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Chapter 1: Introduction

Overview and Purpose

This Clinical Provider Manual is to be used by clinicians as a reference guide and should be used along with your Policy and Procedure manual and in consultation with your Program Manager to understand chart documentation requirements. Additional reference documents include QI-issued Alerts, the Beneficiaries 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 ODS 1115 Waiver Pilot, the California Code of Regulations, Department of Health Care Services (DHCS) guidelines, the Santa Clara County BHSD Substance Use Treatment Services policies & procedures, directives, and memos; 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 clinicians, interns, 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). The ASAM 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 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 with acknowledgement of their cultural perspective and beliefs.
- 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 ASAM Stage of Readiness to Change principles.
- To meet HHS Triple Aims: Improved Outcomes, Customer Experience, and Reduced Costs.

Strategic Priorities

Behavioral Health, as a whole, is focusing 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 SUTS and MH move forward to be one BHS Department, we will increase collaboration and cross referral with Mental Health as well as co-location of services. We may use the four-quadrant model (Ries, 1993) to recommend the location of treatment for clients with different combinations of severity of mental health and substance use disorders. Quadrant I clients will be served in primary health care settings, Quadrant II clients in substance-use focused treatment settings, Quadrant III clients in mental health settings and Quadrant IV clients in fully integrated service settings.

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

Modalities Covered By Manual

The SUTS-BHSD Manual covers the following modalities:
- Outpatient Drug Free (OP or ODF)
- Intensive Outpatient Treatment Services (IOT)
- Medication Assisted Treatment (Additional MAT)
- Narcotic Treatment Program (OTP/NTP)
- Residentially Based Substance Use Services (RES) for Youth and Adult
- Withdrawal Management Services for Adults
- Perinatal Treatment Services
- Targeted Case Management Services
- Recovery Services
- Recovery Residences (THUs)
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 in regards to client engagement and billing. To maintain simplicity and brevity, readers should refer to other documents for more details, including the 1115 ODS Waiver Pilot, Title 22, Title 9 and other State & Federal guidelines. Clinicians should also familiarize themselves with the new Beneficiary Handbook, the Business Operations Manual and new Grievance procedures. The SUTS P&P will be revised to reflect the changes due to the waiver. The old P & P is now available on the new BHSD website for your access and may result in changes to current practices. Website Link: BHSDPARTNERS

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 clinician, 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, including the Mental Health online Documentation training. Link: sccLearn

You will see the ladder symbol throughout the manual. This reflects the ASAM “Decisional Ladder” which should be familiar to those who have completed the mandatory ASAM trainings.
For the complete ladder, see Appendix A: Table 1: Table1Decision

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.
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) within Santa Clara County. SUTS must ensure Federal and State regulations are met. SUTS must also make sure that provider agencies 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 ODS 1115 Waiver Pilot provides for Santa Clara County SUTS to operate as a Managed Care Plan (MCP). SUTS now shifts to a formal insurance plan that principally serves Medi-Cal beneficiaries and unsponsored clients. SUTS services as a MCP now fall under the Federal guidelines of 42 CFR Part 438-Managed Care.* Clients are “beneficiaries” with a specific set of entitlements and rights of access to substance use treatment services. *“Mega Rules”

System Performance:

The Managed Care Plan requires specific performance metrics in areas such as access to care, appropriate placement, and 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:

- **Timeliness to Treatment Services:** The following metrics are tracked: access from initial contact to first appointment, timely appointments, no-shows and other measures.
- **Quality of Care Standards:** MCP will ensure Providers operate within their scope of practice, have evidence of fidelity to ASAM Criteria and meet medical necessity as well as obtain authorization for Residential Treatment services. MCP will measure clinical and/or functional outcomes of clients and other measures.
- **Engagement:** Outpatient providers shall provide 4 client contacts within the first 30 days of treatment.
- **Use of:** Evidenced Based treatment and practice guidelines.
- **Fidelity to:** ASAM
- **Client Satisfaction Survey & TEA**

What are the outcome measurements?
Out of County Clients

Please refer to DHCS Information Notice 17-036 DHCSInfo as of July 28, 2017. All out of county Medi-Cal beneficiaries will be referred back to their county of origin except as follows:

1. If a client is out of county and in transition moving to Santa Clara County, the goal is to ensure that they are working with SCC SSA. The counselor will document the client’s attempts to complete the Medi-Cal package and request verification of submission to SSA.

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

3. If the client had already started Social Services Agency paperwork to have county of origin transferred to SCC they must provide proof.

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:

- A client identifier
- Client date of birth
- Client gender
- Client race/ethnicity
- Client address & phone number
- Client Authorization for treatment
- Appropriate Advisements, Authorizations and Acknowledgement of Receipts
- Client’s emergency contact and if none, so indicate
- Referral source and reason for referral
- 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 including but 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 Primary Care
- Treatment Plans
- Discharge Plan
- Discharge Summary
- Continuing services justifications
- Proof of parental involvement 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.

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.

Require items that must be in the chart records include:

- Documentation of Medi-Cal eligibility status for each month in treatment.
- Identification of Primary Counselor on Treatment Plan

Each site must all maintain a separate record of Group and Supervision sign in sheets and documentation of individual and group consultation.

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 be maintained in a locked unit at all times. All electronic devices must also be secured.

Audits

SUTS QI is responsible for performing regular clinical audits. Audits conform to DHCS and DMC regulations as well as internal contract performance measures. SUTS Administration also conducts fiscal and administrative audits annually. The audits identify areas of compliance and deficiencies that may affect reimbursement. The audits also evaluate whether providers meet clinical performance standards. The MCP requires each modality to demonstrate that they are providing a minimum two out the following five EBPs: Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Trauma Informed Treatment, Relapse Prevention (Gorski Model) and Psychoeducation. Additional Evidenced Based Practices (EBP) may be used but providers need to implement at least two of the above. EBPs shall be incorporated into Progress notes and manual audits used to establish the use of EBPs. Please note that requirements may be subject to changes and revisions by DHCS and other contracting entities.
Peer Utilization Reviews (UR) & Counselor Self-Checks:

Internal Peer Reviews must be conducted every quarter, reviewing a selection of charts for both regulatory and clinical compliance. Documentation of the Internal Peer Review must be kept in the client chart. Each agency must document their review process and findings and submit to SUTS QI and SUTS Administration/Finance. Peer reviews allow the clinician and/or agency to catch patterns of errors and take corrective actions, request training, and improve outcomes.

Counselor self-checks:

All clinicians should check their work in Pro-Filer to catch documentation and service errors using the Today or Past Recorded Services Reconciliation Reports* (*AR USI 10101 (today) AND AR USI 101042 (past)). The new DADS3007 report is now available to check CalOMS annual due dates. CBOs with their own EHR’s may have similar reports available and/or may also request their clerical run Pro-Filer reports. 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 Documentation standards:

Audits also review the provider’s contract specifications for clinical supervision. Requirements include documentation (minutes or notes) of clinical supervision for both individual and group supervision and corresponding sign-in sheets.

This documentation must have:
1. Time and date of the session
2. Name of the practitioner(s) attendees
3. Outline/summary of the cases/issues discussed with special attention to legal and ethical requirements and risk management
4. Outcomes and action plan for next clinical steps
5. Trainings provided to staff including topic and presenter.

Signature Requirements:

Signature Requirements:

Provider Signature

Signatures and corresponding dates are an integral part of the documentation process. The signature and date is 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 signifies 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
- 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 detailed 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. The client should still be encouraged to sign this updated Treatment Plan and the counselor should document efforts to have the client sign. 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:

DHCS link to Federal, State and DHCS laws and regulations

DHCS Supplement 3 TN No. 13-038 : DHCS SUD Services
Chapter 3: Scope of Practice

The Scope of Practice for a credentialed or licensed provider as defined by State, Federal and County regulations and is ensures that clinicians 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 or Trainees 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 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 NPI-National Provider Identifier. See: NPPES Website and work with your Program Manager to obtain your NPI.

The type of actual 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.

Under the ODS Waiver, registered ASWs, AMFTs, and APCCs and PHDAs who are licensed 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.
LPHAs may confirm diagnoses, validate medical necessity, and review, approve and sign treatment plans. This means that they do not require co-signatures for their notes, treatment plans, etc., except as required by their specific agency and clinic. OTP/NTP programs are not in the waiver and operate under the supervision of the MD with more conservative requirements.

Note: SCC SUTS policy is that pre-licensed providers may not sign off on notes, treatment plans, medical necessity, and diagnosis for (pre)Credentialed, (pre) Certified counselors. This requires fully licensed LPHAs.

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

Certified/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. (CAADE, CCAPP, CADTP) ¹

¹ CA Association for Alcohol/Drug Educators, CA Consortium of Addiction Programs & Professionals, CA Association of DUI TX programs

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

Community Workers and Peer Mentors currently do not require licensing but must complete all SUTS mandatory trainings.

See Appendix A: Table 2 for Crosswalk for Services Scope of Practice Crosswalk-Table2SOP
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

Clients entering through Gateway (1.800.488.9919) are screened using the Gateway Referral for Services (GRS). Pre-Authorization sites will use the (new) Registration and Referral for Services form (RRS) for registration and complete the Assessment and Authorization Form (ALOC), which summarizes the ASAM severity score and used to indicate which modality and intensity of services (Level of Care) will best serve the client’s needs and Stage of Change. Providers will also determine clients SUD diagnosis, and document the rationale for a level of care placement and medical necessity for treatment.

*All ALOCs that require an external Clinic site or modality or QI to view; i.e., Transfers, Authorizations (and Re-Authorizations) for Residential, Recovery Residence placement are done at Client Level. All others (regular Admits & Discharges) are at Cost Ctr Level.*

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; The GRS continues to be valid for 6 months, while the ALOC is only valid for 30 days and must be re-done if there has been a gap between referral and placement or if client has significant change in status.

⇒ Please refer to Table 4, ASAM Residential Levels of Care: [Table4ResAsam](#). 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
- All Pre-Authorization sites will use the RRS for registration (Includes: DWC, MH Juvenile Hall, Re-entry Center and Withdrawal Management Sites).
- Medical-Homes assessors use the RRS for registration for Screening and ALOC for placement and HealthLink for all other documentation.
- Methadone Screenings vary greatly based on referral source and admission type. They will, however complete Pre-Authorization Registration and ALOC. Please refer to the OTP/NTP P & P for specifics on these screening/intakes.
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 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 Pro-Filer. If there is no prior admission, the Referral Coordinator will complete the GRS screening, and the case is assigned to a provider. When a direct referral is received from school staff to the Youth services provider on site, the client can be admitted directly using the RRS for registration for registration.

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 referred to Adult Withdrawal Management, Recovery Residences, or Residential when appropriate.

Documentation Tip: TIP!
Document in the Progress Notes all forms and consents completed with the client at intake, including registration forms, CalOMS admission form, health screening questionnaires, ALOC, acknowledgements, and parental involvement. Clinicians 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: If the intake and ALOC are completed and the client opened in your Cost Center 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.
For a Timelines Overview, please refer to Table 3: Table3Timelines
Note: Please also refer back to LPHA definitions in: Chapter 3: Scope of Practice
### Timelines and Treatment Requirements

#### Outpatient & Intensive Outpatient Treatment (ASAM Level 1 and 2.1)

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Timelines</th>
<th>Process</th>
</tr>
</thead>
</table>
| **Intake**<br>Definition: First Face to Face contact with the client & starts clock for all Timelines requirements | First Face to Face contact must be within fourteen days of receipt of the referral | • Complete ALOC Assessment  
• Determine SUD DSM/ICD Diagnosis and Medical Necessity  
• Document Intake summary with statement of SUD diagnoses and description of symptomology, nature of impairment or distress and specific criteria of the substance use disorder diagnosis.  
• Complete Consent to Treatment  
• Review all acknowledgements, advisements and consents |
| **Other Admission Procedures** | Due within first 30 days | • HSQ must be reviewed with client and obtain client signature at admission.  
• HSQ must be reviewed & signed by MD within 30 days and prior to completion of TX plan.  
• Determine whether client had physical examination within last 12 months and obtain documentation of exam or document no exam and referral made.  
• For minors, the counselor must document attempts to involve client’s parents. |
| **Initial Treatment Plan** | Within 30 days of admission | • Must be completed, signed and dated by primary counselor and client  
• Must be reviewed by LPHA, if the primary counselor if primary counselor is not a LPHA, and signed and dated within 15 days of the initial signature of the counselor.  
• If clinician 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 Targeted Case Management) must be documented on the Treatment Plan. |
| **Updated Treatment Plans** | 90 days after last Treatment Plan | • Subsequent Treatment Plans are completed no later than 90 days calendar days after last Treatment Plan or when a change in problem or focus of treatment.  
• Must be reviewed, approved, signed, and dated by the counselor and client no later than 90 calendar days after signing the initial Treatment Plan.  
• Must be reviewed by LPHA if the primary counselor, if the primary counselor is not a LPHA, and signed and dated within 15 days of the initial signature of the counselor. |
<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Timelines</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Engagement</td>
<td>4 clinical contacts in first 30 days</td>
<td>• All Outpatient clients should receive a <em>minimum</em> of 4 counseling sessions within first 30 days and as determined by individual need.</td>
</tr>
<tr>
<td>Treatment IOT Adult</td>
<td>IOT Adult</td>
<td>• Treatment must be a minimum of 9 and a maximum of 19 hours of structured programming weekly.</td>
</tr>
<tr>
<td>Treatment IOT Youth</td>
<td>IOT Youth</td>
<td>• Treatment must be a minimum of 6 and a maximum of 19 hours of structured programming weekly.</td>
</tr>
</tbody>
</table>
| ASAM Review           | At Admission & Discharge & as clinically indicated | • The ALOC form must be completed at Admit and at Discharge *  
• The ASAM 6 Dimensions should be regularly reviewed with the client, are documented within Progress Notes, and be reflected in the Treatment Plan. |
| Bi-Annual Review      | Between 5<sup>th</sup> and 6<sup>th</sup> month of Treatment | • The review must be a “face-to-face” interaction between the LPHA and the primary counselor if they are credentialed or certified.  
• The LPHA signature is validating or verifying the determination of medical necessity and must be completed by date review is due.  
• The client may be included in this review. |
| Annual Review         | Between 11<sup>th</sup> and 12<sup>th</sup> month of Treatment | • The review must be a “face-to-face” interaction between the LPHA and the primary counselor if they are credentialed or certified.  
• The LPHA signature is validating or verifying the determination of medical necessity and must be completed by date review is due.  
• The client may be included in this review. |
| 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 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.  
• Complete ALOC at Discharge  
  * Note: All documentation is required within 48 hours of date of service per SUTS Policy, 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. |
## Outpatient Perinatal Specific Treatment Requirements

### Admission Criteria

- Clients must be pregnant or with children 5 years or under.
- 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.

### OTP/NTP Specific Requirements (Methadone)

#### Intake

- Must conduct laboratory tests and certify fitness for treatment.
- Includes Physical Exam
- 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

- Must be signed at admission and re-signed within 30 days.
## Residential Specific Requirements (ASAM Level 3.1, 3.3 and 3.5)

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Timelines</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake</strong>&lt;br&gt;First Face to Face contact with the client &amp; starts clock for all Timelines requirements&lt;br&gt;<strong>Timelines</strong>&lt;br&gt;First face to face contact by clinician within 24 hours of admission</td>
<td>• Complete new ALOC if no current authorization ALOC&lt;br&gt;• Determine SUD DSM/ICD Diagnosis and Medical Necessity&lt;br&gt;• Document Intake summary with statement of SUD diagnoses and description of symptomology, nature of impairment or distress and specific criteria of the substance use disorder diagnosis.&lt;br&gt;• Review all acknowledgements, advisements and consents</td>
<td></td>
</tr>
<tr>
<td><strong>Other Admission Procedures</strong>&lt;br&gt;Due within 10 calendar days</td>
<td>• Review Health Screening Questionnaire with client and obtain signature. HSQ must be reviewed &amp; signed by MD within 10 days and prior to completion of TX plan.&lt;br&gt;• Must be signed by MD.&lt;br&gt;• Determine whether client had physical examination within last 12 months and obtain documentation of exam or document no exam and referral made.&lt;br&gt;• Begin full Biopsychosocial Assessment.&lt;br&gt;• Complete CalOMS admission form by 10&lt;sup&gt;th&lt;/sup&gt; day.</td>
<td></td>
</tr>
<tr>
<td><strong>Initial Treatment Plan-Specific to Residential</strong>&lt;br&gt;Due within 10 calendar days</td>
<td>• Must be completed, signed, and dated within 10 days of client’s admission to treatment.&lt;br&gt;• Must be reviewed and signed by LPHA within 10 days of admission if primary counselor is not a LPHA</td>
<td></td>
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<tr>
<td><strong>Updated Treatment Plans</strong>&lt;br&gt;As needed</td>
<td>• Subsequent Treatment Plans are completed when a change in problem identification or focus of treatment occurs.&lt;br&gt;• Must be reviewed and signed by LPHA by due date of updated TX plan if primary counselor is not a LPHA</td>
<td></td>
</tr>
<tr>
<td><strong>ASAM Review</strong>&lt;br&gt;ALOC at Admit &amp; at Discharge and as needed throughout Treatment</td>
<td>• The ALOC form should be completed at Admission and Discharge&lt;br&gt;• The ASAM 6 Dimensions should be regularly reviewed with the client, are documented within Progress Notes, and be reflected in the Treatment Plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Discharge Plan</strong>&lt;br&gt;Completed by discharge date with client.</td>
<td>• The Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources.&lt;br&gt;• Must be signed and dated by the counselor and the client with a copy offered to the client and placed in the client record.</td>
<td></td>
</tr>
<tr>
<td><strong>Discharge</strong>&lt;br&gt;Completed within 48 hours of last face to face or last clinical telephone contact with client.</td>
<td>• Written summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary and discharge prognosis.&lt;br&gt;• Complete CalOMS Discharge Questionnaire&lt;br&gt;• Use the CalOMS Administrative Discharge if client has left treatment and cannot be interviewed&lt;br&gt;• ALOC must also be completed at Discharge</td>
<td></td>
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</tbody>
</table>
Withdrawal Management Requirements (ASAM Level 3.2)

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Timelines</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake</strong></td>
<td>First face to face contact by clinician within 24 hours of entry</td>
<td>• Complete new ALOC if no current ALOC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Determine SUD DSM/ICD Diagnosis and Medical Necessity</td>
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<td></td>
<td></td>
<td>• Document Intake summary with statement of SUD diagnoses and description of symptomology, nature of impairment or distress and specific criteria of the substance use disorder diagnosis.</td>
</tr>
<tr>
<td><strong>Other Admission</strong></td>
<td>At admission</td>
<td>• Complete Pre-Authorization Registration form if no GRS done by Gateway.</td>
</tr>
<tr>
<td>Procedures</td>
<td></td>
<td>• Complete CIWA at intake and as required thereafter</td>
</tr>
<tr>
<td><strong>WM Care Plan</strong></td>
<td>Within 48 hours of admit</td>
<td>• Complete Withdrawal Management Care Plan within 48 hrs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Must be completed, signed and dated by LPHA and client</td>
</tr>
<tr>
<td><strong>Discharge Plan</strong></td>
<td>Completed by discharge date with client</td>
<td>• The Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Must be signed and dated by the counselor and the client with a copy offered to the client and placed in the client record.</td>
</tr>
<tr>
<td><strong>Discharge</strong></td>
<td>Completed within 48 hours of last face to face with client</td>
<td>• Written summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary and discharge prognosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complete CalOMS Discharge Questionnaire</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use the CalOMS Administrative Discharge if client has left treatment and cannot be interviewed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ALOC is completed at Discharge</td>
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SUTS currently has WM 3.2 only. For a complete review of all levels of WM please refer to Table 5, WM.

**Definition of Annual Period and Lengths of Stay**

In the SUTS Managed Care Plan (MCP), per DHCS guidelines, the year begins on July 1 and ends on June 30. This means that tracking Residential Treatment episodes per year refers to that period between July 1 and 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.

Reimbursement through Medi-Cal allows for two non-continuous episodes of treatment in any one-year period. Both Adults and Youth may be authorized for one 30-day extension per annum. Additional treatment episodes may be authorized by QI, when medically necessary; however, these episodes cannot be charged to Medi-Cal and will be reimbursed through SUTS during the Waiver Pilot.
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 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 and shall be reviewed and signed by the MD prior to the completion of the Treatment plan, which is due by the 10 days from admission date. 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.

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 MAT 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 ASAM Dimension 2. This includes TB testing which is required for admission to Residential and Recovery Residences. It is the clinician’s responsibility to continue to encourage and assist the client in obtaining medical care and the exam throughout the treatment episode.

To review:

Physical Exam:

a) Completed by MD/NLP/PA within 30 days of admit date in OP/IOT and 10 days in Residential

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

   a. If TB test need indicated by MD, OP/IOT counselor must assist client in obtaining.
Care Coordination

The minimum requirements for coordination with physical health involve:

a) Linking clients without a primary care physician to health services for immediate needs
b) Linking clients to a primary care physician 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 requirement 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 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 include the Discharge Diagnosis in your Discharge summary. This should also be included on your Progress Note. Prognosis is identified as “Good, Fair or Poor”. This also requires some explanation as to why the clinician selected the prognosis.

For example:

**Patient's Prognosis:** ☒ 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.

*There are some exceptions to completing ALOC at Discharge which are addressed in Chapter 5, page 28.
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 Targeted Case Management needs, and where applicable, and based on the counselor’s scope of practice, any mental health diagnosis. The complete assessment should also address family and cultural issues, school and vocational issues, legal issues, preferred language and gender identity.

Assessment is an ongoing aspect of treatment and the clinician should evaluate the client’s progress and document areas of new concern at each contact. SUTS 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.

ASAM

Regular review of the client’s appropriate placement in the correct Level of Care is required to assure fidelity to ASAM. The review of all 6 dimensions is documented at Admission and at all Discharges using the ALOC and should 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 ASAM 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.

ASAM 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 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 Assessment and Authorization Level of Care (ALOC) is used to document the severity at each of the 6 dimensions. It is required at Intake, Transfers, and Authorization requests for Residential Treatment, requests for Recovery Residences and at Discharge. It will not be the only assessment used at your specific agency. Each agency should determine what format is used to complete the full biopsychosocial assessment.
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 further in Chapter 10.

There are some exceptions to the need to complete a new ALOC. Here are some examples:

1. If a client is in one LOC and referred to another LOC using the ALOC, and that ALOC referral is completed concurrently to the discharge (within a few days) there may not be a need to complete a separate discharge ALOC.

2. Similarly if a client is referred by OP/IOT and authorized for Residential and is admitted within a short span of time from discharge from OP/IOT (7 days approx.) there may not be a need for a new intake ALOC at Residential.

3. If client is referred to a RR from residential and this corresponds with date of discharge, it is not necessary to do another ALOC.

If in doubt, consult with your supervisor and, if needed, QI. The 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 4, ASAM Residential Levels of Care: Table4ResAsam.
- See Table 5 in Appendix A: Levels of Care Placement Overview: Table5LOC
- 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 and maintain abstinence. 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, 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 clinicians degree of concern (How worried are you?). (“Three H’s”) (From The ASAM Criteria, 2013)

**Assessment of Imminent Danger**

Requires the presence of all of 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, lead a person the Emergency Room.
3. Dimension 3:
   a. Possibility of immediate danger to self or others.
   b. Possibility of uncontrolled intoxication, which could threaten the imminent safety of self or others.
4. Dimension 4:
   a. Ambivalence or disinterest in change, especially in the light of potential high risks in other dimensions.
5. Dimension 5:
   a. Further use may cause acute psychosis or mania, which may threaten 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 regards 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, rather than deficits and problems, creates an opportunity to see possibilities, and options, and promotes change (Adams & Grieder 2005).

In your Assessment 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. These items should be considered in any assessment however, and represent best clinical practice standards. A counselor must include all of the items in an assessment that are relevant to a particular client and document what is not applicable and why. SUTS expects that any assessment include a comprehensive assessment of all 6 ASAM dimensions.
Required elements for an integrated assessment include:

1. Identifying information including emergency contact information
2. Primary clinician 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 (ASAM) in all areas (Dim 1-6)
11. Client Strengths (All)
12. 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)
13. Accommodations necessary to address language and other needs. (All)
14. Family or parent involvement both past and present, and family strengths. (Dim 6)
15. Social, peer and community relationships (Dim 6)
16. Economic Status (Dim 6)
17. Educational and/or vocational status (Dim 6)
18. Housing status and needs (Dim 6)
19. Legal Issues past and present (Dim 6)
20. Clinical Summary and Recommendations for Level of Care and intensity of services (All)

A “Master Problem” list, if required by your agency, would typically be included in the Assessment Summary as those areas needing to be addressed in the Treatment Plan.
Chapter 6: Diagnosis, Medical and Clinical Necessity

Diagnosis and Medical Necessity

Diagnosis

A Credentialed or Licensed, or Pre-Credentialed or Pre-Licensed counselor, within their scope of practice, will determine a principle (primary) and, when appropriate, any additional Substance Use Disorder diagnosis. Licensed or Pre-Licensed counselors only may add a secondary Mental Health diagnosis. These diagnoses are determined through the assessment of the client and are addressed within the Treatment Plan whether through referral or as part of treatment. The DSM diagnosis is based on the information collected during assessment, documenting all the critical issues of an individual’s symptomology, impairment, and distress. Note: Max of 5 Diagnoses in Pro-Filer

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 are currently using ICD-10 and DSM 5. 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 Alcohol Use Disorder, severe

If the 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. In Pro-Filer, if the primary diagnosis is changed, then the old diagnosis must be expired one day prior to the entry of the new diagnosis.

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. DSM 5 criteria are used to refine the diagnosis for the specific substance 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](http://www.dhcs.ca.gov/services/adp/Documents/Title_22_Diagnosis_Medical_Necessity_DSM.pdf)

The LPHA or doctor’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 the counselor reaches by applying the relevant DSM 5 and ICD 10 criteria.

**Role of Physicians**

Health issues and medical eligibility for the client are determined via a Health Screening Questionnaire (HSQ) and/or Physical Exam and the ASAM 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 ASAM Dimension Two. If the MD recommends Mental Health assessment or care than this must be documented under ASAM 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 Physical care and document those efforts within the client chart.
DHCS Requirement of Face to Face Review

An update on 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.”

Clinical Necessity

If the LPHA or doctor does not agree that the client meets SUD criteria for medical necessity, some bridge services may 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.
Chapter 7: Treatment Planning

The provider shall prepare an individualized written Treatment Plan, based upon information obtained in the assessment process and in collaboration with the client. The Treatment Plan will be signed by the counselor and client within: 30 days of admission (OP/IOT), 28 days (OTP/NTP) or within 10 days (Residential). The Treatment Plan must be updated every subsequent 90 days in OP/IOT (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 client’s strengths should be incorporated into every Treatment Plan along with incorporating the EBPs utilized during treatment.

Withdrawal Management requires a “Care Plan”. The WM 3.2 Care Plan is to be completed by utilizing the three short-term strength based objectives on the ALOC within 48 hours. Typical Care Plan objectives might be; Complete withdrawal from alcohol; Manage withdrawal symptoms with support from staff who will complete CIWA as needed; transition to Outpatient (or Residential) Treatment. Recovery Services requires a “Care Plan” which is completed within 30 days of admission.

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.

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 (ASAM) should be noted next to each Problem Statement on the Treatment Plan

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)
4. **Target dates** are agreed upon by the counselor and client for accomplishment of action steps and goals.

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 be consistent with and indicate the qualifying SUD diagnosis.
3. The Treatment Plan starts when both the client and counselor have signed it.
4. The Treatment Plan must be cosigned by a (fully licensed) LPHA, if the primary counselor is credentialed, certified, or pre-credentialed.
   a. A review and signature by a MD may be required by individual agencies or clinics.
   b. Counselors should consult with their supervisor for specific instructions about agency or clinic-specific requirements.
5. Timelines for Treatment Plans and co-signature requirements are in Table 3: Timelines
6. The client should **always** be offered a copy of the Treatment Plan and the counselor should document this in the Progress Note.
7. The Treatment Plan must be offered in the client’s preferred language and in English.

**Documentation Tip:**

Progress Notes should **always refer to the Treatment Plan** and document client’s progress and barriers to accomplishing the Treatment Plan Goals and Action Steps within the correct ASAM Dimension. Group notes must also carry the thread of the TX Plan. The TX plan must indicate the frequency of Individual, Group and TCM.
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 new BHSD “Authorization for Use or Disclosure of Protected Health Information” form, please see SCVHHS Administrative P&P #585.12 Authorization for Use or Disclosure of Protected Health Information form (APHI) and refer to SUTS Alert sent 5-16-17.

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. The purpose of “informed consent” is to ensure that clients understand the purpose and nature of any signed agreements regarding their treatment. The informed consent also functions as the legal record of that treatment and disclosures. 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 (APHI)
2. Authorization for Audit/Monitoring and Billing
3. Group Confidentiality Agreement
4. Notice of Privacy Practices and Acknowledgement of Receipt
5. Client Rights
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
9. Acknowledgement of Receipt of Beneficiary Handbook
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

**Clients who are pregnant, either adult or youth**
1. For pregnant and postpartum women, medical documentation that substantiates the client’s pregnancy and the last day of pregnancy. (Title 22)

**Youth Services clients**
1. Record of Parent Involvement
2. School Staff Confidentiality Agreement
3. Multi-Service Team Confidentiality Agreement

Minors (12 years and older) can consent for their own treatment. 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.

**Note:** In the future, there will be integrated BHSD P&P and forms, wherever possible.

**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. 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 should not to be charged as Targeted Case Management but must be documented in the clinical record.

**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, legal record of the course of treatment. It provides the information needed for both guiding the treatment process and for billing purposes.

Progress Notes 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 and best clinical standards practices. (Please refer to Title 22 § 51341.1 (h) (3))

Documentation of all services is required regardless of reimbursement. Progress 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 always 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 clearly reflect the application or utilization of Evidenced Based Practices (EBP) during 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

Time Requirements

A Progress Note is recorded for each service by clinician providing the service. SUTS BHSD requires that notes be done within 48 hours of date of service. Progress Notes should reflect the Process of change as per BHSD P&P 1015.
Documentation Tip:

Progress Notes must include:

- **Type** of service: Services allowed for charging/billing are limited to those services outlined in Chapter 11 under each LOC. All Progress Notes, however, should identify the exact type of encounter, such as Treatment Planning, Discharge Planning, Crises Intervention, etc. This will assist the Auditors in finding the related service when reviewing charts.

- The **date**, **start time** and **end time** and **duration** for each service.

- Attendance: **No-shows** or **cancellations** must be documented along with attempts to contact the client. The time entered should be the time and duration of the planned appointment.

- 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** (ex. MFT, LCSW, CAADE, etc.) and **Date** the note was completed and signed.

There are many acronyms to remind the counselor of what must be within the Progress Note. BHSD has adopted **P I R P** (Problem, Interventions, Response, and Plan).

For Example: **P I R P**

- **P**-Problem: Description of client’s problem that they are presenting with, and the Dimension being addressed, in the current session and how it is related to the *Treatment Plan goals and actions steps*.
- **I**-Interventions: Counselor’s Intervention 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.
- **P**-Plan of action/assignments given

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

- Show evidence of Medical Necessity
- 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.
- Demonstrate fidelity to ASAM and document priority 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.
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.

All Progress Notes should include description of client’s progress on the Treatment Plan challenges, goals, action steps, objectives, and/or referrals; record of the client’s attendance at each counseling session including the date, start and end times and topic of the counseling session.

**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 the client understood and signed these documents.

**Groups**

1. A sign-in sheet must be kept which includes the list of client’s 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.
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, which includes EBP descriptive language.

*Note: If a client is late for group, the client’s actual time in group must be noted in the Progress Notes including how the counselor clinically addressed this issue. Continue to document No Shows.*
Targeted Case Management (TCM):

Progress notes should include the type of case management service provided such as linkage, care coordination, the location of services and should be tied to the Treatment Plan.

Documentation Tip:

✓ TCM 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 Plan goals.
✓ Beginning notes with Linkage, Placement, or Consultation (depending on the type of TCM provided) is helpful for auditors and other counselors working with your client.

Youth Services:

Notes must show evidence of efforts to engage parents and collaboration with school and Multi-Disciplinary Team.

OTP/NTP: Methadone: Title 9 §10345

1. Duration of sessions must be in 10 minute units as OTP/NTP is a “carve out” from the 1115 Waiver.
2. Clinician 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.

IOT/IOP Treatment

IOT/IOP services now require that the counselor document all services that are provided. The distinct services are Intake SUTS, IOP Treatment SUTS, and Targeted Case Management SUTS.

Residential Providers and Withdrawal Management Providers:

A summary of all clinical services shall be documented for each day and must include evidence of those clinical services. Example: Groups must have sign-in sheets and are documented in the same format as above for outpatient.

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.
Community Workers, Peer Support Workers, and Health Educations Specialists:

These staff members will continue to do they type of documentation required by their individual program and are not currently part of the Waiver.

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 indicated 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 TX forms: https://www.sccgov.org/sites/bhd/partners/Policies-Procedures/adult-system-of-care--policy-procedure/Pages/Appendix-D--Client-Tx-Forms.aspx

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 P&P311 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. It can be subpoenaed by courts. Legal and clinical standards for the documentation of the services must be followed. Only the client's name should appear in the client chart and no other clients name should be included in another client's chart. Only initials may be used to refer to another person. Names of family members should not be recorded except as required for Emergency Contact information, minor/parent involvement, etc. On the Progress Notes and other documentation, 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.
Chapter 10: Continuum of Care

Authorization for Treatment and Placement

The SUTS Quality Improvement Division manages system capacity, client flow, and throughput, including authorization for an increased level of care and initial authorization request from residential treatment. QIC’s also authorize for extensions in Residential treatment. QI also manages placement for Recovery Residences (RRs). QIC’s will continue to be responsible for authorizations for Residential Treatment. In the future, the Capacity Management Unit will take over tracking and placement of clients for both Residential treatment and Recovery Residences (RRs). QI Coordinators also review length of stay (LOS) in Outpatient services and justifications for LOS longer than expected treatment completion times based on the system benchmarks.

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 from 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 ASAM dimensions, and use the ALOC to refer to a different level of care. If the client was “opened”, in a particular agency’s cost center, that service can be charged to Medi-Cal. If the client was not opened, 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 6: TransferMatrix for information on required documents.

These Transfers do not require a QI Authorization:

- Residential Withdrawal Management to:
  1. Outpatient or Intensive Outpatient Treatment

- Residential to:
  2. Withdrawal Management
  3. Outpatient or Intensive Outpatient Treatment
  4. Another Residential (lateral transfer)

- Outpatient to:
  5. Withdrawal Management only and back to Outpatient
  6. Another Outpatient program (lateral transfer)
Outpatient Services
Referral to Outpatient or Intensive Outpatient 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 OP-to-OP 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)
If the client is incarcerated and client’s Medi-Cal has been deactivated, the client or the parents 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. However, 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 16 for further information. Insurance

Adult Services
Residential treatment must be authorized. To obtain initial authorization for an Increased Level of Care (ILOC), the referring outpatient or pre-authorization site counselor must complete the ALOC, and contacts the QIC on-call for authorization. The Authorization for use or Disclosure of PHI form must be sent to QI via email. This encrypted email should go to the authorization email address, which is: SUTSAuthorization@hhs.sccgov.org. If an agency does not have the capacity to send encrypted communication, request the QIC send a “SCCSecure” email. 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 for authorization for placement concurrently with the referral. 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

1. Providers must follow the same procedure as for adult above. However, additional documents are required for youth clients:
   a. The fillable Adolescent Residential Demographics (ARDs) form.
      i. Medi-Cal Insurance: Please have your clerical staff run Medi-Cal and include the Eligibility number on the ARDS.
   b. IEP or 504 (if applicable): The IEP/504 must be included at the time of referral, as school placement cannot occur without these.

If the client is incarcerated and client’s Medi-Cal has been deactivated, parents need to apply for reactivation. SUTS accepts “unsponsored” clients, i.e. those who do not qualify for Medi-Cal and have no other insurance. If the 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.

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.

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 the SUTs MCP 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 currently made through the Children, Family & community Services (CFCS) Alexian Clinic. The contact number for referrals is (408) 272-6594. Cases are assigned to an outpatient counselor who completes the ALOC to summarize ASAM 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 at this time 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” (APHI). 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 Residences (RR)

The Adult System of Care provides transitional 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 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 180 days. 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 the ALOC in Pro-Filer. They will then send a secure email to the Capacity Management Unit’s (CMU) email addresses as follows:
   a. Trevor.Bottorff@hhs.sccgov.org
   b. Rosalina.Moreno@hhs.sccgov.org
   c. Marinela.McCall@hhs.sccgov.org
   d. Yvonne.Martinez@hhs.sccgov.org

2. 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 and Pro-Filer ID number
   b. The SCC SUTS Advisement form (where applicable) and the System Consent now called: *Authorization for Use or Disclosure of Protected Health Information* form (APHI)

3. The Capacity Management Unit (CMU) will look up client in Pro-Filer, accessing both the GRS/IJS and ALOC, and enters the complete documentation into RR Database. The CMU will then places the client on the Placement List until a bed becomes available.

4. Once a placement is available, the CMU will prepare the Client Disposition form.

5. The CMU will send the receiving Provider the Client name and Pro-Filer number, the Criminal Justice and APHI consents and the Client Disposition form.

6. The receiving Provider will admit the client in Pro-Filer and access the GRS/IJS and ALOC within Pro-Filer at the “Profile of Client Level” UDD for client demographics and clinical referral information.

7. 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.

**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.

**Required RR Exit Plan:**

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

**RR Placement Coordinator:** Phone: 408-792-5084 Fax: 408-947-8708
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. 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 in regards to dealing 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.

b. Recovery services are to provide relapse prevention services, continuing Case Management, monitoring of recovery progress and other services as needed.

c. 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 OP/IOT or Residential.

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 OP services are closed. There is no need for a new GRS if the transfer occurs within 30 days. The counselor 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 OP/IOT and Recovery services.

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.
Referral to SUTS Psychiatrist

The overall goal of the SUTS Psychiatric Treatment Services is to assess and prescribe psychotropic medications if needed, in order to stabilize referred clients with ASAM 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 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 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 (APHI) 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 (APHI) 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 6: SUTS Transfer Crosswalk-**Table6Transfer**

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) criteria 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 ASAM level of care. Example: Treatment Planning is now charged under “Individual.” Please note that the services that can be charged to Med-Cal for reimbursement have changed. The Services Rendered Document (SRD) has been revised to reflect new services for each billable modality. 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 provider is associated with a DHCS credentialed site. Services must be provided in a manner that protects client confidentiality. Note: Telehealth services will not be offered in the first year of the Waiver but will be introduced.

TRAVEL TIME:

According to the Medi-Cal billing manual section 7.5.8, travel time between an agency's provider sites, including satellite sites, is not a reimbursable activity. This includes travel from a provider's home to the provider's site. You may claim staff travel time (one-way) to provide services if from a provider site. Travel time is to be included in the service time and cannot be claimed separately. Travel time must also be documented in the Progress Notes and linked to the services provided.

Clinical Services and Charging

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.
Outpatient Drug Free Service (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
- Targeted 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. However, SUTS has a set a standard of four services in the first 30 days of admission, including intake.)

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

Number of minutes for the group / Number of clients = Total minutes per client.

For example: If a group ran 90 minutes with 6 clients and one counselor the formula would be (X) 90 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 Treatment (ASAM Level 2.1)**

Services are under the umbrella of “IOP Treatment-SUTS” and 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, treatment, and discharge planning services.

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

- Intake
- IOP Treatment SUTS
- Targeted Case Management SUTS

**Targeted Case Management**

Targeted Case management is a separate service that is provided to link a client to needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. It differs from other Case Management services in that it must be provided by a LPHA, pre-licensed or (pre) credentialed/certified AOD counselor. TCM is based on Medical Necessity. (CCR Title 9 Division 1, 1810.249)

These services are rolled up under one category:

- Targeted 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, family therapy, patient education, safeguarding medications, Family, and collateral services, crisis intervention, treatment planning, transportation services and discharge services. 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 will only offer Level 3.1 Residential the first year of waiver.

**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
- Targeted Case Management SUTS (Counselors will use this non-billable service in place of Activity as OTP/NTP is not part of the Waiver.)

Additional Medical Services provided by MD and/or Nurse

- Dosing
- Suboxone
- Medication Visit MD - 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) (ASAM: 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 for year one of the waiver will be provided only at County 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
- Targeted 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
- Recovery Group Counseling
- Recovery Case Management
- 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. The DMC_ODS Waiver Pilot changes do not apply at this time. 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, 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:**

- The complete information recorded in an Assessment form, 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.

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 crises 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 Discharge Summary. The Plan must include description of relapse triggers and a support plan to avoid relapse.

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 support 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 Face to Face with therapists, social workers, and other professionals who have an active role in supporting 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 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.

**Group Treatment Services:**

Group Treatment now includes both process-oriented and 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 Groups must contain a minimum of 2 and a maximum of 12 in the group, focusing on the needs of the individuals served.

All Group sessions must be documented with a sign-in sheet for group members and that document 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 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.

**Targeted Case Management (TCM)**

Targeted 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 or with the client on the telephone.

**TCM 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.
Recovery Services

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. Recovery Services is a new modality of services, with 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 distress or impairment that warrants further treatment may also be in Recovery Services.
✓ Medical necessity criteria for recovery services must be appropriately documented in the medical record.
✓ Services include Recovery: Individual, Group, Case Management, and 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 OP/IOT to Recovery services within 30 days does not need a new GRS.
✓ Recovery Services should be included in client’s OP 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 OP Group with one counselor and then stay for an OP individual session, even if this is with a different counselor. Multiple billing in the same day is allowed as long as 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 OP 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 Table7Samedaybilling 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 9: Table9EHR
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 MCP (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 he/she may file a complaint directly with his/her provider. Further, if a client is a DMC beneficiary, the client has the choice to file their complaint directly with the State Hearings Department (listed below). This process is outlined thoroughly in BHSD SUTS P & P 500, in the Beneficiary Handbook, and on the DHCS website. 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 from MCP is available to help clients, if need be, to complete the form. This form should be made available at all SUTS sites.

Notice of Adverse Benefit Determination (NOA)

An NOA is a form that is executed and sent from the Provider to the client when a decision is made at the denial, reduction, modification, or termination of DMC benefits. A Notice of Adverse Benefit Determination (NOA) 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 change. 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. A NOA must also be given to unsponsored clients along with an explanation of how to request an Internal Fair Hearing.

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. (Counselors should refer to the Beneficiary Handbook and SUTS P & P 500 for a complete discussion of requirements, forms and other relevant information.)

The written notice 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 Fair Hearing for the purpose of appealing the intended action;
5. An explanation that the client may request a Fair Hearing by submitting a request to:

California Department of Social Services  
State Hearings Division, ACAB  
744 P Street, MS 9-17-97  
Sacramento, CA 95814  
Or Fax to: 1-916-651-2789  
Call toll free: 1-855-795-0634 or TDD, 1-800-952-8349

a. An explanation that the provider shall continue treatment services pending a Fair Hearing decision 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 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 make contact with a patient that has stopped attending a program.

6. A copy of all NOAs must be sent to the Clinical Standards Coordinator.

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 the MCP to make an authorization decision. A client may also file an Appeal or an Expedited Appeal to any decision. Please refer to the standard “Grievance-Appeal-Expedited Appeal Form.” (See SUTS P&P 500 and Title 22, CCR, Section: 50951) Fair Hearing-See P.13

Documentation Tip:

All activities related to Grievances, Appeals and Fair Hearings with the exception of Face-to-Face meetings with the client are not billable. The NOA, 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 Decision Letter must be kept in the client's chart.

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

If the complaint (problem) is resolved at the provider level, notification using the “Problem Decision Letter” is sent to the client by the provider and a copy is kept in the clinical chart. A copy is also sent to the MCP 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, the MCP is responsible for sending a copy of the Problem Decision Letter to the client and to the provider, as well as, sending a copy to the MCP CSC.
Chapter 13: Electronic Health Records

The County of Santa Clara currently uses *Pro-Filer* (Unicare) for registration, service encounter entry, claims, and reports. OTP/NTP also uses *AVATAR* to dispense Methadone and *HealthLink* for client medical information. In the future, BHSD will transition to Netsmart to replace Pro-Filer for charging, reporting, and Managed Care functions. The approximate roll out of this project is 2018/19.

Each agency is expected to have its own Electronic Health Record (EHR) system that is compliant with 42 CFR Part 438 and BHSD standards. Each agency should maintain a typed list of all clinical staff with signature, license or certification & number. All agencies are required to use Pro-Filer for processing claims, uploading CalOMS data, running reports and client registration to obtain a “Unicare number” Medical Record Numbers for many clients are already in HealthLink.

The complete requirements for EHR access and use are on the new “BHSD website” including the “Pro-Filer Training Registration Form” and the “Pro-Filer EHR Enrollment Protocol.”

Note: Counselors may attend training *prior* to having access to Pro-Filer.

The current Pro-Filer training requirements for all staff is, based on their role, is as follows:

1. Contract Provider for Registration, billing, service entry: A minimum 4 hour Training
2. Clinical Staff: A minimum of 4 hour training on Pro-Filer Navigator.
3. Clerical Staff: A minimum 2 hour Training
4. AMT/MAT Clerical Staff: A minimum 2 hour Training
5. Charging/Billing Staff: A minimum 2 hour Training

Contacts for Training:

- **Clinical Training:** Nancy Taylor, MFT/Clinical Trainer at nancy.taylor@hhs.sccgov.org
  Phone number is 408.792-5208.

- **Clerical Training:** Michelle Swanson-Calhoun at michelle.swanson@hhs.sccgov.org
  Phone number is 408.792.5669.

- **MAT and OTP/NTP Clerical Training:** Christine Gibbins at christine.gibbins@hhs.sccgov.org
  Phone number is 408.885.5402

- **Charging/ Billing Training:** Martha G. Martinez at Martha.G.Martinez@hhs.sccgov.org
  Phone number is 408.792.5685

- **Contract Provider Training:** Tammy Ramsey at tammy.ramsey@hhs.sccgov.org
  Phone number is 408.792-5687

Again, you may refer to Table 9 regarding EHR terms related to Services: *Table9EHR*
Chapter 14: CalOMS Data Review

What is the CalOMS? It stands for the California Outcomes Measurement System. The data domains gathered in CalOMS include admission information, client identifiers, substance use, employment status, legal status, medical status, mental health status, and social connections. CalOMS is also used to monitor treatment with the goals of improving treatment, being responsive to the service recipients and their families and communities.

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 form is not 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 into Pro-Filer 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 or recovery Services* (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, OP, IOT, Residential and Withdrawal Management. Refer to Timelines in Chapter 4.
Appendix A: Reference Tables

Table 1. ASAM Decision Ladder

What is the progress of the treatment plan and placement decision? What are the outcome measurements?

What "dose" or intensity of these services is needed for each dimension?

Choose a specific focus and target for each priority dimension

Multidimensional severity/level of functioning profile

Conduct a multidimensional assessment

What does the participant want? Why now?

Where can these services be provided, in the least intensive but safe level of care or site of care?

What specific services are needed for each dimension?

Identify which assessment dimensions are currently most important to determine treatment priorities

What are the DSM diagnoses?

Does the participant have immediate needs due to imminent risk in any of the six assessment dimensions?

Taken from eLearning: “ASAM: Assessment to Service Planning”, The Change Companies®
http://www.changecompanies.net/elearning
<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 1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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</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 Treatment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family (Collateral)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Crises 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</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
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<td>Targeted Case Management</td>
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<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Case management</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Diagnosis: SUD</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Diagnosis: Mental Health</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Verifies Medical Necessity on TX Plan</td>
<td>X</td>
<td>X</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Must be Co-Signed by (licensed)LPHA *</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

1 Individual Services include: Treatment Planning, Discharge Planning, Crises Intervention, Family/Collateral TX and Individual Counseling

2 LPCC may only do Family TX if they have additional training in Family Therapy.

*Note: Additional MAT and OTP/NTP programs require co-signature of Assessment & TX plan by MD.
### Table 3: Timelines Overview

<table>
<thead>
<tr>
<th>CalOMS ADMIT</th>
<th>ALOC</th>
<th>ASSESS</th>
<th>INITIAL TX or CARE PLAN</th>
<th>BI-ANNUAL</th>
<th>ANNUAL</th>
<th>CalOMS DISCHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OP/IOT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior to 3rd session</td>
<td>Intake &amp; Discharge</td>
<td>30 days</td>
<td>30 days</td>
<td>Between 5th &amp; 6th month</td>
<td>Between 11th &amp; 12th month</td>
<td>30 days from last clinical contact</td>
</tr>
<tr>
<td><strong>NTP OTP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior to 3rd session</td>
<td>Intake &amp; Discharge</td>
<td>28 days</td>
<td>28 days</td>
<td>Between 5th &amp; 6th month</td>
<td>Between 11th &amp; 12th month</td>
<td>14 days from last dose</td>
</tr>
<tr>
<td><strong>RES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 2nd &amp; 10th day</td>
<td>Intake &amp; Discharge</td>
<td>10 days</td>
<td>By day 10</td>
<td>NA</td>
<td>NA</td>
<td>48 hours</td>
</tr>
<tr>
<td><strong>WM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48 hours</td>
<td>Intake &amp; Discharge</td>
<td>CIWA as needed</td>
<td>48 hours</td>
<td>NA</td>
<td>NA</td>
<td>48 hours</td>
</tr>
<tr>
<td><strong>RS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NA at admit or DC</td>
<td>Intake &amp; Discharge</td>
<td>30 days</td>
<td>30 days</td>
<td>Between 5th &amp; 6th month</td>
<td>Between 11th &amp; 12th month</td>
<td>NA: DC 30 days from last clinical contact</td>
</tr>
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</table>

### Table 4: Residential ASAM Levels 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>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 stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for Outpatient treatment. (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>
</tbody>
</table>
### Table 5: Levels of Care Placement Overview


<table>
<thead>
<tr>
<th>Criteria by Dimensions</th>
<th>SUTS Prevention</th>
<th>SUTS MAT OP</th>
<th>SUTS Outpatient</th>
<th>SUTS IOT &amp; Perinatal</th>
<th>NOT AVAILABLE IN SUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIMENSION 1</strong>: Alcohol Intoxication And/or Withdrawal Potential</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</strong>: Biomedical Conditions &amp; Complications</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</strong>: Emotional / Behavioral / Cognitive Conditions &amp; Complications</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</strong>: Readiness to Change</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</strong>: Relapse / Continued Use / Continued Problem Potential</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 1 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</strong>: Recovery Environment</td>
<td>Social support system or significant others increase the risk of personal conflict about AOD use</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 support, the patient can cope</td>
<td>Recovery environment NOT supportive but, with structure and support and relief from home environment, the patient can cope</td>
</tr>
</tbody>
</table>
### Levels 3.1 Through 4

<table>
<thead>
<tr>
<th>Criteria by Dimensions</th>
<th>SUTS Residential</th>
<th>Not currently available in SUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIMENSION 1: Alcohol Intoxication and/or Withdrawal Potential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3.1 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>
</tr>
<tr>
<td>No withdrawal (WX) risk, or minimal or stable WX. If WX is present, manageable at 3.2-WM (see WX 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>
</tr>
</tbody>
</table>

| DIMENSION 2: Biomedical Conditions and Complications | | |
| None or stable, or receiving concurrent medical monitoring | None or stable, or receiving concurrent medical monitoring | None or stable, or receiving concurrent medical monitoring | Patient requires 24-hour medical monitoring but not intensive treatment | Patient requires 24-hour medical and nursing care and the full resources of a licensed hospital |

| DIMENSION 3: Emotional / Behavioral / Cognitive Conditions and Complications | | |
| 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 | 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 | 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 w/ severe and chronic mental illness | Moderate severity, needs a 24-hour structured setting. If the patient has a co-occurring mental disorder, requires concurrent mental health services in a medically monitored setting | Because of severe and unstable problems, requires 24-hour psychiatric care with concomitant addiction treatment (co-occurring enhanced) |

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 only 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. Please note that DHCS AOD Certification standards for Residential treatment is a minimum of 20 hours per week of therapeutic activities including individual and group counseling.
 Levels 3.1 through 4 -Continued

<table>
<thead>
<tr>
<th>Criteria by Dimensions</th>
<th>SUTS Residential</th>
<th>Not currently available in SUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3.1 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>
</tr>
<tr>
<td><strong>DIMENSION 4:</strong> Readiness to Change</td>
<td></td>
<td></td>
</tr>
<tr>
<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>
</tr>
<tr>
<td><strong>DIMENSION 5:</strong> Relapse/Continued Use/Continued Problem Potential</td>
<td></td>
<td></td>
</tr>
<tr>
<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>
</tr>
<tr>
<td><strong>DIMENSION 6:</strong> Recovery Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<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>
</tr>
<tr>
<td>ASAM Level of Care</td>
<td>Service Name</td>
<td>Description of Care</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>1-WM</strong></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><strong>2-WM</strong></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><strong>3.2-WM</strong></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><strong>3.7-WM</strong></td>
<td>Medically-Monitored Inpatient Withdrawal Management</td>
<td>Provides for 24-hour evaluation and withdrawal management. Services are provided by medical and nursing professionals, under a defined set of physician-approved policies and physician-monitored procedures.</td>
</tr>
<tr>
<td><strong>4-WM</strong></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>
</tbody>
</table>

LOC highlighted in [ ] are currently not available in SUTS.
### Table 6: SUTS Transfer Grid

<table>
<thead>
<tr>
<th>MODALITY</th>
<th>WITHDRAWAL MANAGEMENT</th>
<th>RESIDENTIAL</th>
<th>OUT PATIENT, INTENSIVE OUTPATIENT AND NTP</th>
<th>ALL</th>
</tr>
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<tbody>
<tr>
<td>FORM</td>
<td>WM to RES</td>
<td>WM to OP or IOT</td>
<td>RES to WM</td>
<td>RES to OP or IOT</td>
</tr>
<tr>
<td>ALOC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sec B 1 (Auth)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Sec B 2 (Res Extension)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Section B 3 (Non-Auth)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>APHI²</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Other Consents</td>
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<tr>
<td>SCC SUTS Advisement Form¹</td>
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<tr>
<td>Psych Referral Form</td>
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</table>

X = Required  
O = If Applicable

### ABBREVIATIONS

<table>
<thead>
<tr>
<th>ABBREVIATION</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>ALOC</td>
<td>Assessment &amp; Authorization for Level of Care</td>
</tr>
<tr>
<td>APHI²</td>
<td>Authorization for Use or Disclosure of Protected Health Information form</td>
</tr>
<tr>
<td>Auth</td>
<td>Authorization (for residential only)</td>
</tr>
<tr>
<td>Non-Auth</td>
<td>Non-Authorization</td>
</tr>
<tr>
<td>Reauth</td>
<td>Reauthorization</td>
</tr>
<tr>
<td>OP</td>
<td>Outpatient (1)</td>
</tr>
<tr>
<td>IOT</td>
<td>Intensive Outpatient Treatment (2.1)</td>
</tr>
<tr>
<td>RR</td>
<td>Recovery Residence (Formerly THU)</td>
</tr>
<tr>
<td>Rec Services</td>
<td>Recovery Services</td>
</tr>
<tr>
<td>RES</td>
<td>Residential (3.1)</td>
</tr>
<tr>
<td>WM</td>
<td>Withdrawal Management (3.2)</td>
</tr>
</tbody>
</table>

¹ Santa Clara County Adult Drug and Alcohol Facility Advisement Form  
² No longer called System Consent
**Table 7: Title 22 & Title 9 DMC Services Crosswalk**

<table>
<thead>
<tr>
<th>Review Step</th>
<th>ODF/DCH/Residential</th>
<th>OTP/NTP</th>
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<tbody>
<tr>
<td>Admission</td>
<td>Title 22, 51341.1 (h)(1)</td>
<td>Title 9, 10270</td>
</tr>
<tr>
<td>DSM Code*</td>
<td>Title 22,51341.1 (h)(1)(D)(ii)</td>
<td>Same</td>
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<tr>
<td>Assessment</td>
<td>Title 22, 51341.1 (b)(10),(h)(1)</td>
<td>Title 9, 10305</td>
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<tr>
<td>Treatment Planning*</td>
<td>Title 22, 51341.1 (h)(2)</td>
<td>Title 9, 10305</td>
</tr>
<tr>
<td>Treatment Requirements</td>
<td>Title 22, 51341.1 (d) &amp; I</td>
<td>Same</td>
</tr>
<tr>
<td>Progress Notes</td>
<td>Title 22, 51341.1 (d)(2),(h)(3)</td>
<td>Title 9, 10345</td>
</tr>
<tr>
<td>Group Counseling Sign-in</td>
<td>Title 22, 51341.1 (g)(2)</td>
<td>Same</td>
</tr>
<tr>
<td>Dosing Services</td>
<td>n/a</td>
<td>Title 9, 10255</td>
</tr>
<tr>
<td>Provider &amp; Client Contact</td>
<td>Title 22, 51341.1 (h)(4)</td>
<td>Title 9, 10345</td>
</tr>
<tr>
<td>Continuing Services*</td>
<td>Title 22, 51341.1 (h)(5)</td>
<td>Title 9, 10410</td>
</tr>
<tr>
<td>Discharge</td>
<td>Title 22, 51341.1 (h)(6)</td>
<td>Title 9, 10415</td>
</tr>
<tr>
<td>Fees Charged to Client</td>
<td>Title 22, 51341.1 (h)(7)</td>
<td>Same</td>
</tr>
<tr>
<td>Good Cause Codes</td>
<td>Title 22, 51490.1 (a)</td>
<td>Same</td>
</tr>
<tr>
<td>Second Service</td>
<td>Title 22, 51490.1 (d)</td>
<td>n/a</td>
</tr>
<tr>
<td>Fair Hearing</td>
<td>Title 22, 51341.1 (p)</td>
<td>Same</td>
</tr>
</tbody>
</table>

*These areas establish medical necessity for treatment services and deficiencies can result in recoupment of the entire treatment episode.*

For further information see Title 22 and Title 9 at:
https://govt.westlaw.com/calregs/Index?transitionType=Default&contextData=(sc.Default)
Table 8: DMC ODS Same Day Billing Matrix

<table>
<thead>
<tr>
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Table 9: EHR Service Terms Crosswalk

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### Appendix B: Acronyms Glossary

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<td>Assessment &amp; Authorization for LOC</td>
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<td>APHI</td>
<td>Authorization for Use or Disclosure of Protected Health Information (form)</td>
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<td>Adolescent Residential Demographics</td>
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<td>ASAM</td>
<td>American Society of Addiction Medicine</td>
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<td>ASOC</td>
<td>Adult System of Care</td>
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<td>BBS</td>
<td>Board of Behavioral Science</td>
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<td>California Outcome Measures System</td>
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### Appendix C: Index by Key Word

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Afterword

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

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The final version was reviewed and approved by the SUTS Administration Executive Management Group. Please note that many SUTS Policy and Procedures are in the process of being reviewed and rewritten. There will continue to be changes as we clarify the requirements for the DHCS-ODS 1115 Waiver Pilot. You may find them here: https://www.sccgov.org/sites/bhd/partners/Policies-Procedures/Pages/home.aspx

Every attempt was made to review and include Medi-Cal, DHCS State and Federal Guidelines, the ODS 1115 Waiver Pilot and current SUTS policy and procedures and current 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.