolee), DWC (Dependency Wellness), WPC (Whole Person Care), Department 61, CAPS and Criminal Justice programs. SCC employees: See: https://hhsconnect.sccgov.org/sites/scvhhs/compliance/Pages/Authorization-Form.aspx

Best clinical practice regarding PHI requires that all authorizations, consents, and advisements be explained to clients in their preferred language and in a developmentally appropriate manner. This explanatory process is called informed consent and is mandatory. The process of informed consent ensures that clients understand “what” documents they are signing and “why” they are signing those documents. The signed authorizations and consents function as part of the legal record. All authorizations, advisements, and acknowledgements must be completely filled out, signed, and dated. Authorizations have various timelines; most require annual update.

Standard Authorizations, Acknowledgements, and Advisements:

1. Authorization for Use or Disclosure of Protected Health Information form (ROI)
2. Group Confidentiality Agreement
3. Consent to Treatment
4. Notice of Privacy Practices and Acknowledgement of Receipt (HIPAA)
5. Client Rights and Program Rules
6. Emergency Contact Authorization (including type of or no message to be left).
7. Third Party Consents which must include Notice of Prohibition of Redisclosure of Information
8. Review of Beneficiary Handbook which includes:
   a. Adverse Benefit Determination
   b. Privacy Practices and Confidentiality
   c. Problem Resolution process:
      i. Appeal
      ii. Fair Hearing
      iii. Grievance Process

Additional Advisement and/or Authorization forms:

There may be other requirements based on program or client type or agency. This list may not include all of the forms required at your clinic or agency. Please check with your supervisor to ensure that the correct forms have been completed for each client:

**Clients in Dependency Court**
1. Dependency Wellness Court Authorization.

**Clients in Methadone Treatment**
1. Authorization for Methadone Treatment
2. Informed Authorization for Naloxone Administration
3. Multiple Program Registration Authorization
4. Authorization for Examination and Treatment
5. Heart Risks of Methadone
6. Benzodiazepine Policy

**Youth Services clients**
1. Record of Parent Contact

Minors (12 years and older) can consent for their own treatment, if they are found mature enough and developmentally appropriate to consent. Any parental involvement for minor seeking treatment, must involve a written Authorization per 42 CFR. DMC expects quarterly documentation of why a parent is NOT directly involved in the youth’s treatment.

**Status Report Form (TSR and CSR):**

Many clients are referred to the System by outside agencies, such as: Criminal Courts;
Department of Corrections; Pre-Trial, Probation, and Parole Agencies; the Social Services Agency; Family Court, and the Juvenile Dependency Court. The Treatment Status Report (TSR) Form is the standard tool for this communication process for treatment providers and the Client Status Report (CSR) is used by RRs. CSR’S are also used to communicate status of client between Outpatient and Recovery Residence. Youth has its own version of the TSR. SUTS does not permit other types of status reporting, such as personalized letters written by counselors. TSRs prepared without the client present may not be charged as Case Management.

Utilization of Encrypted Email Services

All electronic communications containing PHI must be done using encryption software. Please consult with your Program Manager, if you work in a contract agency, to identify which service you use and how to create and open/read a secure email. The County providers will enter “sccsecure” in the subject line of their emails when transmitting PHI.

Additional Links: Title 22: TITLE 22-2010 Title 9: Confidentiality: CCR10155

Chapter 9: Progress Notes

The “Golden Thread"

It is essential that clinical documentation reflect the individual client’s story, treatment needs and demonstrate medical necessity for care. The golden thread links the processes of treatment starting with engaging the client, conducting the assessment, formulating the Treatment Plan, providing services and documenting progress towards treatment goals in the progress notes. The thread of documentation establishes a written and legal record of the course of treatment. It provides the information needed for both guiding the treatment process and for billing purposes. Progress notes are individual narrative summaries and may differ substantially based on location and services provided. There are, however, common elements that must be present in all progress notes based on Title 22, DHCS ODS IA and best clinical standards practices. Please refer to: Title 22 51341.1 and IA Agreement, § Exhibit A, Attachment A1, Section III,OO.,14., i.

Documentation of all services is required regardless of reimbursement, including no shows and cancellations. Progress notes must include the topic or purpose of the session, for all service types. In addition, notes must include the problem(s) addressed, specific interventions, and
responses to these interventions and must have enough detail to accurately describe the client’s individual story. Generalized statements such as, “Client completed relapse prevention plan”, does not address a description of progress. Content, such as personal triggers, specific warning signs, and people the client can turn to when in distress, etc., provides a more thorough understanding of progress.

Notes should refer to the client’s strengths and the efforts the counselor has made to help the individual meet their goals and objectives. Progress notes must demonstrate the client’s treatment progress in achieving the Treatment Plan identified problems, corresponding client goals, objectives, and action steps with respect to the client’s specific stage of change in each area.

Notes should reflect the application or utilization of Evidenced Based Practices (EBP) during the course of treatment. They should also show whether services were offered in the client’s preferred language, including whether any paper handout given to the client was in client’s preferred language. Specific EBP’s may also be included in the Treatment Plan.

Note: Please refer to Chapter 11 for Travel Time documentation requirements. Traveltime TOC

Additional Requirements

A progress note is recorded for each service by the counselor providing the service. SUTS BHSD expects notes to be written within 48 hours of date of service. Remember that all progress notes for all service types must contain a topic or purpose of the session at the top of each note.

Location and type of Service Delivery:

Documentation of services provided outside of a confidential office setting must include an explanation of how the provider ensured confidentiality, where the service was provided and rationale for location outside of office. Progress notes must also identify if services were provided in-person, by telephone or by telehealth.

There are many acronyms to remind the counselor of what must be within the progress note, for example P I R P (Problem, Interventions, Response, and Plan).

❖ P-Problem: Description of client’s current problem, which Dimension being addressed and how this relates to the Treatment Plan goals and actions steps and client’s progress on these goals.
❖ I-Interventions: Counselor’s Interventions during the session directed at achieving individual client goals as indicated in the Action Steps on the Treatment Plan.
❖ R-Response: Client’s Response to counselor’s interventions.
Plan of action/assignments given

The entire Client record, as evidenced by the Progress Notes overall, must:

- Show evidence of Medical Necessity
- Demonstrate follow-up on required physical exam.
- Support SUD and any MH diagnosis.
- Demonstrate client’s progress on the Treatment Plan problems, goals and action steps and/or referrals.
- Demonstrate fidelity to the ASAM model and Treatment priorities based on Dimensions and Stage of Change.
- Document client strengths.
- Show evidence of work on the Discharge Plan and referrals made.
- Demonstrate application and utilization of Evidenced Based Practices.
- Document care coordination including referrals & consultation with physical and MH providers.
- Notes must also include client’s response to counselor interventions.

Progress Notes for Unique Services

Guidelines for specific Types of Sessions:

Each type of service has its own set of items to be addressed. For example, at “Intake” the counselor must review authorizations and consents, complete the ALOC and other requirements. In a Treatment Planning session, the counselor must document that the client and counselor developed the Treatment Plan collaboratively, that it was signed, and a copy offered to client in their preferred language. Your progress notes should reflect these activities.

Informed Consent:

At Intake and at any other point in treatment where confidentiality and consents are addressed, the counselor must include a progress note which includes which advisement, authorization, acknowledgement or consent was completed and reflect that the counselor reviewed, and that the client understood and signed these documents.

Groups

1. A sign-in sheet must be kept which includes the list of clients attending the group, the topic, counselor name & license/credential number, and the date.
2. Clients must **sign-in and record the time they entered group**. They should be invited to record the time they leave group. If they forget to do the “time out”, the counselor must complete this. The Counselor may charge for the actual number of minutes of group divided by number of clients and documentation time.

3. While group notes may have a similar description regarding topic discussed, involvement of group members, counselor interventions, etc., they **must** also include an individualized note about the client's interaction, response to intervention and any updates on Treatment Plan goals and Action Steps.

4. Group progress notes must contain the date and time of the group, the number of clients served, and the topic of the group. If more than one counselor is present, this must be justified in the progress note and each counselor must document their time spent in group. There must be a separate progress note for each client by each counselor.

5. If you provide a break for clients during the group then you must document the start/end time of first section of group and start/end time of second section of group, indicating in your notes that a break was held and including total number of minutes for group excluding break time.

**Documentation Tip:**

*Note: If a client is late for group, or leaves early, the client's actual time in group must be noted in the progress notes including how the counselor will clinically address this issue.*

**Documentation Tip:**

*The time taken to document the progress note for an individual service is up to 10 minutes per note and is included in the total billed service time. The documentation time used is noted at the top of the progress note. For Group the maximum time is 5 minutes per note per client (max of 60 min).*

**Case Management (CM):**

Progress notes should include the type of case management service provided such as linkage, care coordination and should include the location of services. CM notes must be tied to the Treatment Plan, including whether goals specified in the care plan have been achieved. In addition, document; a) Whether the individual has declined services in the care plan; b) The need for, and occurrences of, coordination with other professionals; c) A timeline for obtaining needed services; and d) A timeline for reevaluation of the plan.

*(CM does not include simply leaving a phone messages for client or others.)*

**Documentation Tip:**

✓ CM progress notes should include the focus of the linkage provided to the client (e.g., accessing medical services or community activities)
✓ Describe how the individual’s substance use and/or mental health condition interferes with their ability to accomplish the activity on their own.
✓ Is linked to the Treatment (or Recovery or Care) Plan goals.
✓ The need for, and occurrences of, coordination with other case managers and a timeline for obtaining needed services along with a timeline for reevaluation of the plan.
✓ Beginning notes with Linkage, Placement, or Consultation (depending on the type of CM provided) is helpful for auditors and other counselors working with your client.

**Youth Services:**
Notes must show evidence of efforts to engage parents quarterly and collaboration with school and Multi-Disciplinary Team, when deemed appropriate and given proper consent by the youth.

**OTP/NTP: Methadone:** Title 9 §10345
1. Duration of sessions are in 10-minute units.
2. Counselor must also include client’s response to positive drug screening results.

**Additional Medication Assisted Treatment (MAT)**
Additional MAT counselors will use the same services as Outpatient in 15-minute increments with additional Medical services available for MD’s. Progress notes should include the client’s self-reported response to medication, concerns and increase or decrease of symptoms related to cravings and/or withdrawal.

**Intensive Outpatient Services (IOS)**
IOS documentation is to include a daily tally of all services and activities provided in a daily note and a weekly summary progress note. Information Notice (19-031) states daily services should be broken out to DMC-ODS reimbursable services: Intake, Individual, Group, Patient Education and Case Management (CM). Other “activities” should be listed and described but are NOT DMC-ODS reimbursable services. The documentation of group services in a daily note must include the topic of each service or activity, start and end times, duration, and provider of the service. The calculation of the billable group time per client is the duration (minutes) of the group divided by the number of clients in attendance plus the documentation time per client. Individual sessions, case management and medical transportation services must be documented similarly. They should tie to the treatment plan goals, reflect the EBP used and state the client’s progress. The weekly progress notes are to be a summary of client’s response to the weekly services and activities and client’s progress towards achieving their treatment plan goals. The weekly progress can be documented as part of a progress note of an individual session. The notes are to be completed, signed and dated by the provider of services. The documentation time of the services is to be noted separately from the service time but added to the total time rendered. The total hours of services offered are to meet the minimum required hours for IOS.

TOC
Partial Hospitalization Services (PHS)
These modalities require the counselor(s) to document all services that are provided, in a daily summary or individual notes for each clinical service, if preferred. PHS includes clients having access to medical, psychological, psychiatric services through consultation or referral.

Residential Providers and Withdrawal Management Providers:
Documentation of daily residential services and activities must have a minimum of one daily qualifying DMC reimbursable service. Reimbursable services include Individual, Group, Case Management and Patient Education. The service then justifies a “billable” DMC bed day. Additional non billable activities must also be documented and are included in the total required minimum of 20 hours per week. Supporting documentation should include the time and duration the service the topics covered during the session and the total weekly hours of service should add up to a minimum of 20 hours per client. The Progress note must include the provider of the service. Progress notes must still focus on client’s progress towards goals on the Treatment Plan, counselor interventions and client’s responses. Providers must document the dates and times of each service as well as other activities received. A tally of all service and activity hours is to be documented daily, or as part of a weekly note. If documented in a weekly note, service hours should be delineated for each date covered by the weekly note. Providers must include group sign in sheets. A weekly summary “narrative” note must summarize all services and activities, the client’s response to interventions, and progress tying back to the treatment plan goals.

Late entries:
When documenting a late progress note begin with the title “Late Entry” at the top. The date of service is the actual date service is provided. Documentation should also include the type of the service and rationale of why the note is late such as counselor was out of office.

Community Workers, Peer Support Workers, and Health Education Specialists:
These staff members will continue to do the type of documentation required by their individual program and are not currently part of the Waiver. They do not charge for services.

Definition of Cancellations, No Shows and Late Arrivals:
1. A Cancellation refers to a planned or unplanned absence from a scheduled session, about which a client notifies the counselor and/or front desk prior to appointment time.
2. A No-Show is an absence from a schedule session without prior notice or communication with the counselor and/or front desk.
3. A Late Arrival for group is handled differently based on your agency’s standards. The client could be a) Allowed to join the group late, b) Not allowed to join group and be rescheduled or
c) scheduled for an individual session. In all cases where the client is allowed late arrival, this shall be included in the client documentation and sign in sheet with their time of arrival.

**Note: Incomplete, inaccurate, unclear documentation does not allow for:**

a. Another provider to step in, in the event of your illness or absence.
b. Auditors to clearly understand what you have and have not done.
c. Accurate review in the event of an incident resulting in a complaint, injury or lawsuit.

**Documentation Tip:** In summary, Progress Notes must include:

- **Type** of service: Group, Individual, Case Management
  - Services allowed for charging/billing are limited to those services outlined in Chapter 11 under each LOC.
- **Purpose or Topic**: Group Topic is always put on the group sign in sheet and at the top of the Progress note.
  - All progress notes should identify the exact purpose of encounter. With individual service that could be Treatment or Discharge Planning, Family, Collateral, Crises, etc. *This will also assist the Auditors in finding the progress note related to a billed service.*
- The **date**, **start time** and **end time** and **duration** for each service
- You should separate out the **time spent documenting** the service within the progress note. This should include date of documentation (if different than service date) and times. Example: Service was 9/1/18. Documentation: 9/2/19, 9:03- 9:10 am, Duration: 7 minutes.
- **Attendance**: **No-shows** or **cancellations** must be documented along with attempts to contact the client.
- Description of the **client’s progress**, or lack thereof, toward one or more Treatment Plan goals.
- **Identification** of treatment issues discussed, and any new problems identified.
- Description of **EBP** elements utilized in treatment.
- The counselor who conducted the session shall provide their **Printed and Signed name**, **license/certification type and number** and **Date** the note was completed and signed.
- **Location** of service if out of office and how service delivered, i.e. telephone, face to face or telehealth.
- **Never** use white out or correction tape in the medical record. Should you need to delete a note or make slight changes, make a single line through the error and initial and date next to the change.
- **IOS/PHS** providers may write a **summary** of all clinical services daily or as a weekly note
if all services are clearly designated by date, time of service with accompanying sign in sheets for groups. Progress notes must focus on client’s progress towards goals on the Treatment Plan, counselor interventions and client’s responses. A weekly tally of number of hours of services offered during that week is helpful to auditors.

**AIDS/HIV:**
AIDS/HIV: Counselors should not document AIDS/HIV status. However, it is permissible to ask whether the client was tested for HIV and whether they received the results. You may indicate that the client has a “chronic medical condition” without specifying the client’s HIV status. Please note that these two questions are part of the CalOMS admission questionnaire and must be completed.

**Special Issues:**

1. **Suicide Protocol:** Counselors must complete the Suicide Potential Protocol threat assessment and Safety Plan when a client presents with a risk of self-harm. The counselor must clearly document in the progress note that a risk assessment was done, the nature of the intervention and the development of a written Safety Plan in collaboration with the client to address suicide risk. For youth clients, the counselor also is also required to document that the client’s guardian and/or emergency contact were notified. See: [SUTS P&P 313](#)

2. **Threats of Violence:** The counselor must use reasonable efforts to inform the victim and contact law enforcement. In so doing, they should disclose only that protected health information which is necessary to enable the potential victim to recognize the seriousness of the threat and to take proper precautions to protect him or herself. Please refer to [SUTS P&P 311-312](#) and BHSD P&P Mental Health, Section 412-206.

3. **Child Abuse and Elder Abuse:** Please refer to CCR Title 11, Article 1:[§901](#) for child abuse guidelines and CCR [§15630](#) for guidelines for reporting elder abuse and your agency Policy and Procedures. Again, assessment, intervention, and plan must be clearly documented. The actual report or copy should never be placed in the client chart.

4. **Incident reports:** In the event there is an incident report, it must be documented in the progress note that an incident report was made and submitted to Compliance Officer. The actual incident report or copy should never be placed in the client chart.
5. **Other**: The medical record chart is a confidential and protected *legal* document and can be subpoenaed by courts. No other clients' names should be included in another client's chart. Names of family members or friends should not be recorded except as required for Emergency Contact information, minor/parent involvement, etc. It is best to refer to the relationships as, “mother”, “father”, “friend” and not to use names. If names are used, then only first name or initials should be used for clarification. In circumstances that involve other clients, such as a Tarasoff report, and the use of another client's name, that person should *not* be identified as a substance use or mental health client.

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**Chapter 10: Continuum of Care**

**Authorization for Treatment and Placement**

The SUTS Quality Improvement Division manages system capacity, client flow throughout the system of care, and authorization for increased level of care requests for residential treatment. Quality Improvement Coordinators also authorize extensions for Residential treatment and serve as a resource to the CMU to facilitate residential placement. The Capacity Management Unit (CMU) manages the Recovery Residences (RRs) placement list, assists in tracking and placing clients for Residential treatment and manages the Certification process for RRs (with Executive oversight).

**Transfers:**

Transfers can be from one level of service either to a more intense level of service (example Outpatient to Intensive Outpatient) or to a less intense level of service (example Residential Withdrawal Management (3.2) to Outpatient) or to a different site at the same LOC. On occasion, a client’s needs may change between the initial screening (at Gateway for instance) and the Intake
appointment. In that case, the counselor should complete a reassessment of the client on all 6 dimensions and use the ALOC to refer to a different level of care. The client should be offered services if the next LOC will be delayed. If the client was “opened”, in an agency’s cost center then the service can be charged to Medi-Cal. If the client was not opened, then the service cannot be billed to Medi-Cal. In the following section, we will refer to both those transfers that can be initiated and completed by the counselor and those that require QI Authorization.

All transfers require the completion of an ALOC but not all require Authorization.

Note: Please refer to Appendix A., Table 7: TransferMatrix for information on required documents.

**These Transfers do NOT currently require a QI Authorization:**

**Residential Withdrawal Management to:**
1. Outpatient, Intensive Outpatient or Partial Hospitalization

**Residential to:**
2. Withdrawal Management
3. Outpatient, Intensive Outpatient or Partial Hospitalization
4. Another Residential (lateral transfer)

**Outpatient to:**
5. Withdrawal Management only and back to Outpatient
6. Another Outpatient program (lateral transfer), IOS or PHS

**Outpatient Services**
Referral to Outpatient, Intensive Outpatient or Partial Hospitalization services may be from Gateway, a pre-authorization site or from one provider to another. Transfer among these levels of care; do not require authorization from QI.

Transfers from Outpatient to OTP/NTP for Methadone and daily Buprenorphine requires the normal OS-to-OS paperwork but may also require extensive coordination between counselors due to the additional requirements for those treatments.

Referrals to Additional MAT: Counselors may Contact: (408) 272-6577 for more information.

When a youth client transfers from a school site to the Main Office or from the Main Office site back to the school site, the counselor will need to complete discharge paperwork for the previous site and submit a new admission form for the new location.

**Residential Referrals (Res) and Insurance Requirements**
If the client is incarcerated and client’s Medi-Cal has been deactivated, the adult client or the
guardian of a youth client will need to apply for reactivation. SUTS will accept “unsponsored” clients, i.e. those who do not qualify for Medi-Cal and have no other insurance. If a client has private insurance, including Covered California, they are not eligible for SUTS Residential services unless they provide a “denial letter” from their insurance plan. Please also refer to page 26 for further information.  

**Insurance**

**Adult Services**

Residential treatment must be authorized. To obtain initial authorization for an Increased Level of Care (ILOC), the referring counselor must complete the ALOC and contact the QIC on-call for authorization. This encrypted email should go to the authorization email address, which is: [SUTSAuthorization@hhs.sccgov.org](mailto:SUTSAuthorization@hhs.sccgov.org) with the Client’s name, DOB & Unicare ID. Upon QI authorization, the QIC will notify the receiving agency and the referring provider.

If the client is transferred to Residential via Withdrawal Management (WM) then the counselor must inform the receiving provider that the ALOC has been completed. Admission to WM does not require Authorization. If the Counselor believes the client will require residential treatment following WM, they must request authorization for Residential placement concurrently with the referral to WM. Refer to the Transfer Matrix for required consents and/or additional documents. [TransferMatrix](#)

**QI On-Call:** 408-792-5670  
**QI Residential Placement Coordinator** Fax: 408-947-8707

**Youth Services**

Providers must follow the same procedure as for adult above. However, additional documents are necessary for youth clients.

1. **For Authorization:** Submit the following:
   a. An ALOC requesting residential authorization
   b. The fillable Adolescent Residential Demographics (ARDs) form.
      i. Medi-Cal Insurance: Please have your clerical staff run the client’s Medi-Cal and include the Eligibility number on the ARDS

2. **For placement to occur**, the referring provider should work with the client, guardian and/or probation officer and the residential facility to obtain the following:
   a. A copy of the Medi-Cal card
   b. A copy of client’s Immunization records
   c. The current IEP or 504 when applicable
**Required Documentation for Residential Extension:**

Each client is covered by Medi-Cal for two episodes of Residential care along with one extension per annum. The year is based on the Fiscal year from June 30 the current year to July 1 the following year. Clients who require a third episode of Residential care will require consultation with the QIC for authorization.

A client awaiting a Recovery Residence and who requires an extension to remain in Residential treatment for that reason, but no longer meets medical necessity, will require QI authorization. Residential providers will use the ALOC to justify the extension of treatment outside of DMC regulations and QI will provide a “QI Authorization” for the extension.

**Adult Services**

Extension of residential treatment beyond 90 days requires re-authorization. If a residential treatment provider determines that client would benefit from extended stay in order to reach stabilization goals and medical necessity can be established, the provider must submit the ALOC extension request to Quality Improvement no later than the 80th day of treatment.

**Youth Services**

Extension of Residential level of care beyond 30 days requires re-authorization. Youth within SUTs are provided two 30-day Residential treatment episodes a year with one 30-day extension a year. Additional stabilization, if needed, will not be covered by Medi-Cal. If a residential treatment provider determines that the client would benefit from extended stay in order to reach stabilization goals and the client meets medical necessity, the provider must submit the ALOC extension request to assigned QIC no later than the 20th day of treatment.

**Community Referrals within Youth Services**

Referrals from Juvenile Probation, the Department of Family and Children Services, community-based organizations, families and others are referred to the Children, Family & community Services (CFCS) Alexian Clinic HSR who acts as Gateway for youth. The contact number for referrals is (408) 272-6594. Cases are assigned to an outpatient counselor who completes the ALOC to summarize assessment and determine level of care and then, refers the client to the appropriate treatment modality, outpatient, or residential treatment.

**Residential Withdrawal Management (ASAM 3.2 WM)**

Withdrawal Management services do not require authorization and are currently only available for Adults. Referral to Withdrawal Management services for clients not currently in treatment can be initiated by the client calling Gateway. The client will need to call at regular intervals until a bed becomes available.
If a client is already in treatment, the counselor will need to complete an ALOC and send the respective facility the “Authorization for Use and/or Disclosure of Protected Health Information” (ROI). The Counselor should call the WM program (Horizon South for men and Pathway Mariposa Lodge for women) and enquire about open slots. If there is a placement list, the client should be informed that they should call the WM program every two hours until an opening becomes available.

**Recovery Services**

Recovery Services are now a part of the SUTS Continuum of Care. The criteria for admission to Recovery Services include the following: medical necessity can be established, and the client is assessed as being in remission or partial remission. Services may be appropriate if the client is in partial remission under the additional condition that the client is no longer experiencing significant distress or impairment from their use. Clients who have not been in treatment in the past year may also be referred to Recovery Services, but they must meet the admission criteria.

**TO CLARIFY:**

a. Admission to Recovery Services is conditional on previously participating in OS treatment. (Client does not have to have “completed”.)

b. The client meets the requirements by having been previously diagnosed with a SUD and is in partial or full remission. They may currently experience some distress dealing with relapse triggers or need additional case management services to obtain outside supports, such as housing, vocational assistance, etc. However, this distress does not rise to the need for a return to Outpatient services.

c. Recovery services are to provide relapse prevention services, continuing case management, family support, monitoring of recovery progress and other services as needed.

d. The difference is that, while the client may have intermittent periods of significant challenge, they are not returning to regular use with the severity of impairment needed to meet medical necessity for OS/IOS or Residential.

e. **TOC**

If a client is referred to Recovery Services after completion of outpatient treatment, the client must be discharged from the outpatient treatment episode and opened in Recovery Services with a new intake date. The outpatient continuing care plan (discharge plan) should document the need for Recovery Services.

Services are available to clients whether they are triggered, have relapsed, or as a preventative measure to prevent relapse. The client cannot be opened the same day that OS services are closed. There is no need for a new GRS if the transfer occurs within 30 days. The outpatient counselor will complete an ALOC for the transfer. Recovery Services will review that ALOC at intake. A new ALOC is required if there was a significant break in treatment between OS/IOS and Recovery services. The Authorization for use or Disclosure of PHI form must be sent to QI via email.
Recovery Services require Recovery Service Plan to be completed within 30 days of intake. The Recovery Services Plan and reviewed and signed by a LPHA to verify medical necessity. Medical necessity must be evaluated every 6 months if the client is open in Recovery Services. All other timelines and DMC regulations relevant to outpatient treatment apply to Recovery Services as well. Being in Recovery Services qualifies a client to remain or go into a Recovery Residence.

Additional Resources:

Recovery Residences (RR)
The Adult System of Care provides temporary housing for clients who are engaged in outpatient treatment. Recovery Residences provide a structured and safe living environment that provides additional support to a client during the recovery process. Recovery Residences are available to men, women, pregnant women, and women with children, men with children, individuals with co-occurring disorders and individuals coming directly from custody, who are residents of Santa Clara County and in need of Substance Use Treatment. It may also include those clients who are in the youth treatment system who are 18 years and older.

SUTS QI authorizes and CMU manages Recovery Residence placement. QI accepts RR referrals from the following types of providers: Residential and outpatient providers, Withdrawal Management providers and in-custody screeners. The process and required documentation for referring a client to a RR varies, depending on the type of the referring provider, client status, and timing of the request.

Clients are initially authorized for 90 days and Dependency Wellness Court (DWC) clients are initially authorized for up to 180 days dependent on whether they are in family reunification. Recovery Residence extensions are only available to DWC, CDCR & STEP clients. Recovery Residence extensions requires QI re-authorization. The Outpatient provider submits an extension request to the QI RR placement Coordinator, by the 60th day of placement for Adult clients and by the 150th day for Dependency Wellness Court (DWC) clients.

Required documentation for initial RR placement authorization:

1. Referring Providers must complete an ALOC. They will then send a secure email to the Capacity Management Unit’s (CMU) email address: SUTSRR@hhs.sccgov.org. If the referring provider does not presently have the means to send an encrypted email, they should email a request for a sccsecure email from the CMU, from which they can respond.
   a. The email needs to contain: The Client name, Unicare ID and DOB.
   b. The SCC SUTS Advisement form (where applicable) and the Release of Information called: Authorization for Use or Disclosure of Protected Health Information form (ROI)
2. The Capacity Management Unit (CMU) will look up client in our EHR, accessing both the GRS.
and ALOC, and will enter the complete documentation into RR Database. The CMU then places the client on the Placement List until a bed becomes available.

3. Once a placement is available, the CMU will prepare the Client Disposition form.
4. The CMU will send the \textit{receiving} Provider the Client name and Client Unicare ID, the Criminal Justice and ROI consents and the Client Disposition form.
5. The receiving Provider will admit the client in Profiler (Unicare).
6. Upon admission and discharge, the Recovery Residence Provider will send a secure email with the Client Disposition form to the CMU to confirm admission and discharge dates.

\textbf{Required documentation for re-authorization/ extension of RR placement:}

(Extensions are now only available for DWC, CDCR & STEP clients.)
1. RR Extension form: When client is still in treatment the Outpatient provider must submit the completed extension forms to QI via email.
2. If the client has completed treatment, the RR provider will submit completed extension form to QI via email.

\textbf{Required RR Exit Plan:}

All clients must have a housing exit plan prior to discharge utilizing the RR Housing Exit Plan Form.

\textbf{RR Placement Coordinator:} Phone: 408-792-5084 Fax: 408-947-8708

\textit{Note: All clients who are in a Recovery Residence and no longer meet medical necessity for Outpatient (OS) or Intensive Outpatient (IOS) services should be referred to Recovery Services. All clients in Recovery Residences are required to attend Outpatient Services and are subject to discharge if they fail to attend counseling. Outpatient providers and Recovery Residence providers must keep each other informed about the client's status, either by phone, encrypted email or using the CSR form.}

\textbf{Referral to SUTS Psychiatrist}

The goal of Psychiatric Treatment Services is to assess and prescribe psychotropic medications, if needed, in order to stabilize clients with Dimension 3 issues. Clients who require extensive psychiatric care and mental health services should be referred to Mental Health Services via the Call Center. Counselors who refer clients to the SUTS psychiatrist \textit{must} assist their client in obtaining a primary care physician (PCP) who can continue their medication refills once their psychiatric evaluation is completed.

Documentation of care coordination with the psychiatrist, and primary care physician, if
applicable, should be included in client progress notes.

The referring provider will fax the following documents before an appointment will be scheduled:

**Adult:**
1. Assessment Level of Care authorization form (ALOC)
2. Psychiatric Referral Client Information form
3. Authorization for Use and/or Disclosure of Protected Health Information (ROI) form
4. Letter from PCP, if available.

**Youth:**
1. Assessment Level of Care authorization form (ALOC)
2. Psychiatric Referral Client Information form
3. Authorization for Use and/or Disclosure of Protected Health Information (ROI) form
4. Parent/Legal Guardian consent (if medication to be prescribed)
5. Authorization for the Release of Confidential Client Information (Minor specifies what alcohol and drug related information is permitted for exchange with parent/legal guardian)

**Address, Phone and Fax Information for all referrals:**

Alexian Health Clinic
2101 Alexian Drive Suite B
San Jose, CA 95116

*Main Phone line: (408) 272-6070  Fax Line: (408) 272-6570*

For a complete list of paperwork required for all transfers:

➤Please see Table 7: SUTS Transfer Crosswalk-Table7Transfer

For additional information on DHCS Certification regulations, across the continuum of care, please see: [http://www.dhcs.ca.gov/Documents/DHCS_AOD_Certification_Standards.pdf](http://www.dhcs.ca.gov/Documents/DHCS_AOD_Certification_Standards.pdf)

**Chapter 11: Service Types and Charging Requirements**
Drug Medi-Cal Organized Delivery System:

Counties who have opted in to the 1115 Waiver Pilot, Drug Medi-Cal Organized Delivery System (DMC-ODS) are required to provide all of the proposed services of the DMC-ODS to eligible beneficiaries. These services include a continuum of care based on the American Society of Addiction Medicine (ASAM) that ensures clients can enter SUD treatment at a level that is appropriate to their needs and step up or down to a different intensity of treatment based on their recovery process. An expanded range of services are now reimbursable under the DMC-ODS waiver. The menu of services provided is unique to each level of care. Please note that the services that can be charged to Med-Cal for reimbursement have changed. Example: Treatment Planning is now charged under “Individual.” Medi-Cal eligibility should be run at intake and every month and a record kept in the paper chart (or binder if utilizing electronic records only).

Services can now be provided in any appropriate and confidential setting in the community and can be provided in-person or by telephone, if the counselor is associated with a DHCS credentialed site. Services must be provided in a manner that protects client confidentiality and counselor must document how they ensured confidentiality in their progress note. The counselor must also indicate why the service was not held in the office in their corresponding progress note. Examples: “Client has no transportation or “Client preference”.

Non-emergency transportation services for clients are based on medical necessity determination by the LPHA. An example would be to assist a client in getting to a medical appointment when the client is unable to do this on their own due to cognitive or anxiety issues.

TRAVEL TIME:

Providers may now claim for staff travel time to and from providing direct services under the DMC-ODS Pilot Program. Travel and documentation time are to be included in the service time and must not be claimed separately. Travel and documentation time must be linked to the service provided, documented in the treatment notes, and subject to federal standards. Travel time is counted from the provider’s clinic site to the client at home or community site and return to your clinic site (or satellite site) or to the next community-based client appointment. If you do not return to the clinic site (e.g. you return to your home) then travel time is counted only one way.
All services are documented based on the **exact number of minutes served** except in Residential Treatment and Partial Hospitalization Services which use a day rate.

The following describes the range of services within each Modality of treatment under the DMC ODS Waiver followed by the “Charging Service Types” for that Modality. All clinical services submitted for DMC claims must be provided under a valid and signed Treatment Plan where both medical necessity and appropriate level of care have been established.

**Outpatient Services (ASAM Level 1)**

Intake, Individual counseling, Group counseling, family therapy, patient education, medication services, collateral services, crisis intervention, treatment planning, and discharge services are provided to clients up to 9 hours a week for adults, and less than 6 hours a week for adolescents. These services are rolled up under one of the four categories shown below:

- Intake
- Individual Treatment SUTS
- Group Treatment SUTS
- Case Management SUTS

**Group Treatment Services**

Group Treatment now includes both process oriented and psycho-educational group services. All Groups must contain a minimum of 2 and a maximum of 12 in the group, focusing on the needs of the individuals served. Units of service are in 15-minute increments and claims can be submitted in fractional units of service (whole numbers only). (The DMC regulation of requiring client attend 2 groups each 30 days is no longer applicable. SUTS has a set a standard of four clinical services to be offered to the client in the first 30 days of admission, including intake.)

*The formula for calculating how many minutes to document for each client is:*

\[
\text{Number of minutes for the group} / \text{Number of clients} = \text{Total minutes per client.}
\]

*For example:* If a group ran 90 minutes with 6 clients and one counselor the formula would be:

\[(X) \ 90 \text{ divided by } (Y) \ 6 = (Z) \ 15\]

Therefore you document 15 minutes for each client.

If the group starts at 9 am then each participant will have a documented **Service** from 9:00 am to 9:15 am. The counselor(s) must also document each service using the **same** start and end time.

Under the Waiver, the counselor is charging for the period of time he/she provided services. If a client is late then this is a clinical issue that should be addressed as such. This would not affect the number of minutes charged. Client should enter the actual time in and out on sign-in sheet and the counselor should document in the **progress notes** that client was late or left early with the actual time spent in group. Example: Group time was from 9:00 am to 10:30 am.

*Note: If no client is there on time, counselors should document the start time as that time when at least two members present in the group.*
If there is more than one counselor for a group session, a justification needs to be provided in the documentation. In order to be reimbursed accurately, each counselor will need to document the time and service that was delivered in a separate progress note. If there are two providers, each counselor will document a group note on all of the participants, listing themselves as the primary provider. If the calculation derives partial minutes, always round down to a whole number. Example: 60-minute group/7 clients = 8.57 minutes per client. This group session would be recorded as 8 minutes.

**Intensive Outpatient Services (ASAM Level 2.1)**

Each service must now to be documented separately similar to OS with one addition of “Patient Education”. Services are provided to clients for a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for adolescents.

Services include Intake, individual counseling, group counseling, patient education, family therapy, medication services, collateral services, crisis intervention, and treatment and discharge planning services. Group services are provided with no less than two and no more than twelve clients except for Patient education which is not limited to the two-to-twelve group size.

These services are rolled up under one of the three categories shown below:

- Intake
- Individual Treatment SUTS
- Group Treatment SUTS
- Case Management SUTS
- Patient Education SUTS

**Partial Hospitalization Services (ASAM Level 2.5) **

Services are under the umbrella of “PHS Treatment SUTS” and provided to clients for a minimum of twenty (20) hours of structure programming each week for adults and adolescents.

Services include Intake, individual counseling, group counseling, patient education, family therapy, medication services, collateral services, crisis intervention, treatment, and discharge planning services.

These services are rolled up under one of the three categories shown below:

- PHS Treatment SUTS (or PHP)
- Case Management SUTS

**Case Management**

Case management (CM) is a service that assists or links a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, housing, legal, transportation and interaction with the criminal justice system or other community services. CM is a method to help beneficiaries achieve their goals throughout treatment. These services support beneficiaries as
they move through the DMC-ODS continuum of care from initial engagement and early intervention, through treatment, to recovery supports. They focus on coordination of SUD care and integration around primary care especially for beneficiaries with a chronic SUD and interaction with mental health services.

These services are rolled up under one category:

- Case Management SUTS

  **Residential Treatment (ASAM Level 3.1)**

Services are under the umbrella of a 3.1 SUTS Res Treatment. Residential services include Intake, individual counseling, group counseling, patient education, Family, and collateral services, crisis intervention, treatment planning, transportation services and discharge services. A bed day will be reimbursable if a service listed above is provided and documented to the standards of DMC-ODS on the date of the billing. A summary of all service activities shall be documented for each service day and entered in real time. Bed Census is also to be entered in “Real Time.”

These services are rolled up under one of the two categories shown below:

- Intake (Not a separate billable item)
- 3.1 SUTS RES Treatment

* SUTS offers Level 3.1 Residential currently. Once 3.3 and 3.5 is added, the service may be 3.3 and 3.5 SUTS RES Treatment.

**Withdrawal Management Services (ASAM Level 3.2-WM)**

Residential Withdrawal Management services include Intake, observation, medication services, and discharge services. A summary of all service activities shall be documented for each service day. Bed Census is to be entered in “Real Time.”

These services are rolled up under one of the two categories shown below:

- Intake (Not a separate billable item)
- 3.2 SUTS WM Bed Day

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

OTP/NTP refers to daily dosing of Suboxone and Methadone. Services include; Intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention, treatment planning and discharge services. This includes OTP/NTP Perinatal. Units of service for OTP/NTP treatment are in **10-minute increments**.

These services are rolled up under one of the four counseling categories:

- Intake
- Individual Treatment OTP/NTP
- Group Treatment OTP/NTP
- Case Management SUTS
- Additional Medical Services provided by MD and/or Nurse
- Dosing
- Suboxone
- Medication Visit MD - SUTS only
- Medical Visit MD - SUTS only
- MD Physical Exam - SUTS only
Note: OTP/NTP Dosing services may be provided concurrently at the Residential WM & Residential Treatment sites. *OTP/NTP is not part of the Waiver at this time.

Additional Medical Treatment Services (MAT) (Multiple levels of care)

Additional Medication Assisted Treatment (MAT) is the use of prescription medications in combination with counseling and behavioral therapies. MAT refers to the use of approved medications that do not require daily dosing at a clinic in conjunction with outpatient treatment. Further, MAT services are not limited to treatment for opioid addiction. Additional MAT includes medications such as Naltrexone (Vivitrol), Naloxone, Disulfiram, and Suboxone (that is not daily dosed at a clinic).

MAT services are provided at County NTP Clinics. Services include; Intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention, treatment planning and discharge services. Units of service are in 15-minute increments and claims can be submitted in fractional units of service.

These services are rolled up under one of the four counseling categories:

- Intake
- Individual Treatment SUTS
- Group Treatment SUTS
- Case Management SUTS

Additional Medical Services provided by MD

- MAT Evaluation & Management SUTS
- MAT MD Visit SUTS

Recovery Services

Recovery Services is a new modality of services, with a new intake date. Clients may access medically necessary recovery services after completing their course of outpatient treatment and must meet medical necessity. Services are available to clients whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.

These services will be rolled up under one of the four categories:

- Recovery Individual Counseling SUTS
- Recovery Group Counseling SUTS
- Recovery Case Management SUTS
- Recovery Monitoring *

*Peer to Peer services is not covered until SUTS submits Training Plan
**Outpatient Case Management Services:**
Services provided through the County the Offender Treatment Program (OTP) or other Case Management programs will remain the same however documentation standards are similar. These services are not currently billable to Medi-Cal. Providers should always consult with their program manager to confirm the appropriate services.

These services are:

- Intake
- Case Management
- Crisis Intervention
- Discharge Planning
- Group Treatment
- Individual Treatment

Community-workers and peer mentors will work under the direction of credentialed or licensed counselor to provide a range of case management services, depending on the client’s needs.
Service Definitions

**Individual Treatment Services**

*Under the 1115 Waiver, Individual Treatment is the umbrella term for multiple types of service, including Individual treatment, Crisis Intervention, Collateral and Family Services, 1:1 Patient Education, Treatment Planning and Discharge Planning.*

**Intake**

While Intake is charged at the same rate as Individual, it has been separated out for purposes of data collection in our EHR/PMS. The Intake is the first face-to-face of the client with the counselor. Intake is the process of determining that a client meets the medical necessity criteria and is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders, the diagnosis of substance use disorders, and the assessment of treatment needs to provide medically necessary services. It may include a physical examination and laboratory testing necessary for substance use disorder treatment. Intake has been separated out from other Individual services for the purpose of data measurement and is only done once at the beginning of treatment.

*Documentation Tip:* 

V1.5 OCT/19 NAT BHSD-SUTS Clinical Documentation Standards Manual 63
The complete information recorded in an Assessment, Treatment Plan, Discharge Plan, etc. is not repeated in the Progress note. However, the Progress note should include some summary information about what transpired.

Each service requires a corresponding Progress note and the specific type of Individual session done should be identified, such as Treatment Planning, Individual, etc.

**Individual Treatment**
Individual Treatment means face-to-face or telephone contacts between a client and counselor. Individual counseling sessions between a counselor and a client must be conducted in a confidential setting where individuals not participating in the counseling session cannot hear the comments of the client or counselor. These services can be provided in an office, outpatient facility, or when appropriate, the home of the client or other confidential setting. Each individual session should continue the on-going process of assessment and evaluation of progress with the Treatment Plan.

**Treatment Planning**
The provider prepares an individualized written Treatment Plan, with the client, based on information obtained in the intake and assessment process. Updated Treatment plans developed between the client and the counselor every 90 days for outpatient treatment and by the 10th day in residential treatment. Withdrawal management care plans are to be done within 48 hours.

**Crisis Intervention**
Services shall focus on alleviating crisis problems. “Crisis” means an actual relapse or an unforeseen event or circumstance that presents to the client an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the client’s emergency situation.

**Documentation Tip:**
- An excellent Crisis Intervention Progress note contains a clear description of the “crisis,” in order to distinguish the situation from a routine event, and the interventions used to help stabilize the Individual.
- A well-written crisis intervention note also describes the final disposition and plan and relates how the crisis situation relates directly to the risk of or actual relapse to substance use.

**Discharge Planning**
Discharge Services are defined as the process to prepare the client for referral into another level of care, reentry into the community, and/or the linkage of the individual to essential community, housing and human services. This includes both the process of developing the Discharge Plan with the client and completing the clinical Discharge Summary. The Plan must include description
of relapse triggers and a support plan to avoid relapse. Discharge services are to be documented no sooner than 30 days prior to discharge.  (See: IA Agreement, § Exhibit A, Attachment A1, Section III,OO,16.)

**Family Treatment**
Services include Face-to-Face sessions with the counselor and significant persons in the life of a client. Services focus on treatment needs of the client and ways in which they can be supported to achieve their treatment goals. In Family Treatment, these significant individuals are those that have a personal, not a professional relationship with the client.

**Collateral Services**
Services include professionals and significant persons (i.e. personal, not official or professional persons) who have an active role in supporting the achievement of the client’s treatment goals. Collateral services may include their participation in Transition Plan Meetings or other Multi-Disciplinary group consultation with the client.

**Patient Education**
Patient Education, either individual or in a group, is a 1:1 learning experience, using a combination of methods such as teaching, counseling, writing assignments and other techniques to develop a clients’ knowledge and understanding of the impact of substance use on their psychological and physical health, family and other relationships in the community including work and legal issues. Must be done by a licensed, pre-licensed or registered counselor.

**Group Treatment Services:**
Group Treatment can be either clinical process-oriented or non-clinical psycho-educational group services. The purpose of psycho-educational groups is the expansion of awareness about the behavioral, medical, and psychological consequences of substance use. All group counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. All process Groups must contain a minimum of 2 and a maximum of 12 in the group, focusing on the needs of the individuals served and must directly reflect the individual client’s Treatment Plan goals and actions steps. All Group sessions must be documented with a sign-in sheet for group members and it must be maintained in a binder or other easily accessible format. The sign-in sheet must include the date of service, the printed and signed name of the counselor(s) and the printed and signed name of each client and their time signed in. It must also include and the start and end time of group, duration and the group topic.

**Documentation Tip:**
The Progress notes should state the beginning and end time of the group (ex. 9:00– 10:30am), group duration (e.g. 90 minutes), group topic, EBPs, treatment plan issues addressed, and action steps addressed.
Case Management (CM)

Case management must be identified as a service modality within the client’s Treatment Plan directly related to the client’s recovery. It may be offered as a service to the client prior to the completion of the treatment plan if the client Assessment has been completed. Services may be offered with the client face-to-face, on the telephone, or in service for the client without the client’s presence. *It does not include leaving phone messages for client or others.*

CM Services include:

- Transition to a higher or lower level of substance use disorder (SUD) care;
- Development and periodic revision of a client plan that includes service activities;
- Communication, coordination, referral, and related activities;
- Monitoring service delivery to ensure client access to service and the service delivery system;
- Monitoring the client’s progress;
- Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

*Note that service unit Targeted Case Management in Pro-Filer has been replaced with Case Management SUTS. The services you have available to you are geared to your location and modality.*

Recovery Services (RS)

Clients may access medically necessary Recovery Services after completing their course of outpatient treatment or if they are diagnosed as being in remission or partial remission. Services are available to clients whether they are triggered, have relapsed, or as a preventative measure to prevent relapse. Clients moving from regular OS to RS require a new intake date. Recovery services can be provided to a client Face-to-face, by telephone or in the community when the provider delivering the service is linked to a physical site/facility that is DMC certified.

Recovery services are offered to clients who:

- Meet medical necessity with an “in remission” modifier of the ICD code and DSM diagnosis. A client in *partial remission* with no significant distress or impairment that warrants further OS treatment may also be in Recovery Services.
- Medical necessity criteria for recovery services must be appropriately documented in the medical record.
- Services include: Individual, Group, Case Management, and Recovery Monitoring.
- Clients must have clinical contact at least once every 30 days and services beyond 6 months require redetermination of medical necessity.
- CalOMS data are not reported for Recovery Services.
✓ A client moving from OS/IOS to Recovery services within 30 days does not need a new GRS.
✓ Recovery Services should be included in client’s OS Discharge plan.

The components of recovery services are:

❑ Counseling services in the form of individual or group counseling to stabilize the client and reassess if further care is needed;
❑ Recovery Monitoring, including recovery coaching and monitoring via telephone;
❑ Support for education and job skills, such as linkages to life skills, employment services, job training, and education services;
❑ Family Support, such as linkages to childcare, parent education, child development support services, and family/marriage education;
❑ Support Groups, including linkages to self-help and faith-based support; and,
❑ Ancillary Services, such as linkages to housing assistance, transportation, case management, and individual services coordination.

Billing (Same Day-Second Service)

With implementation of the DMC-ODS Waiver, same day services are now allowed under certain circumstances. Providers will not be required to use a multiple billing override code when submitting their claim for reimbursement. For example: Client may attend OS Group with one counselor and then stay for an OS individual session, even if this is with a different counselor. Multiple billing in the same day is allowed if the combination of services does not conflict. An example of same day billing that would not be allowed includes two different Residential Treatment services or Treatment in OS the same day as treatment in Recovery Services. Same day second service still requires documentation to indicate why the service had to be provided on the same day.

Resources

1. The DMC ODS Same Day Billing Matrix is shown in Table9Samedaybilling and is available online at:
2. For the complete charging information, please reference the 2017 Drug Medi-Cal Billing Manual. The requirements specific to the Waiver are found in Chapter 6.
3. For the 1115 Waiver FAQs and Resources, please reference the DHCS site

4. The exact Service item terms used in SUTS are shown in Table 10 however as we move forward with implementation of 2 new EHR systems, these may change: Table10EHR

5. Also refer to Table 8: Title 22 and Title 9 DMC Services Crosswalk Table8Services

6. The IN for the Intensive Outpatient Services can be found at: DHCS IN for IOS

**Chapter 12: Client Problem Resolution Process**

All clients are entitled to have access to the problem resolution process. The process allows clients to express any dissatisfaction they may have with their health care services, health care provider, or decisions made about their treatment services by their covering plan (in the case of a Medi-Cal beneficiary). A client may file a complaint verbally or in writing at any time during the course of their treatment. Both DMC insured clients and unsponsored clients may call the beneficiary phone line (408-792-5666) to file a complaint or a client may file a complaint directly with the client’s provider. The problem resolution process is outlined thoroughly in BHSD P & P# 12000, and in the Beneficiary Handbook. P & P# 12000 can be found on the BHSD website BHSD #12000. Note that all forms that you will need are included in the P&P. Look under SUTs Attachments, not MHD Attachments. Providers must inform clients of the problem resolution process at the outset of treatment and all clients shall sign an “Acknowledgement of Receipt” that they have received a copy of the handbook and been informed of the problem resolution process. If a client wishes to file their complaint in writing, the provider may offer the Grievance/ Appeal/Expedited Appeal form. The provider or staff within the plan are to be available to help clients, if need be, to complete the form. This form should be made available at all SUTS sites.

*Note: The following is only a brief summary of the Problem Resolution Process. Providers should refer to the Policy and Procedure for more information. Beneficiary Problem Resolution*

**Notice of Adverse Benefit Determination (NOABD)**

An NOABD is a form that is executed and sent from the Provider to the client when a decision is made for the following reasons:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit.

2. The reduction, suspension or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of grievances and appeals.
6. The denial of a beneficiary's request to dispute financial liability.

A Notice of Adverse Benefit Determination (NOABD) must explain the reason for the change in treatment services and then be mailed or hand-delivered to the client 10 days prior to any action taken by the provider. Providers of DMC services must also advise DMC clients of their State Fair Hearing Rights upon admission and again at any adverse change in treatment services.

The “Your Rights” form is distributed with the NOABD to the client; the “Your Rights” form explains the State Fair Hearing process to Medi-Cal beneficiaries. Additionally, providers will send nondiscrimination notices and language assistance taglines as required by DHCS whenever distributing significant communication to clients, such as an NOABD, or Notice of Appeal Resolution (NAR). A NOA type letter must also be given to unsponsored clients along with an explanation of how to request an Internal Fair Hearing, which is an equitable problem resolution process for uninsured clients.

NOAs are kept in the client’s record and clinical staff will document in the progress notes any attempts to contact the client about an adverse change in services and their client rights.

**The NOABDs and written notices shall include:**

1. A statement of the action the provider intends to take;
2. The reason for the intended action;
3. A citation of the specific regulation(s) supporting the intended action;
4. An explanation of the client’s right to a State Fair Hearing or internal hearing for the purpose of appealing the intended action;
5. An explanation, if all lower levels of problem resolution have been exhausted, that the client may request a Fair Hearing by submitting the request to:

   California Department of Social Services  
   State Hearings Division, ACAB  
   P.O. Box 944243,  
   Mail Station 9-17-37  
   Sacramento, CA 94244-2430  
   Or Fax to: 1-916-651-2789  
   Call toll free: Call 1.800.952.5253 or TTY/TDD 1.800.952.8349
a. An explanation that the provider shall continue treatment services pending State and Internal Hearings decisions only if the client appeals in writing to DHCS for a hearing within ten (10) calendar days of the mailing or personal delivery of the notice of intended action.
b. This notification of Fair Hearing and Internal Hearing rights must be provided even if the client is being discharged for failure to attend the program. One good way to do this is to include The Fair Hearing information on a last letter attempting to contact a patient that has stopped attending a program.

6. A copy of all NOABDs must be sent to the Clinical Standards Coordinator (CSC).

Grievances, Appeals and Expedited Appeals

Grievance means an expression of dissatisfaction about any matter. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships and failure to respect the client’s rights regardless of whether remedial action is requested. Grievance includes a client’s right to dispute an extension of time proposed by SUTS investigators of the grievance to make an authorization decision. If a client is dissatisfied with the resolution of the grievance, the client may file another grievance. Please refer to the standard “Grievance-Appeal-Expedited Appeal Form.” (See Behavioral Health Services P&P #12000 and Title 22, CCR, Section: 50951) Fair Hearing-See P.13

An Appeal is a request by the beneficiary for a review of an action executed by a provider or the MCP in response to a problem. Appeals may be filed orally or in writing. Beneficiaries may request an appeal or expedited appeal after receipt of a NOABD. Appeals are filed with the MCP and addressed at the MCP level. Please refer to the Behavioral Health Services procedure for Beneficiary Problem Resolution-Processes for more detailed information regarding the appeal process. ProblemResolutionProcedure

The NOABD, the Notice of Title 22 Fair Hearing Rights, the Acknowledgement of receipt of both the beneficiary handbook and the problem resolution process and the beneficiary Problem Resolution Letter must be kept in the client’s chart.

Please note: Copies of all grievances/appeals/expedited appeals are sent to the SUTS Clinical Standards Coordinator (CSC), who monitors the resolution process, and must report to the State.

If the complaint (problem) is resolved at the provider internal level, notification using the "Notice of Grievance Resolution" is sent to the client by the provider and a copy is kept in the clinical chart. A copy is also sent to the CSC. This letter describes the initial complaint, how it was addressed, and all decisions regarding the complaint. If the grievance is filed with the MCP via the CSC of
SUTS, the person investigating the grievance is responsible for sending a copy of the Notice of Grievance Resolution to the client and to the provider, as well as, sending a copy to the CSC. If the provider believes a resolution has been achieved but the client chooses to address their concerns with the MCP, the MCP resolution process supersedes that of the provider.

**Documentation Tip:**
All activities related to Grievances, Appeals and Fair Hearings apart from Face-to-Face meetings with the client are not billable.

### Chapter 13: CalOMS Data Review


CalOMS data are gathered for a variety of reasons:

1. **Analysis of changes in Treatment:** Data collected at admission and discharge on the domains of substance use, legal status, mental status, and social connections.
2. **Reporting to SAMHSA** (*Substance Abuse Mental Health Services Administration*): CalOMS data are fed into the Treatment Episode Data System (TED), which are used to study national substance use treatment trends.
3. **Reconciling admissions for Medi-Cal reimbursement:** Although CalOMS and Medi-Cal maintain separate systems, Medi-Cal uses the CalOMS admissions record to corroborate that a client was in fact in treatment during the period for which services were claimed. CalOMS data are gathered only from clients who are admitted to a reportable modality including Outpatient and Intensive Outpatient services, Additional MAT, OTP/NTP, Withdrawal Management, and Residential Treatment. All other services are currently NOT reportable to CalOMS. *Note: A CalOMS admission or discharge is not currently required for Recovery Services.*

DHCS guidelines specify that the CalOMS admission questionnaire should not be administered to a client, until after the client has been formally admitted to treatment services and has begun development of a Treatment Plan. This means that the CalOMS admission questionnaire *should be completed by the 3rd counseling session* in Outpatient Treatment. In Residential Treatment, it should be entered no sooner than the second (2nd) day of treatment and no later than the tenth (10th) day of treatment. Individual agencies may opt to administer the CalOMS admission questionnaire sooner, based on the workflows at their agency.
CalOMS requires that the CalOMS admissions questionnaire be administered only to those clients who meet the following criteria:

✓ Have an Alcohol or Drug (AOD) related problem;
✓ Consented to participate in treatment
✓ Completed screening and admission procedures;
✓ Has begun development of an individual treatment or recovery plan;
✓ *Been formally admitted to an AOD program facility for treatment* (treatment services must have commenced).

Waiting until the client is fully engaged in treatment will increase the reliability of the outcome measures and reduce the number of invalid CalOMS admissions forms submitted for clients who never return after the first meeting. CalOMS data is also collected at discharge and can be done by telephone. An Administrative discharge should be completed for a client who cannot be located for a face-to-face or telephone interview. The reason for discharge must be documented at all levels of care, OS, IOS, Residential and Withdrawal Management.

**Appendix A: Reference Tables**
Table 1: 4 Quadrant model

The Four Quadrant Clinical Integration Model for Substance Use Disorders

<table>
<thead>
<tr>
<th>Quadrant II</th>
<th>Quadrant IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU↑ PH↓</td>
<td>SU↑ PH↑</td>
</tr>
<tr>
<td>• Outstationed medical nurse practitioner/physician at SU site (with standard screening tools and guidelines) or community PCP</td>
<td></td>
</tr>
<tr>
<td>• SU clinician/case manager w/responsibility for coordination w/ PCP</td>
<td></td>
</tr>
<tr>
<td>• Specialty outpatient SU treatment including medication-assisted therapy</td>
<td></td>
</tr>
<tr>
<td>• Residential SU treatment</td>
<td></td>
</tr>
<tr>
<td>• Crisis/ED based SU interventions</td>
<td></td>
</tr>
<tr>
<td>• Detox/sobering</td>
<td></td>
</tr>
<tr>
<td>• Wellness programming</td>
<td></td>
</tr>
<tr>
<td>• Other community supports</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant III</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/SU↓ PH↓</td>
<td>MH/SU↓ PH↑</td>
</tr>
<tr>
<td>• PCP (with standard screening tools and MH/SU practice guidelines for medications and medication-assisted therapy)</td>
<td></td>
</tr>
<tr>
<td>• PCP-based BHC/care manager competent in both MH/SU</td>
<td></td>
</tr>
<tr>
<td>• Specialty prescribing consultation</td>
<td></td>
</tr>
<tr>
<td>• Crisis/ED based SU interventions</td>
<td></td>
</tr>
<tr>
<td>• Wellness programming</td>
<td></td>
</tr>
<tr>
<td>• Other community supports</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MH/SU↓ PH↓</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PCP (with standard screening tools and MH/SU practice guidelines for medications and medication-assisted therapy)</td>
</tr>
<tr>
<td>• PCP-based BHC/care manager competent in both MH/SU</td>
</tr>
<tr>
<td>• Specialty prescribing consultation</td>
</tr>
<tr>
<td>• ED based SU interventions</td>
</tr>
<tr>
<td>• Medical/surgical inpatient</td>
</tr>
<tr>
<td>• Nursing home/home based care</td>
</tr>
<tr>
<td>• Wellness programming</td>
</tr>
<tr>
<td>• Other community supports</td>
</tr>
</tbody>
</table>

Persons with serious SU disorders could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.

References:
1. Minkoff K, Cline CA. Personal communication December 2009. Barbara Mauer

Table 2: Steps to Engagement and Successful Treatment

<table>
<thead>
<tr>
<th>What help has the client asked for and why now?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the treatment priorities based on the client’s concerns &amp; risk factors?</td>
</tr>
<tr>
<td>Am I meeting access, quality and other performance measures?</td>
</tr>
<tr>
<td>Do my Action Steps match client’s Stage of Readiness to Change?</td>
</tr>
<tr>
<td>What type and frequency of services are needed?</td>
</tr>
<tr>
<td>What mental health and/or physical health services does the client need?</td>
</tr>
<tr>
<td>What immediate needs and risks must be addressed first?</td>
</tr>
<tr>
<td>Assess all areas of the client’s life.</td>
</tr>
</tbody>
</table>
### Table 3: Service-Related Scope of Practice Crosswalk

<table>
<thead>
<tr>
<th>SERVICE RELATED SCOPE OF PRACTICE</th>
<th>MFT, LCSW, LPCC(+), PhD</th>
<th>ASW, AMFT, APCC or PHDA</th>
<th>Certified Counselors</th>
<th>Pre-Certified Counselors</th>
<th>Community Workers</th>
<th>Peer Mentors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Treatment SUTS(^1)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intake</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family</td>
<td>X(^2)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Collateral</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Crisis Intervention</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment Planning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Discharge Planning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Treatment SUTS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Psycho-Ed</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management SUTS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case management</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis: SUD</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis: Mental Health</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verifies Medical Necessity on TX Plan</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Must be Co-Signed by an LPHA(^3)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Individual Services include: Treatment Planning, Discharge Planning, Crisis Intervention, Family TX, Collateral TX and Individual Counseling

\(^2\) LPCC may only do Family TX if they have additional training in Family Therapy.

\(^3\) Please see definition of LPHA's, pages 16-17 regarding who can co-sign TX plan, DX and determine Medical Necessity

*Note: Additional MAT and OTP/NTP programs require co-signature of Assessment & TX plan by MD.*
Table 4: Timelines Overview

<table>
<thead>
<tr>
<th>ASAM Level of Care</th>
<th>Service Name</th>
<th>Description of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Clinically Managed Low-Intensity Residential Services</td>
<td>24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for Outpatient treatment.</td>
</tr>
<tr>
<td>3.3</td>
<td>Clinically Managed Population-Specific High-Intensity Residential Services</td>
<td>24-hour care with trained counselors to provide high-intensity services, which may be provided in a deliberately repetitive fashion. Generally, for those with cognitive or other impairments unable to use the full active milieu or therapeutic community. (Note: this level is not designated for adolescents).</td>
</tr>
<tr>
<td>3.5</td>
<td>Clinically Managed High-Intensity Residential Services</td>
<td>24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for Outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.</td>
</tr>
<tr>
<td>3.7</td>
<td>Medically Monitored Intensive Inpatient Services</td>
<td>24-hour nursing care with Physician availability for significant problems. 16 hour/day counselor availability.</td>
</tr>
<tr>
<td>4.0</td>
<td>Medically Managed Intensive Inpatient Services</td>
<td>24-hour nursing care with daily physician care for severe, unstable problems. Counseling available to engage patient in treatment.</td>
</tr>
</tbody>
</table>

Table 6: Levels of Care Placement Overview


<table>
<thead>
<tr>
<th>Levels 0.5 through 2.5</th>
<th>Prevention</th>
<th>MAT</th>
<th>Outpatient</th>
<th>IOS &amp; Perinatal</th>
<th>Partial Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criteria by Dimensions</strong></td>
<td>Level 0.5 Early Intervention</td>
<td>Level 1 Medication Assisted Therapy</td>
<td>Level I Outpatient Services</td>
<td>Level 2.1 Intensive Outpatient</td>
<td>Level 2.5 Partial Hospitalization</td>
</tr>
<tr>
<td><strong>DIMENSION 1: Alcohol Intoxication And/or Withdrawal Potential</strong></td>
<td>No withdrawal (WX) risk</td>
<td>Physiologically dependent on opioids and requires MAT to prevent WX</td>
<td>No significant WX or minimal risk of severe WX. Manageable at Level 1-WM (see WX management criteria)</td>
<td>Minimal risk of severe WX, manageable at Level 2-WM (see WX management criteria)</td>
<td>Moderate risk of severe WX, manageable at Level 2-WM (see WX management criteria)</td>
</tr>
<tr>
<td><strong>DIMENSION 2: Biomedical Conditions &amp; Complications</strong></td>
<td>None or very stable</td>
<td>None or manageable with Outpatient medical monitoring</td>
<td>None or very stable or is receiving concurrent medical monitoring</td>
<td>None or not a distraction from treatment. Such problems are manageable at Level 2.1</td>
<td>None or not sufficient to distract from treatment. Such problems are manageable at Level 2.5</td>
</tr>
<tr>
<td><strong>DIMENSION 3: Emotional / Behavioral / Cognitive Conditions &amp; Complications</strong></td>
<td>None or very stable</td>
<td>None or manageable in an Outpatient structured environment</td>
<td>None or very stable, or receiving concurrent mental health monitoring</td>
<td>Mild severity, with potential to distract from recovery; needs monitoring</td>
<td>Mild to moderate severity, with potential to distract from recovery; needs stabilization</td>
</tr>
<tr>
<td><strong>DIMENSION 4: Readiness to Change</strong></td>
<td>Willing to explore how current alcohol, other drug, or medication use, and how high-risk behaviors may affect personal goals</td>
<td>Ready to change the negative effects of opiate use, but not ready for total abstinence from illicit prescription or non-prescription drug use</td>
<td>Ready for recovery but needs motivating &amp; monitoring strategies to strengthen readiness. Or needs on-going monitoring or disease management. Or, high severity in this dimension but not in other dimensions. Needs Level 1 motivational enhancement strategies</td>
<td>Variable engagement in treatment, ambivalence, or lack of awareness of substance use/mental health problem, and requires a structured program several times a week to promote progress through stages of change</td>
<td>Poor engagement in treatment, significant ambivalence, or lack of awareness of substance use/mental health problem, requiring a near-daily structured program or intensive engagement services to promote progress through stages of change</td>
</tr>
<tr>
<td><strong>DIMENSION 5: Relapse / Continued Use / Continued Problem Potential</strong></td>
<td>Needs understanding of, or skills to change, current alcohol, other drug, or medication use patterns and/or high-risk behavior</td>
<td>At high risk of relapse or continued use without MAT and structured therapy to promote treatment progress</td>
<td>Able to maintain abstinence or control use and/or addictive behaviors and pursue recovery or motivational goals with minimal support</td>
<td>Intensification of addiction or mental health symptoms indicate a high likelihood of relapse/continued use or continued problems without close monitoring and support several times a week</td>
<td>Intensification of addiction/mental health symptoms, despite active participation in Level I or 2.1, indicates high likelihood of relapse/continued use/continued problems without near-daily monitoring and support</td>
</tr>
<tr>
<td><strong>DIMENSION 6: Recovery Environment</strong></td>
<td>Social support system or significant others increase the risk</td>
<td>Recovery environment and/or the patient has skills to cope</td>
<td>Recovery environment and/or the patient has skills to cope</td>
<td>Recovery environment NOT supportive, but with structure and</td>
<td>Recovery environment NOT supportive but, with structure and support and relief from home</td>
</tr>
</tbody>
</table>
### Levels 3.1 Through 4

<table>
<thead>
<tr>
<th>Criteria by Dimensions</th>
<th>Residential</th>
<th>Residential-to be implemented</th>
<th>Residential-to be implemented</th>
<th>Future contract TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIMENSION 1:</strong> Alcohol Intoxication and/or Withdrawal Potential</td>
<td>No withdrawal (WX) risk, or minimal or stable WX. Concurrently receiving Level 1 or 2-WM services (See withdrawal management criteria)</td>
<td>At minimal risk of severe WX. If withdrawal present, manageable at Level 3.2-WM</td>
<td>At minimal risk of severe WX. If withdrawal present, manageable at Level 3.2-WM</td>
<td>At high risk of withdrawal, but manageable at Level 3.7-WM. (see Withdrawal Management criteria)</td>
</tr>
<tr>
<td><strong>DIMENSION 2:</strong> Biomedical Conditions and Complications</td>
<td>None or stable, or receiving concurrent medical monitoring</td>
<td>None or stable, or receiving concurrent medical monitoring</td>
<td>None or stable, or receiving concurrent medical monitoring</td>
<td>Patient requires 24-hour medical monitoring but not intensive treatment</td>
</tr>
<tr>
<td><strong>DIMENSION 3:</strong> Emotional / Behavioral / Cognitive Conditions and Complications</td>
<td>None or minimal; not distracting to recovery. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced Program is required</td>
<td>Mild to moderate severity; needs structure to focus on recovery. Treatment should be designed to address significant cognitive deficits. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced Program is required</td>
<td>Demonstrates repeated inability to control impulses, or unstable dangerous signs/symptoms require stabilization. Other functional deficits require stabilization and a 24-hour setting to prepare for community integration and continuing care. A co-occurring enhanced setting is required for those with severe and chronic mental illness</td>
<td>Because of severe and unstable problems, requires 24-hour psychiatric care with concomitant addiction treatment (co-occurring enhanced)</td>
</tr>
</tbody>
</table>

Note: Adolescents have similar levels of care except ASAM 3.3 and Opioid Treatment Program which are highlighted in green and WM 3.2. SUTS currently has Levels .5, 1, 2.1 and 3.1 for adolescents. Please refer to “The ASAM Criteria,” third edition, Pages 90-104 for adolescent specific criteria.

<table>
<thead>
<tr>
<th>Criteria by Dimensions</th>
<th>Residential</th>
<th>Residential-to be implemented</th>
<th>Residential-to be implemented</th>
<th>Future contract TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 3.1</strong></td>
<td>Clinically Managed Low-Intensity Residential Services</td>
<td>Level 3.3 Clinically-Managed Population-Specific High Intensity Residential Services</td>
<td>Level 3.5 Clinically-Managed High Intensity Residential Services</td>
<td>Level 3.7 Medically-Monitored Intensive Inpatient Services</td>
</tr>
<tr>
<td><strong>DIMENSION 4:</strong> Readiness to Change</td>
<td>Open to recovery, but needs a structured environment to maintain therapeutic gains</td>
<td>Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment. If there is high severity Dimension 4 but not in any other dimensions, motivational enhancement strategies should be provided in Level 1.</td>
<td>Has marked difficulty with, or opposition to treatment, with dangerous consequences. If there is high severity Dimension 4 but not in any other dimension, motivational enhancement strategies should be provided in Level 1.</td>
<td>Low interest in treatment and impulse control poor, despite negative consequences; needs motivating strategies only safely available in a 24-hour structured setting. If there is high severity Dimension 4 but not in any other dimensions, motivational enhancement strategies should be provided in Level 1.</td>
</tr>
<tr>
<td><strong>DIMENSION 5:</strong> Relapse/Continued Use/Continued Problem Potential</td>
<td>Understands relapse but needs structure to maintain therapeutic gains</td>
<td>Has little awareness and needs interventions available only at Level 3.3 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction</td>
<td>Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences</td>
<td>Unable to control use, with imminently dangerous consequences, despite active participation at less intensive levels of care</td>
</tr>
<tr>
<td><strong>DIMENSION 6:</strong> Recovery Environment</td>
<td>Environment is dangerous, but recovery is achievable if Level 3.1 24-hour structure is available</td>
<td>Environment is dangerous and patient needs 24-hour structure to learn to cope</td>
<td>Environment is dangerous and patient lacks skills to cope outside of a highly structured 24-hour setting</td>
<td>Environment is dangerous and patient lacks skills to cope outside of a highly structured 24-hour setting</td>
</tr>
</tbody>
</table>

provide brief information about each LOC within the SUTS system of care.

<table>
<thead>
<tr>
<th>ASAM Level of Care</th>
<th>Service Name</th>
<th>Description of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-WM</td>
<td>Ambulatory Withdrawal Management without Extended On-Site Monitoring</td>
<td>This outpatient service may be delivered in an office setting, a health care, or addiction treatment facility or in a patient’s home by trained clinicians who provide medically supervised evaluation, withdrawal management and referral services. Specialized bio, psycho, social services are made available.</td>
</tr>
<tr>
<td>2-WM</td>
<td>Ambulatory Withdrawal Management with Extended On-Site Monitoring</td>
<td>This service may be received in a general health care or mental health care facility, or an addiction treatment facility, by medical and nursing professionals who provide evaluation, withdrawal management and referral services.</td>
</tr>
<tr>
<td>3.2-WM</td>
<td>Clinically managed Residential Withdrawal Management</td>
<td>This service is provided by appropriately trained staff who provide 24-hour supervision, observation and support for those who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than medical and nursing care. There is affiliation with other levels of care.</td>
</tr>
<tr>
<td>3.7-WM</td>
<td>Medically-Monitored Inpatient Withdrawal Management</td>
<td>Provides for 24-hour evaluation and withdrawal management in in-patient beds. Services are provided by medical and nursing professionals, under a defined set of physician-approved policies and physician-monitored procedures.</td>
</tr>
<tr>
<td>4-WM</td>
<td>Medically-Managed Intensive Inpatient Withdrawal Management</td>
<td>Medical and nursing professionals provide 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting.</td>
</tr>
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</table>

LOC highlighted in ▻ are currently not available in SUTS.
Table 7: SUTS Transfer Grid

<table>
<thead>
<tr>
<th>MODALITY</th>
<th>WITHDRAWAL MANAGEMENT</th>
<th>RESIDENTIAL</th>
<th>OUT PATIENT, INTENSIVE OUTPATIENT, PARTIAL HOSPITALIZATION AND NTP</th>
<th>ALL</th>
</tr>
</thead>
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<tr>
<td>FORM</td>
<td>WM to RES</td>
<td>RES to OS/IS/PHS</td>
<td>RES to OS/IS/PHS</td>
<td>RES to QI Extension</td>
</tr>
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<td>ALOC Sec B 1 (Auth)</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>ALOC Sec B 2 (Res Extension)</td>
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<td>X</td>
</tr>
<tr>
<td>ALOC Section B 3 (Non-Auth)</td>
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<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ROI 2</td>
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<tr>
<td>Other Consents</td>
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<td>SCC SUTS Advisement Form 1</td>
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<td>Psych Referral Form</td>
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X = Required  O = If Applicable

1 Santa Clara County Adult Drug and Alcohol Facility Advisement Form
2 No longer called System Consent
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ALOC</td>
<td>Assessment &amp; Authorization for Level of Care</td>
</tr>
<tr>
<td>ROI</td>
<td>Authorization for Use or Disclosure of PHI</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected Health Information</td>
</tr>
<tr>
<td>Auth</td>
<td>Authorization</td>
</tr>
<tr>
<td>Reauth</td>
<td>Reauthorization</td>
</tr>
<tr>
<td>OS</td>
<td>Outpatient (1)</td>
</tr>
<tr>
<td>IOS</td>
<td>Intensive Outpatient Services (2.1)</td>
</tr>
<tr>
<td>PHS</td>
<td>Partial Hospitalization Services (2.5)</td>
</tr>
<tr>
<td>RR</td>
<td>Recovery Residence (Formerly THU)</td>
</tr>
<tr>
<td>RS</td>
<td>Recovery Services</td>
</tr>
<tr>
<td>RES</td>
<td>Residential (3.1, 3.3, 3.5, etc.)</td>
</tr>
<tr>
<td>WM</td>
<td>Withdrawal Management (3.2)</td>
</tr>
<tr>
<td>Review Step</td>
<td>ODF/DCH/Residential</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Admission</td>
<td>Title 22, 51341.1 (h)(1)</td>
</tr>
<tr>
<td>DSM Code*</td>
<td>Title 22, 51341.1 (h)(1)(D)(ii)</td>
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<tr>
<td>Assessment</td>
<td>Title 22, 51341.1 (b)(10),(h)(1)</td>
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<tr>
<td>Treatment Planning*</td>
<td>Title 22, 51341.1 (h)(2)</td>
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<tr>
<td>Treatment Requirements</td>
<td>Title 22, 51341.1 (d) &amp; I</td>
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<tr>
<td>Progress Notes</td>
<td>Title 22, 51341.1 (d)(2),(h)(3)</td>
</tr>
<tr>
<td>Group Counseling Sign-in</td>
<td>Title 22, 51341.1 (g)(2)</td>
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<tr>
<td>Dosing Services</td>
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<tr>
<td>Provider &amp; Client Contact</td>
<td>Title 22, 51341.1 (h)(4)</td>
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<tr>
<td>Continuing Services*</td>
<td>Title 22, 51341.1 (h)(5)</td>
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<td>Discharge</td>
<td>Title 22, 51341.1 (h)(6)</td>
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<td>Fees Charged to Client</td>
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<td>Good Cause Codes</td>
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<td>Second Service</td>
<td>Title 22, 51490.1 (d)</td>
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<td>Fair Hearing</td>
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*These areas establish medical necessity for treatment services and deficiencies can result in recoupment of the entire treatment episode. Refer to Title22Drug Medi-CalSUD and Title9NTP.*

Note: Some of these regulations may have been amended or superseded by our contract as a MCP with DHCS. Please refer to: CountyImplementationPlans
Table 9: DMC ODS Same Day Billing Matrix

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<th></th>
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<td>Y</td>
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<td>Physical Therapy</td>
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<td>Occupational Therapy</td>
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<td>Speech Therapy</td>
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<td>Y means Yes Same Day Billing Allowed</td>
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<tr>
<td>N means No Same Day Billing Not Allowed</td>
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</table>

From DHCS: DMC ODS Same Day Billing Matrix
### Table 10: EHR Service Terms Crosswalk

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Status</th>
<th>Place of Service</th>
<th>Delivery Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake</td>
<td>Attended, Canceled, No Show</td>
<td>Office, Field</td>
<td>Face to Face</td>
</tr>
<tr>
<td>Individual Treatment SUTS</td>
<td>Attended, Canceled, No Show</td>
<td>Office, Field</td>
<td>Face to Face, Telephone</td>
</tr>
<tr>
<td>Case Management SUTS</td>
<td>Attended, Canceled, No Show</td>
<td>Office, Field</td>
<td>Face to Face, Telephone</td>
</tr>
<tr>
<td>Group Treatment SUTS</td>
<td>Attended, Canceled, No Show, More than 12</td>
<td>Office</td>
<td>Face to Face</td>
</tr>
<tr>
<td>Individual Treatment OTP/NTP</td>
<td>Attended, Canceled, No Show</td>
<td>Office</td>
<td>Face to Face</td>
</tr>
<tr>
<td>Group Treatment OTP/NTP</td>
<td>Attended, Canceled, No Show, More than 12</td>
<td>Office</td>
<td>Face to Face</td>
</tr>
<tr>
<td>Patient Education-SUTS</td>
<td>Attended, Canceled, No Show</td>
<td>Office, Field</td>
<td>Face to Face</td>
</tr>
<tr>
<td>PHS Treatment SUTS</td>
<td>Attended, Canceled, No Show</td>
<td>Office, Field</td>
<td>Face to Face</td>
</tr>
<tr>
<td>Recovery Individual Counseling SUTS</td>
<td>Attended, Canceled, No Show</td>
<td>Office, Field</td>
<td>Face to Face, Telephone</td>
</tr>
<tr>
<td>Recovery Group Counseling SUTS</td>
<td>Attended, Canceled, No Show</td>
<td>Office</td>
<td>Face to Face</td>
</tr>
<tr>
<td>Recovery Case Management SUTS</td>
<td>Attended, Canceled, No Show</td>
<td>Office, Field</td>
<td>Face to Face, Telephone</td>
</tr>
<tr>
<td>Recovery Monitoring SUTS</td>
<td>Attended, Canceled, No Show</td>
<td>Office, Field</td>
<td>Face to Face, Telephone</td>
</tr>
<tr>
<td>3.1 SUTS RES Treatment</td>
<td>Attended</td>
<td>Office</td>
<td>Face to Face</td>
</tr>
<tr>
<td>3.2 SUTS WM Bed Day</td>
<td>Attended</td>
<td>Office</td>
<td>Face to Face</td>
</tr>
</tbody>
</table>
Appendix B: Acronyms Glossary

ALOC: Assessment & Authorization for LOC
ARDS: Adolescent Residential Demographics
ASAM: American Society of Addiction Medicine
ASOC: Adult System of Care
Batch: Process of preparing Services for billing
BHSD: Behavioral Health Services Department
BBS: Board of Behavioral Science
CalOMS: California Outcome Measures System
CAP: Corrective Action Plan
CBO: Community Based Organization
CDCR: CA Dept. of Corrections
CFS: Client Feedback Survey
CJS: Criminal Justice System
CMS: Centers for Medicare & Medicaid Services
CSC: Clinical Standards Coordinator
CSJ: Continuing Service Justification
CSR: Client Status Report
CPM: Clinical Performance Measures
DHCS: Department of Health Care Services
DMC: Drug Medi-Cal
ODS: Organized Delivery System
DSM: Diagnostic and Statistical Manual
DWC: Dependency Wellness Court
EBP: Evidence Based Practice
EHR: Electronic Health Record
EQRO: External Quality Review Org.
EPS: Emergency Psychiatric Services
GRS: Gateway Referral for Services
HealthLink: HHS Electronic Health Record
CSCHS: County of Santa Clara Health System
HIPAA: Health Insurance Portability Accountability Act
HSQ: Health Screening Questionnaire
ICD: International Classification of Disorders
IA: Intergovernmental Agreement
IJS: Integrated Justice Services
ILOC: Increased Level of Care
IOS: Intensive Outpatient Services
LOC: Level of care
LOS: Length of Stay
LPHA: Licensed Practitioner of the Healing Arts
MH: Mental Health
MRN: Medical Record Number
NPI: National Provider Identification Number
NPI: National Provider Identifier
NTP: Narcotic Treatment Program
OB: Obstetrician
OTP: Opioid Treatment Program
PCP: Primary Care Physician
PHI: Protected Health Information
PHS: Partial Hospitalization Services
P&P: Policy and Procedures
PSAP: Perinatal Substance Abuse Program
QI: Quality Improvement.
QIC: Quality Improvement Coordinator
RES: Residential
ROI: Authorization for Use or Disclosure of Protected Health Information (form)
RR: Recovery Residences
SAMHSA: Substance Abuse Mental Health Services Agency
SCC: Santa Clara County
SUD: Substance Use Disorder
SUTS: Substance Use Treatment Services
TAY: Transitional Age Youth
TB: Tuberculosis (test)
TP: Treatment Plan
TSR: Treatment Status Report
TX: Treatment
UA: Urinalysis Screening for Drug Use
UM: Utilization Management
URF: Universal Referral Form
VHP: Valley Health Plan
VMC: Valley Medical Center
WM: Withdrawal Management
YSOC: Youth System of Care
<table>
<thead>
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<th>Key Word</th>
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<td>Adolescent Residential Demographics (ARDS)</td>
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<tr>
<td>ALOC... 18, 19, 20, 21, 23, 24, 27, 48, 49, 50, 51, 52, 54, 82</td>
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<tr>
<td>Approved ICD 10 Codes</td>
<td>32</td>
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<tr>
<td>Assessment</td>
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<td>CAADE, CCAPP, CADTP</td>
<td>17</td>
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<td>CalOMS</td>
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<td>Care Plan</td>
<td>11, 24, 32, 33, 35</td>
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<td>Case Management</td>
<td>9, 27, 31, 43, 57, 63</td>
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<td>Certified</td>
<td>16, 17, 72</td>
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<td>Certified/Credentialed</td>
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<td>Clinical Performance Measures</td>
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Afterword

Members who participated in the development of the original manual included QIC staff from the SUTS Quality Improvement Division, Clinical Standards Coordinators, SUTS QI Data support and Financial Administrative Staff. All these contributions were invaluable.

This newer version was amended with minor changes/corrections by the Project Director, Nancy Taylor, in consultation with QI Clinical Standards, ROM, Financial Administration, and Directors. There will continue to be changes in our Policy & Procedures as the Intergovernmental Agreement (DHCS-ODS 1115 Waiver) is further implemented and clarified by both SUTS and DHCS.

Every attempt was made to review and include new Medi-Cal, DHCS State and Federal Guidelines, the updated ODS 1115 Waiver and current SUTS policy, procedures and practices to create this manual. If you believe there are errors or corrections needed in the manual, please contact Nancy Taylor at nancy.taylor@hhs.sccgov.org and/or discuss with your assigned QIC.

Si Se Puede
Chúng ta có thể làm được
TOGETHER