Drug Medi-Cal Organized Delivery System
Documentation Manual

California Advancing and Innovating Medi-Cal (CalAIM)

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Orange County Health Care Agency

Mental Health & Recovery Services

Contents

1. INTRODUCTION

PURPOSE

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

The County of Orange opted in to participate in the State's Drug Medi-Cal Organized Delivery System (DMC-ODS), which was first implemented in July 2018. At the time, it was a demonstration project that would allow for greater coordination of care for clients as they move from one level of care to another, with the hopes of increasing the likelihood of successful treatment outcomes. With the California Advancing and Innovating Medi-Cal (CalAIM) initiative in 2022, the State has moved towards further streamlining documentation requirements to "improve the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate and effective beneficiary care; address equity and disparities; and ensure quality and program integrity" (Behavioral Health Information Notice 22-019).

Documentation is vital to maintaining a record of the quality of the services provided to SUD clients. It is our responsibility to our clients to accurately describe the services provided, which also includes the need to understand how to code services properly. This manual is designed to help provide guidance on documentation standards to all clinical staff who work directly with our clients in our SUD programs so that we may work towards maintaining compliance with the regulations. It is intended to complement the documentation trainings provided by Authority and Quality Improvement Services (AQIS).

Please note that this manual is for educational purposes only.

*****DISCLAIMER*****

This manual is a living document and will be amended as needed, based on changes made by the State as well as any internal program requirements implemented. Please keep in mind that the State sets the minimum requirements, and the County can impose standards above and beyond the State's guidance. This current version is based on the current understanding of the State regulations as well as the County's agreement with the State on what will be provided.

2. AUTHORIZED SERVICE PROVIDERS

Scope of Practice

All staff are expected to provide treatment services within his, her, or their scope of practice. An individual's scope of practice is dependent on education, training, and experience.

A **"Licensed Practitioner of the Healing Arts,"** or **"LPHA,"** includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians. Those in the above disciplines

must also abide by the scope of practice guidelines set forth by the respective certifying or licensing board.

Registered Nurses (RNs) are considered an LPHA; however, a RN's scope of practice limits him/her/them from diagnosing and providing some of the clinical services more appropriate for other professional staff. Please refer to the licensing board standards for Registered Nurses for further information.

Professional staff or **"counselors"** are either licensed, registered, certified, or recognized under California State scope of practice statutes. This includes LPHA and those registered or certified as an Alcohol and/or Drug (AOD) Counselor. Registered or certified AOD Counselors are considered non-LPHA.

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

Licensed Vocational Nurses (LVNs) are not recognized as certified providers within the DMC-ODS and cannot bill for or provide DMC-ODS covered services. LVNs may provide ancillary services within the DMC-ODS, as clinically appropriate. If working within a DMC-ODS program in this support capacity, LVNs must be credentialed through the County's Managed Care Support Team.

Support Staff (i.e., Behavioral Technicians, House Staff, etc.) or non-credentialed/non-licensed workers in direct contact with clients to provide non-clinical, ancillary services (i.e., general supervision of clients, transportation, recreation, etc.) within the DMC-ODS are permitted. However, he/she/they are not able to provide and bill for any clinical services. Staff, whose classification or job description require a license, waiver, certification, and/or registration to deliver Medi-Cal covered services would need to be credentialed through the County's Managed Care Support Team.

DISCLAIMER: Providers involved in patient care need to be listed on the provider directory and undergo credentialing if they possess a license, certification or registration. The link below is a helpful grid provided by the State Department of Health Care Services (DHCS) to clearly show what types of services are allowed to be provided and by whom:

http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/ODS_Staffing_Grid_Revised_031518_Final.pdf

Provider Requirements

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

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

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

Certification with the State as a DMC-ODS provider is required in order to provide and bill for services. Any DMC-ODS services provided and claimed without the proper certification will result in disallowances and/or recoupments as these services may be considered fraud, waste, and/or abuse. For more information on credentialing and certification, please refer to the County's Managed Care Support Team.

3. CONTINUUM OF CARE

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

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

The American Society of Addiction Medicine (ASAM) is a professional medical society, well established in representing professionals in the field of addiction medicine. The ASAM focuses on education, research, access, and improving the quality of treatment. The ASAM has developed a comprehensive guideline for placement of individuals seeking and continuing substance use treatment services, which is commonly referred to as the ASAM Criteria. The ASAM Criteria offers to improve treatment outcomes by accurately assessing the client's needs and ensuring that the services provided meet those needs. The ASAM Criteria has become the industry standard in the assessment and treatment of addiction and provides a streamlined way of determining where in the continuum of care the client may be most appropriate. The intention is to move clients along this continuum as a part of their journey towards a self-sufficient and sustainable life of recovery.

The ASAM Levels of Care are as follows:

Continuum of Care Services within DMC-ODS		
Level 0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Level 1.0	Outpatient Services	Less than 9 hours of service/week (adults); Less than 6 hours of service/week (adolescents)
Level 2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours of service/week (adolescents)
Level 2.5	Partial Hospitalization Services	20 or more hours of service/week (not requiring 24-hour care)
Level 3.1	Clinically Managed Low-Intensity Residential Treatment Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week
Level 3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors; less intense milieu for those with cognitive or other impairments
Level 3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors
Level 3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; 16 hours/day counselor availability
Level 4	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3; counseling available to engage client in treatment
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder
MAT	Medication-Assisted Treatment	FDA-approved medications and biological products to treat Alcohol Use Disorder, Opioid Use Disorder, and any SUD that is provided in clinical or non-clinical settings as a standalone service or as a service delivered as part of a level of care
Recovery Services		Provided based on self-assessment or provider assessment of relapse risk and delivered as a standalone service or concurrently with other levels of care that is designed to support recovery and prevent relapse in order to restore to be possible functioning

Withdrawal Services within DMC-ODS		
Level 1-WM	Ambulatory withdrawal management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision
Level 2-WM	Ambulatory withdrawal management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.
Level 3.2-WM	Clinically managed residential withdrawal management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
Level 3.7-WM	Medically monitored inpatient withdrawal management	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.
Level 4-WM	Medically managed intensive inpatient withdrawal management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

4. BILLING DURING ASSESSMENT PHASE AT OUTPATIENT

A full assessment utilizing the ASAM criteria is not required for clients to begin receiving DMC-ODS services. Billing is allowed prior to the completion of an assessment or the determination of a diagnosis at the outpatient levels of care. This "assessment phase" is up to thirty (30) days following the first visit with a non-LPHA or LPHA or up to sixty (60) days for clients under the age of 21 or for clients documented as experiencing homelessness who require additional time to assess. The time period starts over if the client withdraws from treatment and the episode of care (EOC) is closed prior to the establishment of a SUD diagnosis. However, in order to bill DMC-ODS services, each claim must have an appropriate ICD-10 diagnosis code(s). As a result, the following are some options that will enable us to bill for services provided during the assessment period before a diagnosis is established:

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

   a. Additional specifiers that break each category of Z55-Z65 codes must be used. For

example, Z63 "Other problems related to primary support group, including family circumstances" is NOT a billable code on its own. Instead, we need to be more specific, such as Z63.72 "Alcoholism and drug addiction in family."
b. The Z55-Z65 codes can be used throughout the assessment period. The exception for use after the assessment period is for youth (up to the age of 21) who are receiving Early Intervention Services (Level 0.5). Once the client turns 21, the client must meet the criteria for a SUD diagnosis in order to continue treatment services.

2. **LPHA** may use the **ICD-10 code Z03.89**, "Encounter for observation for other suspected diseases and conditions ruled out."

3. **LPHA** may use **any clinically appropriate ICD-10 code** as a preliminary diagnosis or when a SUD is suspected, but not yet diagnosed. This includes Z codes and codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services."

For options **#2** and **#3**, if the LPHA is going to use these codes based on information gathered by a non-LPHA's encounters with the client, please note that a consultation between the LPHA and non-LPHA is required. Both the LPHA and non-LPHA may bill for the consultation as care coordination. The service start and end times should match between the LPHA and non-LPHA's progress notes. Each provider will need to complete his/her/their own progress note documentation. The LPHA will also need to do his/her/their own documentation explaining the reasoning for the use of the diagnostic code. This may be done within the care coordination progress note (as the outcome of the consultation).

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

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

Billing During the Assessment Phase FAQ

1. ***Why doesn't this apply to Residential Treatment Services?*** Prior Authorization for residential services is required based on DSM and ASAM Criteria. Therefore, billing during the assessment phase does not apply to the Residential Treatment Services.
2. ***Are we able to bill even if the initial assessment later determines that the client does not meet criteria for DMC-ODS services?*** Yes. All clinically appropriate and covered DMC-ODS services provided during the assessment phase are covered and reimbursable.
3. ***What diagnosis should I use if I know at intake that the client is not appropriate for SUD services?*** If you are a non-LPHA, you should consult with the LPHA about how the client does not meet medical necessity and the access criteria so that the LPHA may diagnose using the ICD-10 code Z03.89 in order to bill for that assessment service.
4. ***If a client being assessed for SUD services does not meet medical necessity, but is already receiving mental health services through the Mental Health Plan (MHP) and has a mental health diagnosis, can the provider bill the assessment session using the mental health diagnosis?*** If the provider is a non-LPHA, no. The Z codes (55-65) can be used by the non-LPHA in this case. If the provider who conducted the assessment is an LPHA, yes. This is due to scope of practice.
5. ***How do I need to document that my client is experiencing homelessness and therefore more time is needed for the assessment?*** You can document in any of the progress notes for the services provided where this is determined. For example, it may be in the intake session that you find out that the client is currently homeless in which case documentation may look like, "Client reports having been kicked out of the home by his grandmother and has been living on the streets for the past 3 weeks." It may also be documented in the progress note where you may be billing for the time you spent on completing the client's assessment to explain why the assessment is being completed at 60 days instead of 30. "Where" it is documented is not important, as long as it is documented somewhere!

5. MEDICAL NECESSITY

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

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

1. How is this service going to benefit the client in treating his/her/their SUD?
2. In what ways does this intervention address the client's treatment problems/needs?
3. Does what I am providing fall within the standards of care for the types of issues my client is facing?

4. Is there existing research/evidence of this service/intervention that has been shown to be effective for clients with similar issues/needs as my client? (i.e., Evidence-Based Practices)

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

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

6. ACCESS CRITERIA

Clients Over 21 Years of Age

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

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

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

Under the DMC-ODS, whether a client meets the access criteria can only be established by the LPHA. This is because the client's SUD diagnosis can only be determined by an LPHA. For DSM-5 criteria for SUD diagnoses, see Appendix B.

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

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

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

Outpatient: Within thirty (30) days from the date of admission or up to sixty (60) days if documentation is on file that the client is experiencing homelessness.

Residential: Within three (3) days from the date of admission (prior to obtaining treatment authorization).

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

Adult clients who do not meet the full diagnostic criteria for a SUD cannot be in treatment beyond the assessment period. They may, however, qualify for the 0.5 ASAM Level of Care (Early Intervention) and should be referred to the Beneficiary Access Line for resources.

Clients Under 21 Years of Age

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

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

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

Under the DMC-ODS, whether a client under the age of 21 meets the access criteria can be determined by a non-LPHA, without involvement or documentation by the LPHA, if the client falls under the "at risk" category and does not meet a SUD diagnosis. The LPHA is the only provider who can determine that the client meets the criteria for a SUD diagnosis or the Z03.89 "Encounter for observation for other suspected disease and conditions ruled out." If this is the case and the assessment sessions have been conducted by a non-LPHA, there should be a consult with the LPHA to determine the appropriateness for a SUD diagnosis or the Z03.89 code.

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

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

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

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

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

Outpatient: Within sixty (60) days from the date of admission. After sixty (60) days, clients under the age of 21 are only eligible for Early Intervention Services if deemed "at risk" and do not meet a SUD diagnosis.

Residential: Within three (3) days from the date of admission (prior to obtaining treatment authorization).

7. LEVEL OF CARE DETERMINATION

ASAM & Levels of Care

The ASAM Criteria is required to be used to determine placement into the appropriate level of care for all clients. The level of care determination based on the ASAM Criteria is separate and distinct from determining medical necessity.

The ASAM Criteria takes into consideration various factors of an individual's life to help streamline the determination of what level of care would be most appropriate. As we know, there are many stages within recovery, and it is a fluid, lifelong process to maintain a sober lifestyle for many of our clients. The client's needs are assessed through each of the six (6) dimensions of the ASAM Criteria, which are as follows:

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

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

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

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

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

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

8. INITIAL ASSESSMENT

Requirements

The initial assessment is where the documentation of how the client meets the access criteria begins. As with any standard assessment, it is a compilation of information that is gathered from interviewing the client and, if applicable, with information from significant others that may be involved with the client's treatment or referral for treatment. The County's SUD Assessment form has a dual purpose in that it assesses for how the client meets the access criteria while also determining the client's level of care placement needs. Thus, it consists of sections for the ASAM Criteria Dimensions 1-6, a Placement Summary, a Diagnosis form, and the Case Formulation. Providers may use the County's SUD Assessment or any format to fulfill the requirements for an initial assessment.

The initial assessment must establish a SUD diagnosis as the primary diagnosis by an LPHA. The exception for the diagnosis is when the client is under the age of 21. At this point, the Z55-Z65 codes will no longer be the primary diagnosis or diagnoses. This does not necessarily mean that the Z55-Z65 codes go away as they may still be applicable areas of need for the client and continue to be addressed.

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

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

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

Who Can Complete the Initial Assessment?

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

1. The LPHA conducts the assessment himself/herself/themselves by meeting (in person, by telehealth, or telephone) with the client for an assessment session(s) and documenting findings and observations in an assessment document, or

2. The LPHA needs to consult with the non-LPHA who conducted the assessment session (in person, by telehealth, or telephone) with the client prior to the LPHA documenting how the client meets the diagnostic criteria. The consultation can be completed in person, by video conferencing, or by telephone.

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

How is the Initial Assessment conducted?

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

When Do We Need to Complete the Initial Assessment by?

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

Residential Treatment: It is to be completed and signed within three (3) days of the client's admission. Assessments are to be updated every thirty (30) days, as needed, to demonstrate how the client continues to meet the access criteria for residential level of care.

Intensive Outpatient and Outpatient Drug Free: It is to be completed and signed within thirty (30) days of the client's admission. For homeless clients, up to sixty (60) days is permitted if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. Youth clients (under age 21) are also permitted sixty (60) days to complete. If a client withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders and later returns, the time period starts over. This is applicable for cases that have been closed, whereupon the client returns.

Withdrawal Management: It is to be completed and signed within twenty-four (24) hours of the client's admission. A full assessment is not required for admission to Withdrawal Management. A brief screening or other tool may be used, such as the Brief SUD Level of Care Screening. Since documentation to substantiate the client's diagnosis and placement is still required for Withdrawal Management, the LPHA will need to document this information in the client's chart. A full assessment, brief screening, or other tool completed by a non-LPHA will necessitate a consultation with an LPHA in addition to the LPHA's documentation.

Narcotic Treatment Program (NTP): Follow Title 9 requirements. An ASAM based assessment is required for determining the level of care placement for NTP. See more in the NTP section under "Other Levels of Care & Programs".

*****DISCLAIMER*****

Above timeframes are determined by the State as well as any internal program agreements made between the County and the State. Please keep in mind that the State sets the minimum requirements and the County can impose standards above and beyond the State's guidance.

Providers that must also follow other regulatory requirements, such as the 2020 or current Alcohol and Other Drugs (AOD) Certification Guidelines, Adolescent Substance Use Disorder Best Practices Guide, Perinatal Treatment Guidelines, or Substance Use Prevention Block Grant (SABG), should consult with their internal compliance program or counsel for program specific guidance. Likewise, if any other accrediting bodies monitor your program, you will need to abide by those requirements.

When Assessment Timelines Are Not Met

If the SUD Assessment form cannot be completed within the timeframe specified above, the reason(s) should be documented in the progress notes. If the assessment is not completed by the end of the required timeframe, services may continue to be billed using the billable code. However, be mindful that a significant amount of time where services have been provided and claimed without an initial assessment in place or a pattern of assessments completed outside of the required timeframe for any one provider or as an agency/program could be flagged as potential fraud, waste, and/or abuse. Such cases may be subject to corrective action plans and/or disallowances.

Focus of the Initial Assessment

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

"How does this relate to the substance use?"

This will eventually help us with a diagnosis as well as determining how the substance use has led to problems in different areas of the client's life. These are the problems that we will be addressing in the client's treatment and will inform the problem list. Therefore, what is relevant to the substance use is what we need to clearly document. For the purposes of our initial assessment, it is not enough just to gather information about the client's life. It is a purposeful gathering of information, directed at identifying how the substance use has affected the client.

With the information gathered, we must determine whether the client meets the DSM-5 criteria for a substance use disorder. It is important to keep in mind the criteria for a substance use disorder that can be our guide for the questions that we ask the client during the assessment. It is not enough to say that since Johnnie has been drinking every night for the past 2 years, that he has an Alcohol Use Disorder. Use alone is not enough to warrant a diagnosis. We must identify the impact of the substance use. For a quick guide to the DSM-5 criteria for a substance use disorder, refer to Appendix B. Please remember that the non-LPHA cannot diagnose the client. What the non-LPHA will be doing is gathering the necessary information so that the LPHA can determine the most appropriate diagnosis.

Treating Co-Occurring Disorders

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

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

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

How do we need to document co-occurring disorders?

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

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

10 Psychosocial Elements

Regardless of whether the assessment is completed by a non-LPHA or LPHA, it should include information about the following aspects of the client's life:

1. Drug and/or alcohol use history;
2. Medical history;
3. Family history;
4. Psychiatric/psychological history;
5. Social/recreational history;
6. Financial status/history;
7. Educational history;
8. Employment history;
9. Criminal history, legal status; and
10. Previous SUD treatment history

When using the County's SUD Assessment form, it does not matter where the information is placed or in which specific dimension. If an element does not apply to a particular client, this can be noted. For example, if an adolescent client has no employment history because they are in school, the documentation could be, "Client is a 16 year old high school student and has never had a job." Likewise, if a client is reluctant to provide information in a particular area, a statement like, "Client has declined to provide any information on _____ history," can show that the item was addressed and not simply overlooked.

Failing to address all ten (10) of the psychosocial elements will not result in any disallowances. However, collecting all the information will provide for a richer assessment to inform the person's treatment needs.

Social Determinants of Health (SDOH)

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

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

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

Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

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

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

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

Youth-Specific

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

Youth clients under the age of 21 may receive a full ASAM based assessment at any time, as clinically indicated. The Adolescent SUD Best Practices Guide (formerly Youth Treatment Guidelines) should be adhered to for incorporating elements pertinent to the youth population in conducting a comprehensive assessment.

Perinatal and Postpartum

For clients who are pregnant or postpartum (up to 60 days), regardless of enrollment in a perinatal-specific program, the Perinatal Treatment Guidelines should be adhered to. In order to claim a service using the Perinatal billing codes, there must be medical documentation on file to support the client's pregnancy or post-partum status. "Postpartum," under the DMC-ODS, is defined as the sixty (60) day period beginning on the last day of pregnancy. Eligibility for the use of the perinatal code ends on the last day of the calendar month in which the sixtieth (60th) day occurs.

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

ASAM Criteria Dimensions:	Assessment Information:	DSM-5 Criteria for SUD Diagnosis:
Dimension 1 – Acute Intoxication and/or Withdrawal Potential	• Drug and/or alcohol use history; • Previous SUD treatment history	• Tolerance • Needing to use more to get the same effect • Using the same amount but not getting the same effect • Using more or for longer than anticipated • Withdrawal
Dimension 2 – Biomedical Conditions and/or Complications	• Medical history	• Keep using even when it is physically dangerous to do so • Keep using even though the client knows that there are physical problems caused by or made worse by the use
Dimension 3 – Emotional, Behavioral, and/or Cognitive Conditions and/or Complications	• Psychiatric/psychological history	• Keep using even when it is psychiatrically dangerous to do so • Keep using even though the client knows that there are psychological problems caused by or made worse by the use
Dimension 4 – Readiness to Change	• Previous SUD treatment history (as it relates to motivation and willingness for treatment); • Family history; Social/recreational history; Financial status/history;	• Ongoing use impacting work, school, home; interpersonal problems • Keep using despite knowing it is causing problems

	Educational history; Employment history; and/or Criminal history, legal status (as it relates to severity of problems impacting desire to change)	• Desire to discontinue, but unable to
Dimension 5 – Relapse and/or Continued Use Potential	• Previous SUD treatment history (as it relates to occurrences of relapse)	• Desire to discontinue, but unable to • Keep using despite knowing it is causing problems or is a danger • Inability to tolerate withdrawal (using to avoid withdrawals)
Dimension 6 – Recovery/Living Environment	• Family history; • Social/recreational history; • Financial status/history; • Educational history; • Employment history; • Criminal history, legal status	• School, work, home situation that has suffered as a result of use • Not following through or taking care of responsibilities at home, school, or work because of use • A lot of time and energy going towards trying to get, use, or recover from the use

What is the Case Formulation?

For the County's SUD Assessment form, the Case Formulation section is where the LPHA can clearly identify how the client meets the DSM-5 diagnostic criteria for at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders. For incarcerated clients, the documentation should indicate how the client met the criteria for at least one diagnosis from the DSM-5 for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders, prior to being incarcerated or during incarceration, based on substance use history. The LPHA must clearly document in the Case Formulation how the analysis of the severity of the client's functioning across the six (6) ASAM Criteria dimensions exhibit the client's need for the level of care placement indicated. If the client is accepting a lower level of care than what is

indicated, the Case Formulation should also address how the lower intensity services will be used to properly accommodate for the client's needs.

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

Please note that since the level of care placement determination is separate and distinct from the medical necessity determination and the access criteria, the LPHA will continue to need to document separately on how the client is appropriate for the level of care indicated. Failure to do so is a potential disallowance and/or recoupment.

If using the County's SUD Assessment form, the document is not complete and valid if there is no Case Formulation by an LPHA. Providers not using the County's SUD Assessment form will need to ensure that whatever assessment document is used contains the LPHA's determination of medical necessity and recommendation for services in order to fulfill this requirement.

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

Components of the Case Formulation

To simplify, the Case Formulation can be broken down into the following components:

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

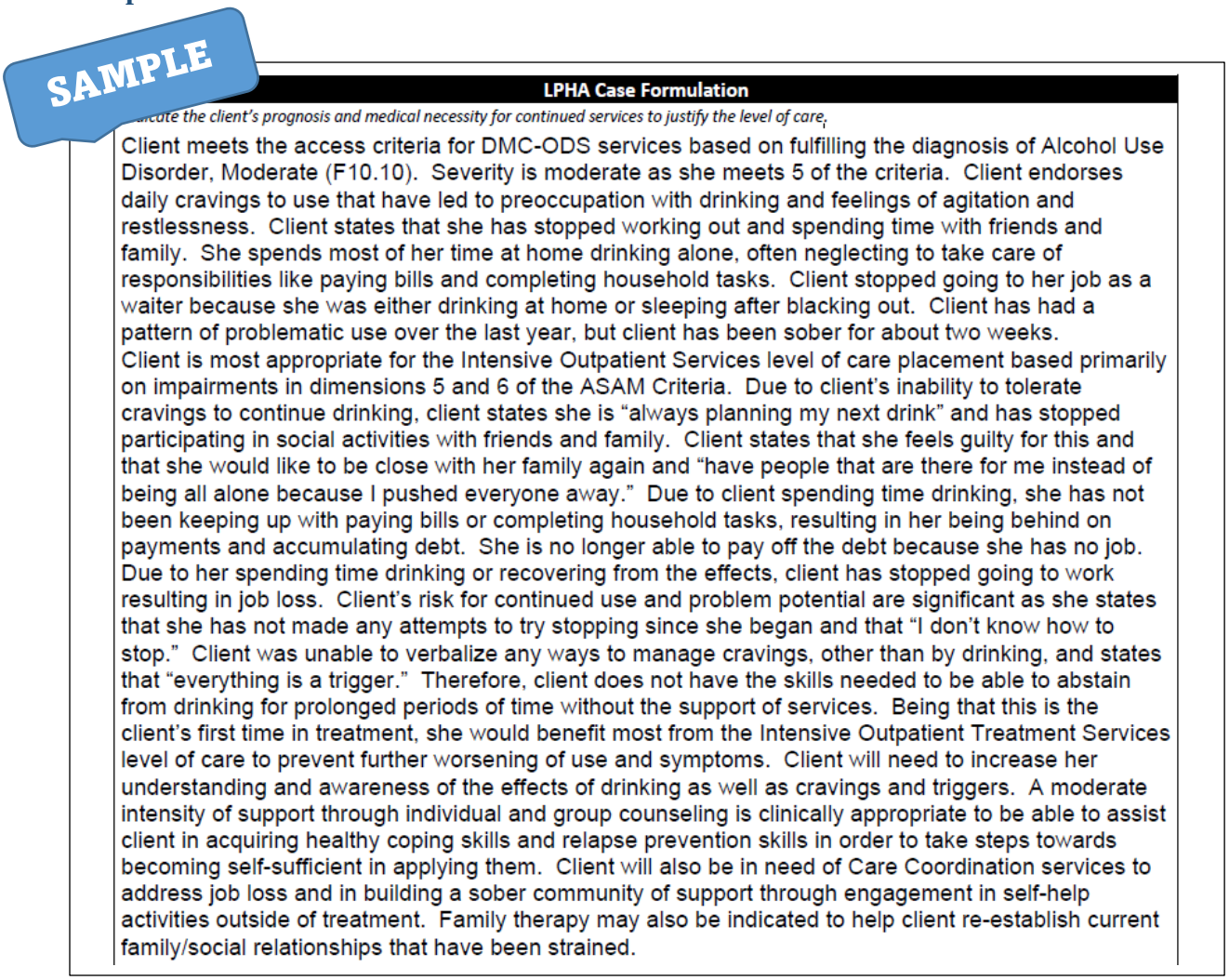
Sample Format:

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

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

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

Sample: Case Formulation



Non-LPHA and LPHA Consultation for the Initial Assessment

If a non-LPHA counselor completes the assessment, there must be a consultation (by face-to-face, telehealth, or telephone) between the non-LPHA counselor and the LPHA who reviews the assessment. This interaction needs to be documented to show evidence that this consultation took place. It can best be captured using a progress note. Both the non-LPHA counselor and the LPHA can account for the time spent in the consultation through a billable Care Coordination note. This means that if the consultation took 23 minutes, both the non-LPHA and the LPHA can claim 23 minutes on each of their progress notes. Please remember that this interaction must be a separate activity from clinical supervision. Clinical supervision is not billable to DMC. The start and end times for the consultation on each note should match. The LPHA must then complete the Case Formulation and the Diagnosis section of the SUD Assessment form, based

on review of the assessment and consultation with the non-LPHA. The LPHA must complete and sign the Case Formulation within thirty (30) calendar days of the client's admission (at the Outpatient Drug Free and Intensive Outpatient Treatment). It is permissible for the LPHA to document that the consultation took place within the Case Formulation in lieu of completing a progress note. However, if there is no separate progress note documenting the consultation, this means that the time spent in that consultation cannot be billed.

Completing Assessment Activities in the Proper Sequence

Be mindful of the sequence in which the assessment activities are completed. For example, it does not make clinical sense for the non-LPHA and LPHA to complete the consultation if the non-LPHA has not gathered all of the information needed for Dimensions 1-6. The purpose of the consultation is for a discussion about the information pertaining to Dimensions 1-6 that is applicable for determining the client's appropriateness for the level of care indicated as well as information to support the diagnosis or diagnoses. The proper sequence is as follows: Dimensions 1-6 should be completed prior to the consultation between the non-LPHA and LPHA. The consultation may lead to modifications of some of the information in Dimensions 1-6, as needed. The LPHA should be documenting the Case Formulation upon completion of the consultation. If the consultation session is utilized by the LPHA to construct the Case Formulation in the presence of the non-LPHA, this is acceptable.

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

Clients Determined to Not Meet the Access Criteria

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

Important note: The Z03.89 code is a diagnosis that can only be established by an LPHA. Therefore, please make sure there is documentation that a consultation was conducted between the LPHA and non-LPHA in those instances where the intake has been completed by a non-LPHA. After the assessment period, at the point at which a client must meet the access criteria to continue with the treatment level of services, the LPHA must determine and document if the client does not meet the access criteria.

Treatment Authorization for Residential Treatment Services

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

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

Use of Assessments Across and Within Programs

In general, a new Assessment or Re-Assessment is needed for a change in the client's condition. This means that if there is a change in the client's diagnosis and/or change in the level of care needed, a new Assessment or Re-Assessment must be completed.

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

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

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

Transitions in level of care within the same provider

For those clients who may transition from one level of care to another within the same provider, the SUD Re-Assessment form completed at the former level of care (which substantiates the need for a different level of care) can also act as the initial assessment for the new level of care that the client is going into. Be sure the SUD Re-Assessment clearly demonstrates how the client meets the access criteria and is most appropriate for the level of care indicated.

Example: The Santa Ana Clinic has Intensive Outpatient Treatment (IOT), Outpatient Drug Free (ODF), and Recovery Services. Client X currently attends ODF at Santa Ana Clinic. The counselor and LPHA complete the SUD Re-Assessment for Client X, which indicates the client is ready for a lower level of care. Client X may transition to Recovery Services (assuming the client is not already involved with Recovery Services) at Santa Ana Clinic and the same SUD Re-Assessment (from ODF) can be used as the assessment that substantiates the need for Client X to receive services at the Recovery Services level.

Note that the State does not consider a transition from IOT to ODF within the same provider as a discharge. Therefore, an initial assessment or the use of an SUD Re-Assessment that documents

the client's readiness for discharge from IOT and the need for ODF does not need to be used as the initial assessment for ODF, since it is not considered a new admission. However, since it is a change in level of care and the needs of the client have changed, there still needs to be documentation of how the client meets the access criteria and it is advised that an SUD Re-Assessment be used to document this. This ensures that the provider has done due diligence in applying the ASAM Criteria to confirm that the client is ready to be transitioned.

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

Transitions in level of care across different providers

The State allows for using the same assessment document when a client transitions from one provider to another. This means that the SUD Re-Assessment completed to justify the client's appropriateness for discharge from Provider A's program can be used as the initial assessment for substantiating the client's admission to Provider B's program. It will be the responsibility of the receiving provider to thoroughly review the assessment document received from the client's previous provider. The receiving provider will need to make sure that the assessment document sufficiently establishes how the client meets the access criteria and justifies services at the new program. The LPHA will need to make this determination based on the information contained within the assessment document. Upon review, if the assessment document received does not contain the necessary information, it is advised that a full assessment or SUD Assessment form be completed to ensure that the requirements of an initial assessment are fully satisfied. Relevant information from the previous provider's assessment document can be referenced as appropriate. If clinically appropriate, it is acceptable to utilize an addendum (such as the Case Formulation section of the SUD Assessment) to capture information that may have been missing from the assessment document. However, if there are a number of significant changes that are needed or if changes will alter the diagnosis or level of care, a full assessment document should be completed.

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

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

Transfers across programs under the same entity

If your organization has several locations that are providing DMC-ODS services, there may be

instances where a client may need to transfer from receiving services in one location to another without any change in level of care. There are two options for transfers:

Option 1: If a client transfers between your locations (within the same level of care), the State allows the client's case to remain open, but the timelines must remain the same. As you know, for the purposes of the County's billing system (IRIS), we must close the client's Episode of Care (EOC) with the first location and open a new EOC at the next location. This will trigger a new admission or start date for the EOC in IRIS; however, the existing timeline stays with the case since it is a transfer within the same provider and level of care. Providers will need to pay attention to the timeline based off the admission or start date of the EOC for the first location where the client was opened. The legal paperwork (i.e., Informed Consent, Receipt of Notice of Privacy Practices, etc.) obtained at intake at the first location can carry over to the new location. In essence, the chart will "move" with the client. If the client has already been open for thirty (30) days (or sixty [60] days if client is a youth or documented to be homeless) at the first location for the Outpatient level of care at the point at which they transfer to another location, a valid assessment should be completed as soon as possible. If an assessment was started or finished at the first location, the documents can be used at the second location. If the assigned primary counselor or provider is changing from one location to the next, the receiving provider should confirm the accuracy and relevancy of the information contained in the assessment document. The new provider should then document on how information from the first location is still applicable or what needs to be updated.

Option 2: Client cases for transfers (across the same level of care, under the same legal entity) can be completed by discharging the client from the first location and re-admitting them as a brand new client at the next location. Doing so will be in line with the process in IRIS (closing of one EOC at the first location and the opening of a new EOC at the next location). However, this will mean that all new intake paperwork is needed for the new location. The assessment document can be used across locations, but it will be the responsibility of the receiving provider to ensure that all of the necessary information has been obtained and adequately demonstrates how the client meets the access criteria and justification for the level of care. The receiving provider should document that the information has been reviewed and continues to be relevant.

Transfers in the same level of care across different providers

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

assessment and/or problem list in place. However, this should be documented along with the plan for completing the assessment and/or problem list.

Important Reminders about the SUD Assessment Form

1. Providers that must also follow other regulatory requirements, such as the 2020 or current Alcohol and Other Drugs (AOD) Certification Guidelines, Adolescent Substance Use Disorder Best Practices Guide, Perinatal Treatment Guidelines, or Substance Use Prevention Block Grant (SABG), should consult with their internal compliance program or counsel for program specific guidance. Likewise, if any other accrediting bodies monitor your program, you will need to abide by those requirements.
2. The non-LPHA counselor or LPHA may complete the Dimensions 1-6 and the Placement Summary. The LPHA must complete the Diagnosis and Case Formulation.
3. The SUD Assessment form is not considered complete and valid without the Case Formulation by an LPHA. For programs not utilizing the County's SUD Assessment form, please note that without documentation of medical necessity by the LPHA, the client's initial assessment is incomplete/invalid.
4. For Narcotic Treatment Programs/Opioid Treatment Programs (NTP/OTP), a history and physical exam done by a physician at the time of a client's admission to an NTP/OTP, qualifies for determining medical necessity.
5. For providers using the hard-copy version of the County's SUD Assessment:
    a. If the SUD Assessment form is completed over multiple sessions, the initials and date on the particular page of the assessment that was worked on should match the date documented on the progress note where it is indicated that it was worked on. This is to show that what was stated as completed in the progress note was actually completed on that date.
    b. If the LPHA is the one who is completing the entire assessment document (no non-LPHA involvement), the LPHA does not need to complete the Counselor Recommendation section of the assessment. The LPHA can indicate "N/A" or "See case formulation." It is advised that the LPHA sign the page that includes the counselor's recommendation since it will make it clear to an auditor who completed Dimensions 1-6 and the Placement Summary.
    c. The Diagnosis page should be initialed and dated by the LPHA since the LPHA is the only provider who is able to diagnose.
6. If it is discovered that a person conducting assessments has not completed ASAM A and B trainings prior to providing the assessment services, then the entire assessment service, and all subsequent services, will be disallowed, as it would fall under fraud, waste, and/or abuse. The corrective action would be to have someone else who has completed the required training complete an assessment (at the point at which the issue is discovered) to bring the chart into compliance.
7. If it is discovered that a person conducting the assessments is not a certified DMC provider or has a lapsed/expired license, credential, or registration, then the entire assessment service and all subsequent services will be disallowed, as it would fall under fraud, waste, and/or abuse.

Initial Assessment FAQ

1. ***What if there is no Case Formulation or additional documentation by the LPHA completed?*** Without a Case Formulation or some kind of documentation by the LPHA, that explains how the client meets the access criteria and is appropriately placed in the most suitable level of care; medical necessity has not been established to warrant the billing of services under the DMC-ODS. This means that services provided after the assessment period without demonstration of how the client meets the access criteria may be considered fraud, waste, and/or abuse resulting in disallowed services.
2. ***What if the Case Formulation does not demonstrate medical necessity?*** If there is not enough information documented to clearly demonstrate how the client meets medical necessity and the access criteria, the initial assessment is considered invalid. This will result in disallowed services, as it would be considered fraud, waste, and/or abuse.
3. ***What if the non-LPHA and/or LPHA forgets to sign the assessment?*** At the point at which it is discovered that a signature is missing, the provider may sign the assessment with the date of signature and add, "Late entry for (date assessment was completed and should have been signed)." DO NOT BACKDATE! Best practice would be to document the reason for the late signature; however, this is not required. Missing signatures will not result in disallowance of services, unless there is a pattern or a particular situation that may suggest fraud, waste, and/or abuse. For staff who are no longer with the agency, the Program Directors, Service Chiefs, or other Head of Service administrator who is also a certified DMC provider, may sign the assessment and add a statement indicating that the rendering provider is no longer available to sign.
4. ***Can the non-LPHA write the Case Formulation and have the LPHA sign it?*** No. It is not within the non-LPHA's scope of practice to complete the Case Formulation, due to the establishment of the SUD diagnosis. Additionally, the LPHA must do his/her/their own documentation and sign. Signing documentation that was not completed by the signer with the intention to make it appear as though he/she/they were the writer is fraudulent and will result in disallowance and a compliance investigation.
5. ***If most of the clients in our program have similar issues, can we just use a template for the Case Formulation?*** No. "Templating" or the "copy/paste" of the same Case Formulation across multiple clients is considered fraud, waste, and/or abuse. Such a pattern will result in disallowance of services. Even if most of your clients have a similar presentation, no two individuals are exactly alike and will have aspects of their lives that are unique. Please do your due diligence to identify what those differences are that may significantly affect the course of treatment for that individual and be sure to document it.

9. PROBLEM LIST

Problem List vs. Treatment Plan

Effective July, 1, 2022, the State will require a problem list in lieu of a treatment plan for DMC-ODS. In an effort to enhance service access and delivery across substance use, mental health, and medical/physical health care and achieve greater "whole person" care, the problem list is intended to foster greater coordination and continuity of care.

We have received confirmation that while the State is continuing to work to update the AOD Certification Standards to align with the CalAIM requirements, the Outpatient levels of care may proceed with implementing a problem list in lieu of a treatment plan. However, if your program is required to follow the SABG (including residential programs), Adolescent SUD Best Practices Guide (formerly Youth Treatment Guidelines), or Perinatal Treatment Guidelines, please continue with the treatment plan until further notice. Likewise, if any other accrediting bodies are monitoring your program, you will need to continue to abide by those requirements.

NTPs will continue to complete treatment plans.

Requirements

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

Diagnoses identified by a provider within his/her/their scope of practice should include diagnosis-specific specifiers from the DSM-5, as needed. An example of a diagnosis-specific specifier is the "mild," "moderate," or "severe" for the substance use disorders (i.e., Alcohol Use Disorder, Severe).

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

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

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

Who Can Complete the Problem List?

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

A non-LPHA or LPHA can complete the problem list, however, keep in mind that the LPHA is the only provider who can diagnose. This means that non-LPHA are limited to the Z55-Z65 ICD-10 codes.

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

When Does the Problem List Need to be completed?

The State is not explicit as to when the problem list needs to be created by. Best practice is to use the timelines for the initial assessment as a guide. This is because the completion of the initial assessment means that a thorough inventory has been taken on what the client may be having difficulties with because of the substance use. Additionally, the period of assessment has highlighted factors in the client's life that may not be directly associated with the substance use, but may have implications on his/her/their ability to abstain or reduce use. These are the problems that may need to be addressed on the problem list. In this way, there should be consistency across the assessment and problem list.

Outpatient*: Since the initial assessment should be completed within thirty (30) days of the client's admission (sixty [60] days for youth under the age of 21 and clients experiencing homelessness), it is reasonable to expect that a comprehensive problem list be developed by this time.

Residential*: Due to the relatively short duration of stay and the need for prior authorization at this level of care, the initial assessment should be completed within three (3) days of the client's admission. However, the recommendation for the development of the problem list is ten (10) days from the date of admit.

Withdrawal Management*: Due to the extremely short length of stay, the initial assessment or Brief SUD Level of Care Screening is recommended to be established within twenty-four (24) hours of the client's admission. As a result, the problem list should also be developed within twenty-four (24) to forty-eight (48) hours from the date of admit.

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

**Note: the timeframes are only recommendations based on the standard of care.*

When Does the Problem List Need to be updated?

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

How Should the Problem List be used?

At the point of its initial development, the provider can utilize the client's problem list as a guide for conceptualizing the course of treatment. Seeing all of the problems in one succinct view can help in prioritizing the areas of need for the client. It may also include thinking about what types

of services the client may need within the current treatment episode or level of care to properly address the identified problems.

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

Since one of the areas of focus for the CalAIM initiative is on improving the client's treatment experience, it is important to engage the client in this process of developing a problem list as much as possible. The client and any significant individuals in his/her/their life should be encouraged to participate in the development and modification of the problem list. Throughout the course of treatment, the problem list serves as a good way to "check in" with the client on how treatment is progressing, which may also prompt further collaboration between the provider, client, and any other parties involved to support the client's treatment. This collaboration should also be evident in the session progress notes where specific problems are explored, identified, and/or addressed.

Pregnant and Postpartum

Regardless of whether enrolled in a perinatal program or not, if the client is pregnant or postpartum, the problem list should address applicable areas of concern relevant to the Perinatal Treatment Guidelines. These may include addressing treatment and recovery services specific to pregnant and postpartum women like relationships; sexual and physical abuse; and development of parenting skills; mother/child habilitative and rehabilitative services; education to reduce harmful effects of alcohol and drugs on the mother and child/fetus; coordination of ancillary services. Please remember that in order to claim services using the Perinatal billing codes, there must be medical documentation on file that supports the client's pregnancy or postpartum status. "Postpartum," under the DMC-ODS, is defined as the sixty (60) day period beginning on the last day of pregnancy. Eligibility for the use of the perinatal code ends on the last day of the calendar month in which the sixtieth (60^{th}) day occurs.

Youth-Specific

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

What about the Physical Exam?

There are no changes with the physical exam requirement. We still need to find out whether a client has received a physical exam within the prior twelve (12) months from the date of admission. This should have been addressed in Dimension 2 of the ASAM Criteria dimensions for the County's SUD Assessment form (or other ASAM based assessment). For those clients who have not had a physical exam within the twelve (12) months prior to admission to treatment, we will need to coordinate care to help the client obtain one. The State is not explicit on how this needs to be accounted for. Therefore, the client's need for a physical exam can best be

addressed by placing it on the problem list. The ICD-10 code of Z75.8 – "Other problems related to medical facilities and other health care" can be used for this purpose. The physical exam requirement is applicable for ALL levels of care, including Withdrawal Management and Recovery Services.

Problem List FAQ

1. ***What happens if the problem list is not created within the recommended timeframes in line with the initial assessment?*** Services can continue to be billed using the billable code. The problem list should be completed as soon as reasonably possible, and efforts should be made to be consistent in timeliness. It is good clinical practice to document the reason for the delay in completion; however, this is not required. Appropriate reasons for delay are those pertaining to the client, such as client missing numerous appointments. Reasons attributed to programmatic restraints like staffing should not be documented. Please keep in mind that a pattern of problem lists not completed in a timely manner may result in disallowance and/or recoupment due to the potential for it to be considered fraud, waste, and/or abuse.
2. ***The client transferred to my caseload and there is no problem list. Are we unable to bill for services?*** Services can continue to be billed using the billable code. However, at the point at which it is discovered that there is no problem list in place, the provider should complete one as soon as possible. It is recommended that the new provider document that the client was transferred without a problem list in place and what the plan is for completing one.
3. ***Does the problem list need to be signed?*** There are no signature requirements for the problem list. This means that the provider and the client do not need to sign the problem list. Only the provider who has added or resolved problems should clearly specify his/her/their name, credentials, and date on which the problem was added or resolved.
4. ***Do I remove the problems from the problem list when the client discharges?*** No. Problems should not be removed from the problem list at the time of client's discharge. If the item is no longer an area of need, the date on which the issue was resolved should be indicated on the problem list. This demonstrates to any other providers who may view the problem list that this was addressed and no longer a treatment need. It is recommended that the discharge summary or termination session progress note indicate those areas that may be of ongoing need.
5. ***The provider who was the primary counselor for the case is no longer working at the agency. Who can "end date" or indicate a problem as "resolved?"*** If the client's case is being transferred to another provider, the receiving provider is now the primary counselor and may identify, add, and/or resolve problems as clinically appropriate. If the client's case is closed and the assigned counselor for the case is no longer with the agency/program, the Program Director, Service Chief, or other Head of Service administrator who is also a certified DMC provider, may add a note to explain that the status of the problem is missing and the provider is no longer with the agency.

6. ***What about the Physical Exam requirement for youth clients under the age of 21 receiving Early Intervention Services?*** Although not explicitly required by the State, best practice would be to address this with our youth clients, even in Early Intervention.
7. ***What about the use of SNOMED codes?*** There is no requirement to use the codes under the Systematized Nomenclature of Medicine (SNOMED) Clinical Terms. If your agency's electronic health record (EHR) allows for the use of SNOMED codes, this is permissible. Please bear in mind scope of practice implications when using the SNOMED codes.
8. ***Should Tobacco Use be added to the problem list?*** Yes, although a Tobacco-Related Disorder on its own is not a qualifying diagnosis to meet the access criteria for DMC-ODS and it cannot be "treated," it should still be added to the problem list, if applicable. For example, it may be that a client will need some referrals and resources to address this issue, in which case you may be providing some care coordination. For county electronic health record (EHR) users, the Tobacco-Related Disorder should not be identified as a "Diagnosis Treated Today."
9. ***Is a problem list needed for youth clients in Early Intervention?*** Although we are not treating a SUD diagnosis for clients under the age of 21 at the Early Intervention level of care, we are still going to be addressing needs and problems in the client's life that are associated with misuse or abuse. Therefore, a problem list is still relevant for youth clients in Early Intervention Services and should be completed.

Sample: Problem List

ODF Problem List

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

10. RE-ASSESSMENTS

Requirements

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

- Change in diagnosis
- Change in level of care

Who needs to complete the Re-Assessment?

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

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

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

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

How is the Re-Assessment conducted?

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

Re-Assessments Used as the Initial Assessment

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

Re-Assessments at the Residential Level of Care

Although there is no State requirement for a client to be re-assessed at any specific point, the County is requiring a re-assessment every thirty (30) days from the date of admission for Residential Treatment. This is in an effort to align with the statewide goal for the average length of stay of thirty (30) days at the residential levels of care. The length of stay is based on individual clinical need. A good question to ask to determine this might be: Is Residential Treatment the least intensive level of care that is clinically appropriate to treat the client's SUD at this time. The re-assessment will allow us to determine treatment progress and justify the client's continued need for the residential level of care or readiness to transition clients to another level of care as needed.

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

There is no required format for the re-assessment. The County's SUD Re-Assessment form may be used by all providers to fulfill this requirement. Since the purpose of the re-assessment at the residential level of care is to re-establish medical necessity and access criteria as well as appropriateness for this level of care, the LPHA will need to document. If the County's SUD Re-Assessment form is utilized, the Diagnosis section and Case Formulation needs to be completed by the LPHA.

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

What needs to be in the Residential Re-Assessment?

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

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

The re-assessment is the time to consider whether the client is appropriate for a stepdown to a lower level of care. If the client is progressing in his/her/their treatment, be sure to document the

areas of need that can now be addressed at a lower intensity level of care. The re-assessment should document how the client meets the criteria for the new level of care. At this point, we will focus on assisting the client through a smooth transition to the new level of care and care coordination will be very important.

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

*****DISCLAIMER*****

Above timeframes are determined by the State as well as any internal program agreements made between the County and the State. Please keep in mind that the State sets the minimum requirements and the County can impose standards above and beyond the State's guidance.

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

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

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

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

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

If the client had a planned discharge, such as a successful completion, from the residential program and a re-assessment was completed by the residential provider that demonstrates the

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

Re-Assessment FAQ

1. ***A consultation between the non-LPHA and LPHA is not required for a re-assessment, but if one is conducted, is it billable?*** Yes, if there is a clinical need for the consultation, this is billable as a Care Coordination service. Both the non-LPHA and LPHA can bill for the time spent.
2. ***What happens if a re-assessment does not establish the client meeting the access criteria and justification for the level of care?*** Services claimed based on a re-assessment that has not properly established how the client meets the access criteria and appropriateness for the level of care received will result in disallowance and recoupment. In order to receive treatment within the DMC-ODS, the client must meet the access criteria and demonstrate a need for the particular level of care. The documentation in the client's chart must support this; otherwise, such instances may be considered fraud, waste, and/or abuse.
3. ***What happens if the non-LPHA completes Dimensions 1-6, but the LPHA does not complete the Diagnosis form and Case Formulation section until a month later?*** The billable codes can continue to be used for the period until the LPHA has completed the required sections. However, depending on the nature of the issue, services may or may not be disallowed and/or recouped in a review or audit. Please remember that a pattern of such issues from any one provider or across an agency/organization will be investigated as potential fraud, waste, and/or abuse.
4. ***What happens if a re-assessment is missing the LPHA's documentation of the client's diagnosis and how the client meets the access criteria?*** The LPHA is the only provider who can diagnose and determine whether the client meets the access criteria. Therefore, any changes to the diagnosis and establishing (or re-establishing) the client's need for a particular level of care must involve the LPHA. As a result, a re-assessment is not considered complete and valid without a diagnosis and documentation on how the client meets the access criteria and need for the level of care by the LPHA. Services provided without the proper documentation, may be considered fraud, waste, and/or abuse and may result in disallowance and/or recoupment.
5. ***I just received a client transitioning from a higher level of care, how can I use the SUD Re-Assessment form that was completed for discharge?*** The LPHA can review the SUD Re-Assessment form completed at discharge for the former level of care to confirm that the information documented is sufficient to stand as the initial assessment for the new level of care. The information should also clearly demonstrate how the client is appropriately placed in the current level of care. The LPHA should document the review of the re-assessment document and the results of doing so. Progress note documentation is necessary to bill for the time spent reviewing the document.
6. ***For Residential Treatment, if there are no re-assessments every thirty (30) days, what happens?*** The services provided without a valid re-assessment(s) are susceptible to

disallowance and/or recoupment if there is no other documentation that substantiates the client's ongoing need for Residential Treatment. Even though a prior authorization for treatment has been obtained for a client at the time of enrollment into the residential level of care, the client must continue to demonstrate the need for this level of care throughout the length of stay. Provision of services without clear documentation of this may be considered fraud, waste, and/or abuse.

7. ***Do we have to do a re-assessment at discharge?*** Clinically, the re-assessment is where the client's readiness for discharge is documented. It is not the discharge that triggers the need for a re-assessment. Some type of change has occurred with the client (such as improved functioning in the ASAM dimensions) that necessitates a thorough re-assessment to determine how the client may meet the access criteria for a different level of care. Although a re-assessment document is not required, it is clinically best practice to ensure there is some type of documentation (i.e., session progress note with inclusion of the consideration of changes in each of the ASAM dimensions) to note how the client's needs at the current level of care have been resolved and/or the client's problems can be better addressed at a different level of care.

*****DISCLAIMER*****

Above timeframes are determined by the State as well as any internal program agreements made between the County and the State. Please keep in mind that the State sets the minimum requirements and the County can impose standards above and beyond the State's minimum requirements.

11. PROGRESS NOTES

Requirements

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

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

The following information must be on each progress note:

- The type of service that was provided
- The date that the service was provided to the client
- Duration of the service, including travel and documentation time
- The location of the client at the time of service
- A narrative that describes the service and how the service addressed the client's SUD and/or problems from the problem list

- Next steps or plan (planned action steps by the provider or the client, collaboration with the client, collaboration with other provider(s), and any update to the problem list)
- The service provider's typed or printed name, signature, and date of signature
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code
- International Classification of Diseases (ICD) 10 code

Service and Documentation Start and End Time

Until there is more specific information from the State, please be sure to continue documenting the start and end times for the service and documentation minutes on the progress notes. Times should be documented to the minute. Avoid estimating and rounding to the nearest quarter-hour/half-hour/hour. As has been in the past, it is important that the start and end times on the progress notes match up with the number of minutes claimed in the billing system. All time that is claimed should be appropriately justified by the documentation.

When do progress notes need to be completed?

Progress notes must be completed within three (3) business days of the date of service.

"Business" days will be any days that the program is open and providing services. For example, at a Residential program, if a provider needs to document a service provided on a Friday, the timeline of three (3) business days will mean that it needs to be completed by Sunday. Remember, that the date of service counts as day one (1). This would also be applicable for programs with any other level of care that may provide services on the weekend.

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

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

What format do the progress notes need to be in?

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

Who can document progress notes?

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

Be sure to keep your license, certification, or registration up to date! Expired or lapsed licenses, certifications, or registrations means that you cannot provide and bill for DMC-ODS services until you are back in good standing. Services claimed for any period of time during which there

is an expiration or lapse will result in recoupment and/or disallowance as these services may be considered fraud, waste, and/or abuse.

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

How do we document the narrative portion of the progress notes?

For those who may be familiar with the GIRP format used in the first few years of the DMC-ODS, think about the narrative as the combination of the "Intervention" and "Response" sections. The difference now is that you do not need to be concerned about "where" the information goes. It is a summary or recounting of what you as the provider did in that session. You will want to make sure that it clearly shows how what you provided was necessary or relevant to the client. It should also include information about how the client presented in the session and what he/she/they did. Remember, the narrative should paint a general picture of how that session went. It should give the reader a good understanding of what the issue was (or issues), how you addressed it, and how the client responded to that. You can include quotes if this is helpful in illustrating the nuances of the session that may give insight into how the client is or is not progressing.

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

How do we document the plan portion of the progress notes?

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

Residential Treatment and Daily Notes

At the Residential Treatment level of care, a daily progress note is needed to capture all claimed services for the day.

What is a daily note?

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

1. A summary note of all services provided to the client for that day;
2. A progress note for an individual counseling or group counseling session for that day*; or
3. Documentation of client's participation in a structured activity for that day

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

Please note that there is no explicit guidance from the State in regards to the format of a daily note. It is up to the discretion of each provider or agency as to how the daily note "looks," as long as it incorporates the required elements.

How should a daily note be written?

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

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

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

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

Required Clinical Hours vs. Structured Hours

All clients enrolled in a residential program will need to receive a minimum of five (5) clinical hours each week. As far as the types of groups that will count towards the clinical hours, the content of the group must be clinical in nature and within the scope of practice for the facilitating provider. This includes individual and group counseling services. Those groups utilizing evidence-based practices (EBPs) are considered clinical groups. Intake and assessment sessions with the client to gather information needed to complete the client's assessment, problem list development sessions with the client, and discharge planning sessions with the client (specifically to discuss non-care coordination related issues pertinent to discharge, such as how

the client will prepare to return to a home where the family member may have a tendency to enable the client) count as individual counseling.

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

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

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

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

Transportation at Residential

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

Sample: Residential Daily Note

SAMPLE

Residential Daily Note

Client: Bobby B. Blueberry

Date: 1/15/22

Location: 123 Residential Way, Santa Ana, CA 92701

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

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

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

1:01pm – 2:31pm Clinical Group CBT

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

7pm – 8:30pm AA/NA Meeting (off-site)

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

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

Total Clinical Hours: 217 minutes (3.6 hours)

Provider Name: Lyle Lemon, CADC

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

Services via Telehealth & Telephone

A telehealth session means office or outpatient visits via interactive audio and video telecommunication systems. Please refer to your program administrator for the specific platform that is used for the interactive audio and video telecommunication system at your site. The ability to utilize telehealth and telephone as a means of providing services to our clients is helpful for ensuring that clients stay connected and have access to the services that are needed.

Although services can be provided from anywhere in the community, there are some important requirements to be aware of.

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

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

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

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

We also need to add the GT modifier to the claim to avoid denials and delays!

Telehealth and Telephone at Residential Treatment Services

Services may be provided in person, by telehealth, or telephone, however, telehealth and telephone services cannot replace in-person services. The expectation is that most services in a residential setting will be provided in-person. Telehealth and telephone services are meant to supplement the client's treatment at this level. Be sure to include documentation of the reason for the use of telehealth or telephone services instead of in person services.

Progress Note FAQ

1. ***Is templated content (or copy/paste) OK?*** No. Please be careful not to "copy and paste" information from one progress note to another, meaning that one progress note looks like a carbon copy of another progress note intended for a different day or different client. This type of documentation is considered fraudulent and will result in recoupment and/or compliance investigations. The exception would be for group service documentation where the same intervention will have been provided to all group attendees. However, there should be some documentation specific to each client so that it is individualized. There may also be times when you may do the same intervention with a client over several individual counseling sessions, but there should be an explanation as to the purpose and intent of doing

so. It is expected that each individual session progress note is specific to the service and to the client. You may use the same intervention but in different ways or focusing on different components depending on the client and his/her/their needs. Therefore, your documentation would need to demonstrate this. It is acceptable to have a general outline of how you would like to structure your progress notes, however, the information needs to be made specific to that client and session.

2. ***If all the groups at our site are 90 minutes and scheduled at the same time every week, do I still have to put the exact start and end time?*** Yes. Even if all groups are scheduled for a specific length of time, the reality is that groups often do not start on time or end on time. It is important to capture these variances as billing with the same exact number of minutes for every group is going to be flagged by the State as needing review. Just as auditors do not like to see content that appears to be a template for progress notes, they do not like the times to be a template.
3. ***Do I have to write down everything that happened in the session?*** No. We want to protect the client's privacy and confidentiality so we do not need to write everything that happened or was said. It is about quality over quantity. Remember that the primary purpose of a progress note is to document the service provided. It is not only necessary for maintaining a good clinical record according to standard practice, but also necessary for reimbursement. It is a record of what we are doing to help the client make progress in the current episode of care. Therefore, it must effectively show how the service is necessary to address the client's needs. Keeping this in mind will help focus the content of the progress notes and keep your notes clear and concise!
4. ***I forgot to sign the progress note, but it has now been 2 months…what should I do?*** At the point at which it is discovered that a progress note has not been signed by the rendering provider, the signature can be added with the statement, "late entry for (date when it should have been signed)" and the date of the correction. Documents should never be backdated!
5. ***Does the ICD-10 and CPT code need to be on the actual progress note?*** No. The ICD-10 and CPT code do not need to be within the body of the progress note. Many providers have become familiar with using what is called the Encounter Document. The Encounter Document is simply a place where information necessary for data entry by your program's billing specialist is compiled, that is attached to the progress note. It typically includes information such as the date of service, date of documentation, the total amount of service time claimed, the total amount of documentation time claimed, the total amount of travel time claimed, face-to-face versus non-face-to-face time, the location where the service was provided, etc. Use of the Encounter Document will continue to be an appropriate way to ensure the ICD-10 and CPT code are captured. Providers may determine, based on the needs of each specific program, how best to clearly identify the ICD-10 and CPT code and making sure it is tied to the progress note.
6. ***What about the weekly note at the Residential levels of care?*** The weekly note requirement is a part of the Alcohol or Drug (AOD) Certification Standards. As you know, the County monitors only to the Medi-Cal standards and cannot provide specific guidance on AOD Certification Standards. For CalAIM, there is a daily note requirement. Each

program/organization is responsible for taking into consideration any other certifications or regulatory authority that your program must abide by.

7. ***Can we bill for couples counseling? How should I document for a session provided to two DMC-ODS clients in a relationship who are attending the same program?*** Couples counseling is not identified as a billable service under the DMC-ODS. Therefore, there are a few of ways that a service provided to two DMC-ODS clients, who are in a relationship and addressing issues pertaining to each of their substance use disorder, can be documented and claimed. One way would be to claim the service as family therapy (only if conducted by an LPHA). In this situation, the time can be split between the two clients and a progress note completed for each of the clients. Each progress note would need to emphasize how addressing the relationship dynamics is necessary for the client's treatment, meaning that each note would need to be written geared towards the respective client's problems and needs. Another way to document this would be to claim the total time as a collateral service under one of the two clients. A "note to chart" or administrative note can be added for the other client so that there is documentation of the service being provided to both clients.
8. ***My client is only going to be out of the state for a few weeks, can I provide services via telehealth or telephone?*** The client must be in the state of California at the time the service is rendered. Those clients who may need to temporarily be out of state for personal business cannot continue to receive telephone and/or telehealth services while away. If clients are going to be out of state for over thirty (30) calendar days, this does require that we discharge the client. The documentation should clearly indicate that you have confirmed that the client is in California.
9. ***What happens at the time of a clinical chart review when there is no progress note for the service that was provided?*** The billing of a service is contingent upon a corresponding progress note because there needs to be supporting documentation to justify the billing. Therefore, a service found to be billed without a corresponding progress note during a clinical chart review will result in disallowance and/or recoupment due to the appearance of fraud, waste, and/or abuse.

Time Components of a Progress Note

Face-to-Face Minutes

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

Non-Face-to-Face Minutes

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

- Telephone session/service
- Collateral sessions (sessions with significant individuals involved in the client's treatment) without client present
- Family Therapy sessions without client present
- Working on pertinent clinical documents (i.e., assessment, problem list, etc.) that do not include the client (i.e., outside of session with client)

Service Minutes

Billable face-to-face and/or non-face-to-face time. Non-billable face-to-face and/or non-face-to-face time, if using the non-billable or non-compliant billing code.
Example: 45 minutes of face-to-face time with the client in a session to obtain information on family, educational/vocational, legal, and social history. 45 minutes of non-face-to-face time spent after session, without the client, working on conceptualizing the level of risk for dimension 6 of the ASAM Assessment. The service time would be 90 minutes, and the note would reflect 45 minutes of face-to-face time and 45 minutes of non-face-to-face time.

If the same service is provided to the same client on the same day by the same provider more than once, it should be submitted as one claim rather than two services, whenever possible.

Service minutes claimed must be substantiated by the interventions provided. Does the documentation clearly reflect what took place in the session and the amount of time it took to provide the service? Are we billing a 60 minute service for an activity that, as documented, appears that it would take only a couple of minutes to do? This does not mean that every detail of the activity needs to be described. For example, if you are billing non-face-to-face time for the time spent compiling the initial assessment, it is not necessary to include all of the content included on the initial assessment into the progress note. In other words, do not copy and paste the initial assessment into the progress note! Provide enough information so that an outside reader can reasonably conclude that the time claimed is appropriate. Excessive service minutes for what is documented may be interpreted as fraud, waste, and/or abuse and result in recoupment.

Documentation Minutes

Time it took to complete the progress note.
Generally, documentation minutes should never be more than service minutes. It should correspond to what is reasonable in comparison to the interventions provided. This does not include typing or writing speed. It also does not include technical difficulties. If the computer freezes and it took 10 minutes to restart and get back to the note, this time cannot be accounted for in the documentation time.
Documentation minutes claimed must be congruent with the amount of the content written. This is the only time that we are allowed to bill for an administrative function of typing or writing. It must be a reasonable amount of time, meaning that an outside observer would concur that the amount of the content would have taken the amount of time that is being billed for documentation. Excessive documentation minutes for what is documented may appear as fraud, waste, and/or abuse and result in recoupment.
When non-face-to-face time has been spent to "document" a form (such as the assessment, case formulation, etc.), this is service time, not documentation time. Documentation time is only the time it takes to complete the progress note for the activity. For example, if 19 minutes was spent working on the case formulation, this is 19 minutes of service time and not documentation time. The time it takes to write the progress note stating that you worked on the case formulation is documentation time, which is separate from the service time.

Travel Minutes

Time it takes to travel from one location to another to meet with the client to provide a billable service.

Transporting a client does not count for this. If solely transporting a client from point A to point B, this time is non-billable (Medi-Cal will not reimburse for us to simply drive a client places). However, if during the course of transporting the client from point A to point B, some billable service is provided (such as discussing recent response to triggers and use of coping skills), this is considered ***Service Minutes*** because a service was provided. It may be helpful to think of travel time as time in the car ***without*** a client and transportation time as time in the car ***with*** a client when there is no service being provided. This does not mean that 5 minutes of counseling provided during a 30-minute drive can be billed as 30 minutes of service! Only the time spent providing an actual service can be billed.

- *Billable Travel Time* is time that can be billed when providing a billable service.
- *Non-Billable Travel Time* is when billable services are not provided or if solely transporting the client (e.g., picking up a client to take to a doctor appointment).

12. CODES & TYPES OF SERVICES

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

Billing

The services provided in the DMC-ODS are going to either be billable, non-billable, or non-compliant. It is important to know what types of activities are able to be billed so that we can document them accordingly.

Billable Services

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

Non-Billable Services

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

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

1. Completing an Authorization to Disclose (ATD)
2. Educational/Vocational services
3. Recreational/Socialization services
4. Drug testing
5. Search of client's belongings/property
6. Suspected Child Abuse and Dependent/Elder Abuse Reporting
7. Waiting time
8. Translating/Interpreting
9. Clerical Services:
    a. Emailing
    b. Faxing
    c. Scheduling/confirming appointments
    d. Photocopying
    e. Filing/organizing client records/chart
    f. Allowing the client to use program telephone, computer
10. Searching for a missing client
11. Checking or leaving voice messages
12. Providing transportation
13. Completion of bus pass application
14. Completing Shelter + Care application/activities
15. Completion of immigration form
16. Conducting internet searches
17. Most letter writing is not billable
18. Services for the sole purposes of addressing anything other than the substance use disorder impairment. This can include solely dealing with:
    a. Mental health and/or other excluded diagnoses
    b. Health care
19. Any service while the client is in prison, jail/juvenile hall, psychiatric hospitalization, or any public institution
    a. Exceptions to this rule for outpatient only:
        1. Day of admission
        2. Day of discharge

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

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

Non-Compliant Services

When the requirements for documentation and billing have not been adhered to properly, a service is considered non-compliant. Essentially, it means we were not compliant with regulations and standards. In some cases, this involves activities or services that could have been billable, but because there was an aspect of it that was done incorrectly, it is unable to be submitted to the State for billing.

Disallowance or Recoupment of Services

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

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

1. No medical necessity established
2. Level of care determination not substantiated
3. A pattern of there being no initial assessment completed within the timeframe when justification for the access criteria is required
4. A pattern of there being no problem list when it is clinically appropriate and reasonable to expect that it be completed
5. No progress note for the date of service claimed
6. A pattern of templated documentation
7. Patterns in billing without appropriate substantiation (either of time or interventions provided)
8. Services provided out of scope of practice
9. Services provided by a non-DMC certified provider
10. Services provided under a lapsed/expired license/credential/registration
11. Assessment services provided without the completion of required trainings (i.e., ASAM A and B)

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

Billing and Coding FAQ

1. ***Can we bill for completing the* Notice of Adverse Benefit Determination *(NOABD)?*** Unfortunately, billing for the time spent to research the client's chart in order to complete the NOABD letter is not a billable activity.
2. ***What is a "blended" note?*** A "blended" note is a progress note that includes activities of two different service types. For example, if a progress note includes both care coordination and individual counseling interventions or both billable and non-billable activities. We can only bill one service type per progress note and the documentation needs to support the billing code used. Therefore, a "blended" note may appear as fraud,

waste, and/or abuse. Depending on the documentation and the time claimed, this may result in disallowance and/or recoupment.

3. ***What happens if a progress note is "blended?"*** There may be some instances where the non-billable activity (or whatever other activity that does not fit the code used for billing), as documented, is incidental to the overall service. This means that based on the documentation, it is reasonable to determine that the activity was a very brief piece of the entirety of the service. In these cases, it may be permissible to allow for the billing without any corrective action. However, if it appears that the service claimed contains a significant amount of time spent on the other service type or activity that does not align with the service code used for billing, there is a greater risk of the appearance of fraud, waste, and/or abuse and may result in disallowance and/or recoupment.
4. ***If the time spent with my client includes both billable and non-billable activities, how do I document? How do I bill?*** You can use the billable code and document what was provided to the client. Be clear in the documentation that a non-billable activity was provided, in addition to the billable activity, and that the time claimed does not include the time spent for the non-billable activity. For example, if you would like to document that you completed a referral form and faxed it, the documentation could look something like, "Treatment Authorization Request form completed and faxed to the County (time not billed)." The total number of minutes claimed for the service can only include the time spent for the billable activity.
   For County EHR only: If the non-billable and billable activity are of the same service type (i.e., both are care coordination), one Financial Identification Number (FIN) may be used where both the non-billable and the billable time can be accounted for.
5. ***I coded the progress note as care coordination, but it should have been billed as individual counseling. Do I have to make it non-compliant?*** No, it is acceptable to correct the billing code to the appropriate service type according to the interventions provided. The service can continue to be billed and does not need to be made non-compliant. If this is a service that has been inputted into the billing system by your program's billing staff, please have them correct it in the billing system to match the progress note.

Types of Services

Broadly, the services we provide to our SUD clients in the DMC-ODS fall under either individual counseling, care coordination, or group counseling. With the CalAIM initiative, there will be some new codes for such activities as assessment and crisis intervention in 2023. More information is forthcoming.

Below is a breakdown of what types of activities are billable for each type of service.

Individual Counseling

Individual counseling encompasses a few different types of activities or sub-categories:

1. Assessment
2. Treatment Planning (problem list development)
3. Individual Counseling

4. Collateral*
5. Family Therapy
6. Crisis Intervention
7. Discharge Planning

* Collateral Services are now a component of assessment, individual counseling, and family therapy.

Assessment

What are assessment activities?

The following are billable assessment activities:

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

Note: For the initial assessment session at the outpatient levels of care where intake paperwork is provided, reviewed, and signatures are obtained in order to enroll or admit the client into the program and the assessment process is started, the CDM/CPT Code used will be for that labelled as "Intake." This code is to be used one (1) time in a client's episode of care.

All other assessment sessions or activities should be coded as assessment or individual counseling.

For Residential levels of care: Assessment services, which are a part of individual counseling, are part of the daily bundled rates. It cannot be claimed as a standalone service. However, assessment services can count towards the required number of clinical hours needed each week when it involves the client's presence. In order for the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

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

Residential **(Billed by the day – includes assessment)**

Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
Residential 3.5	90899-674	90899-675	90899-676
Residential 3.5 Perinatal	90899-692	90899-693	90899-694
Residential 3.3	90899-844	90899-845	90899-846
Residential 3.1	90899-638	90899-639	90899-640
Residential 3.1 Perinatal	90899-656	90899-657	90899-658
Intensive Outpatient Treatment (IOT)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
IOT Individual Intake	90899-554	90899-555	90899-556
IOT Assessment	90899-557	90899-558	90899-559
IOT Individual Counseling	90899-560	90899-561	90899-562
IOT Recovery Individual	90899-566	90899-567	90899-568
IOT Perinatal Individual Intake	90899-581	90899-582	90899-583
IOT Perinatal Assessment	90899-584	90899-585	90899-586
IOT Perinatal Individual Counseling	90899-587	90899-588	90899-589
IOT Perinatal Recovery Individual Counseling	50899-596	90899-597	90899-598
Outpatient Drug Free (ODF)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
ODF Individual Intake	90899-500	90899-501	90899-502
ODF Assessment	90899-503	90899-504	90899-505
ODF Individual Counseling	90899-506	90899-507	90899-508
ODF Recovery Individual Counseling	90899-515	90899-516	90899-517
ODF Perinatal Individual Intake	90899-530	90899-531	90899-532

ODF Perinatal Assessment	90899-527	90899-528	90899-529
ODF Perinatal Individual Counseling	90899-533	90899-534	90899-535
ODF Perinatal Recovery Individual Counseling	90899-542	90899-543	90899-544
OTP/NTP			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
OTP/NTP Individual Counseling	90899-620	90899-621	90899-622
OTP/NTP Perinatal Individual Counseling	90899-795	90899-796	90899-797
OTP/NTP Recovery Individual	90899-614	90899-615	90899-616
Withdrawal Management (WM) (Billed by the day – includes assessment)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
WM Residential Withdrawal Management 3.2	90899-779	90899-780	90899-781

Who can provide an assessment service?

Assessment activities can be performed by an LPHA or non-LPHA (within scope of practice).

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

How can an assessment service be provided?

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

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

Where can an assessment service be provided?

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

Assessment FAQ

1. ***Do we need to do an intake note?*** Yes, for all levels of care, there should be a progress note completed for the intake session. For Intensive Outpatient Treatment and Outpatient Drug

Free levels of care, the "Intake" code should be utilized for billing this service. This code is intended to be used one (1) time for that initial session. For Residential levels of care, there should be documentation of an intake session, even though there is no separate billing. The time spent with the client for the intake session can count towards the weekly clinical hours required at Residential programs.

Regardless of the level of care, the content for an intake note should include information about how legal intake paperwork (i.e., informed consent, notice of privacy practices, limits of confidentiality, etc.) was explained and reviewed with the client. It is not necessary to list all documents, however, be explicit about the client's consent to treatment by clearly indicating that the informed consent was reviewed and the signature was obtained. It should also include some assessment of the client's appropriateness for treatment services (i.e., substance use history, referral source and reason, etc.) to support any problems or issues (i.e., ICD-10 Z55-Z65 codes) that may be necessary to bill for the intake service and begin the problem list.

2. ***I have to write a lot for the assessment, can I bill for that?*** We cannot bill for simply "completing the SUD Assessment form," so we would want to avoid words like "writing" or "typing" that may make it sound like we are doing the clerical aspect of the assessment. Clerical tasks are not billable to Medi-Cal. The "completing" of the SUD Assessment form needs to show that it took a counselor to do this and that some level of clinical judgment was required. Therefore, we want to use words like "formulating," "synthesizing," "conceptualizing," etc.

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

3. ***Can we bill for the assessment at the Residential level of care?*** Since assessment is part of the daily bundled rate for a residential program, it is included as part of what is offered by the program. This means that it cannot be billed as an additional service for a Residential program. Any non-face-to-face time spent completing assessment activities cannot be counted towards the required number of clinical hours for the week. Only activities that directly involve the client should be counted.

4. ***My client has a lot of paperwork from other agencies that I need to review. Can I bill for my time?*** If the activity is relevant to the client's treatment, it may be billable. Reviewing another document (i.e., discharge paperwork, psychological evaluation, previous assessment, etc.) to help inform the assessment or the client's course of treatment would be billable as care coordination. Be sure to clearly document how the activity was medically necessary. The time spent by the LPHA to review the SUD Assessment completed by the non-LPHA as part of determining the client's diagnosis and medical necessity for services is billable as care coordination. It can also be included in the time spent in the consultation with the non-LPHA, if provided on the same day.

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

5. ***I worked on the assessment over multiple sessions. Is this billable?*** Time spent working on analyzing and developing parts of an assessment document are billable. However, be mindful of the potential for the appearance of fraud, waste, and/or abuse with billing multiple instances of assessment. Each time that assessment is claimed, the documentation needs to clearly show that you are billing for an activity that is different from what was previously claimed.

   Here is where the initials and date on each page of the County's SUD Assessment form becomes important, if using a paper copy. If the counselor worked on Dimensions 1 and 2 on pages 2-4, the initials/date on those pages should match what is documented on the progress note. The corresponding progress note may indicate, "This Counselor synthesized information to complete Dimensions 1 and 2 (pages 2-4) on the SUD Assessment…" If the initials/date indicate those pages were done on 11/11/22, then the corresponding progress note for 11/11/22 should document the counselor's work on this part of the assessment. Be sure to print out those completed pages to place in the chart in the event that the chart is audited before the whole assessment is completed. This is to help corroborate what the counselor is claiming to bill for the activity and what is actually done. If the assessment document is going to be completed in sections, over a period of time, make sure that there is one clean copy placed in the chart once completed. This is to help the auditor to be able to read through the assessment with ease and to ensure all sections are in place. If the information was gathered over various sessions, the final copy should be encompassing of all the information gathered up until the point of completion.

6. ***What do I do if I have new information that the client has given since the initial assessment session that I want to add to the assessment document?*** If those sections of the form were printed out to be placed in the chart (to demonstrate that the time billed corresponds with what was worked on), the counselor should document the new information in the session progress note to indicate that the assessment form will include updated information. The counselor may then choose to manually add the information to the printed out pages (with initials/date of addition) or wait to include the new information or changes in the final, clean copy of the assessment document.

7. ***What about assessing for danger to self (DTS), danger to others (DTO), and grave disability (GD)?*** Risk assessments, such as for DTS, DTO, and GD, do not fall under assessment, unless it was during a session where the counselor was working on the assessment. In that case, the documentation for the risk assessment should be included in the progress note for that assessment session or service. The risk assessment alone does not necessitate a separate document as an assessment note. For example, if during a regularly scheduled individual counseling session, the client discloses thoughts about self-harm that requires further evaluation to determine intent, means, and plan, it would be documented in the individual counseling session progress note. Once your risk assessment is completed, follow your agency's protocol for addressing situations involving DTS, DTO, or GD.

Treatment Planning (Problem List Development)

What are treatment planning activities?

Although there is no longer a requirement for a treatment plan under DMC-ODS, this does not mean that determining the course of treatment for each client has gone away. We will still be involved in treatment planning by collaborating with the client on how his/her/their treatment is going to go in the current episode of care. The following are billable treatment planning activities:

- Collaborating with the client on problems for the development of the problem list
- Reviewing and/or updating the problem list
- Planning for the course of treatment, using the information gathered about the client's specific needs, to determine what interventions may be needed to address those needs and promote his/her/their progress towards improving level of functioning

It will be helpful to think of determining needs and services as two different tasks. All information related to addressing the needs of the client and what he/she/they will work on while in treatment is considered treatment planning. For the DMC-ODS, this also means working on the problem list. The aspect of determining what services would best accommodate those needs is considered care coordination.

As mentioned earlier in the problem list section, the collaboration with the client is an important aspect. Therefore, it is important that there be documentation of a discussion with the client about his/her/their needs and what is desired on the problem list.

Treatment planning activities fall under individual counseling services. Therefore, the billing codes for individual counseling at each respective level of care should be used.

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

For Withdrawal Management levels of care: Treatment planning services fall under individual counseling, which is part of the daily bundled rate. It cannot be claimed as a standalone service. If the focus of the session is geared more towards the exploration of the need for community resources or linkages, the billing code for care coordination may be used.

Who can provide a treatment planning service?

Treatment planning services, including developing the problem list, can be provided by a non-LPHA or LPHA, depending on the scope of practice.

How can treatment planning services be provided?

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

Where can a treatment planning service be provided?

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

Individual Counseling

What are individual counseling activities?

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

Some examples of billable individual counseling activities:

- Working with the client on skill-building for the purposes of maintaining sobriety and relapse prevention
- Educating the client on issues related to substance use, such as concepts of withdrawal, recovery, an alcohol and drug-free lifestyle
- Increasing the client's awareness and understanding about the recovery process and utilization of supports like becoming familiar with related community resources
- Contact with family members or other significant individuals in the client's life (collateral services), as long as participation is focused on the needs of the client and how the family/individual can support the client towards achieving treatment progress.

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

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

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

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

Residential (Billed by the day – includes individual counseling)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
Residential 3.5	90899-674	90899-675	90899-676

Residential 3.5 Perinatal	90899-692	90899-693	90899-694
Residential 3.3	90899-844	90899-845	90899-846
Residential 3.1	90899-638	90899-639	90899-640
Residential 3.1 Perinatal	90899-656	90899-657	90899-658
Intensive Outpatient Treatment (IOT)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
IOT Individual Counseling	90899-560	90899-561	90899-562
IOT Recovery Individual	90899-566	90899-567	90899-568
IOT Perinatal Individual Counseling	90899-587	90899-588	90899-589
IOT Perinatal Recovery Individual Counseling	50899-596	90899-597	90899-598
Outpatient Drug Free (ODF)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
ODF Individual Counseling	90899-506	90899-507	90899-508
ODF Recovery Individual Counseling	90899-515	90899-516	90899-517
ODF Perinatal Individual Counseling	90899-533	90899-534	90899-535
ODF Perinatal Recovery Individual Counseling	90899-542	90899-543	90899-544
OTP/NTP			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
OTP/NTP Individual Counseling	90899-620	90899-621	90899-622
OTP/NTP Perinatal Individual Counseling	90899-795	90899-796	90899-797
OTP/NTP Recovery Individual	90899-614	90899-615	90899-616
Withdrawal Management (WM) (Billed by the day – includes individual counseling)			

Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
WM Residential Withdrawal Management 3.2	90899-779	90899-780	90899-781

Who can provide an individual counseling service?

Individual counseling can be provided by a non-LPHA or LPHA. Interventions must be within the scope of practice of the provider.

How can an individual counseling service be provided?

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

Where can an individual counseling service be provided?

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

Sample: Individual Counseling Progress Note

SAMPLE

PROGRESS NOTE

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

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

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

Narrative: Client seen today at the clinic to address her SUD and how it interferes with her day-to-day functioning. Writer processed with client about ways to cope with her feeling "on edge" and restless due to triggers of being in social situations and large crowds of people. Client was able to discuss possible coping skills with some prompting. As the session progressed, she became more at ease and showed reduced psychomotor agitation (stopped tapping foot). Writer helped client to role play situations in which client manages triggers using visualization and relaxation techniques of deep breathing and grounding. She seemed to enjoy the role play and stated that she likes noticing "feeling lighter" after using the relaxation techniques. Writer encouraged her to continue to practice applying these skills at least 2 times per day so that when she is presented with a trigger, she can readily access techniques. Client initially expressed low confidence in her abilities to utilize techniques on her own, but agreed that regularly practicing them outside of the moments when she is triggered will help her to use them more easily. Plan for next session is to follow up on her independent use of coping skills as well as to process any actual instances of being triggered and how it is managed. Client agrees to continue to practice coping skills 2 times per day. Client seems to be improving her ability to track her triggers and note how she is feeling as a result. Client continues to need interventions to process triggering events and use of adaptive coping skills in order to progress towards increasing time in sobriety.

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

Collateral

What are collateral activities?

The following is a billable collateral activity:

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

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

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

Who can provide a collateral service?

Collateral services may be provided by a non-LPHA or LPHA. Since family therapy is not able to be provided by a non-LPHA, collateral allows for an AOD certified or registered counselor to work with the client's family for any psychoeducation or information gathering.

How can a collateral service be provided?

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

Where can a collateral service be provided?

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

For Residential levels of care: Collateral falling under assessment, individual counseling and/or family therapy, is part of the daily bundled rate. Time spent providing collateral services that includes the client can be counted towards the required number of clinical hours needed each week. In order for the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

For Withdrawal Management levels of care: Collateral falling under assessment, individual counseling and/or family therapy, is part of the daily bundled rate. It cannot be claimed as a standalone service.

Discharge Planning

What are discharge planning activities?

The following are billable discharge planning activities:

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

Since discharge planning is part of individual counseling, the billable individual counseling code should be used. The session with the client where the discharge plan is collaborated on should be documented to provide evidence that this occurred.

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

For Residential levels of care: Discharge planning falls under individual counseling and is part of the daily bundled rates. However, the time spent on such activities, if it involves the client's presence, can count towards the required number of clinical hours needed each week. For the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

For Withdrawal Management levels of care: Discharge planning falls under individual counseling and is part of the daily bundled rates. It cannot be claimed as a standalone service. If the service with the client is primarily to discuss potential resources or referrals that are needed upon discharge, this would be considered care coordination and may be claimed as such.

Who can provide a discharge planning service?

Discharge planning services may be provided by a non-LPHA or LPHA.

How can a discharge planning service be provided?

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

Where can a discharge planning service be provided?

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

Family Therapy

What is Family Therapy?

Family therapy brings the family into the treatment process to identify unhealthy family dynamics that enable the addiction to continue. It is considered a rehabilitative service where, as unhealthy behaviors are identified, families can then work on positive and healthy interactions with each other. Family therapy can continue long after treatment is completed through referrals to licensed practitioners. Family therapy is a self-discovery process for the entire family unit and does not focus solely on the needs of the client, however, is for the direct benefit of the client. Family members can provide social support and help with motivating the client to remain in treatment.

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

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

For Withdrawal Management levels of care: Family therapy falls under individual counseling and is part of the daily bundled rate. It cannot be claimed as a standalone service.

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

Residential (Billed by the day – includes family therapy)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
Residential 3.5	90899-674	90899-675	90899-676
Residential 3.5 Perinatal	90899-692	90899-693	90899-694
Residential 3.3	90899-844	90899-845	90899-846
Residential 3.1	90899-638	90899-639	90899-640
Residential 3.1 Perinatal	90899-656	90899-657	90899-658
Intensive Outpatient Treatment (IOT)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
IOT Family Counseling	90899-758	90899-759	90899-760
IOT Perinatal Family Counseling	90899-764	90899-765	90899-766
IOT Perinatal Recovery Family Counseling	90899-767	90899-768	90899-769
IOT Recovery Family Counseling	90899-761	90899-762	90899-763
Outpatient Drug Free (ODF)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
ODF Family Counseling	90899-746	90899-747	90899-748
ODF Perinatal Family Counseling	90899-752	90899-753	90899-754
ODF Perinatal Recovery Family	90899-755	90899-756	90899-757
ODF Recovery Family Counseling	90899-749	90899-750	90899-751

OTP/NTP			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
OTP/NTP Family Counseling	90899-770	90899-771	90899-772
OTP/NTP Perinatal Family Counseling	90899-801	90899-802	90899-803
OTP/NTP Recovery Family	90899-773	90899-774	90899-775
Withdrawal Management (WM) (Billed by the day – includes family therapy)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
WM Residential Withdrawal Management 3.2	90899-779	90899-780	90899-781

Who can provide a family therapy service?

Only an LPHA working in their scope of practice can provide this service.

How can a family therapy service be provided?

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

Where can a family therapy service be provided?

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

Family Therapy FAQ

1. ***What is the difference between collateral sessions and family therapy?*** Collateral sessions involves counselors meeting with a client's family or significant others that can support their treatment needs. This service focuses on the treatment needs of the client and how loved ones can support the client in his/her/their recovery process. These services are mostly educational or for information gathering. Family therapy, on the other hand, is a therapeutic process that can also address the needs of the family and the larger, systemic issues contributing to the substance use or hindering the client's recovery.

Crisis Intervention

What is Crisis Intervention?

The following are billable crisis activities:

- Relapse
- Unforeseen event/circumstance presenting an imminent threat of relapse

The focus of the session or service is on alleviating the crisis problem and limited to the stabilization of the client's emergency. For example, a client who discloses thoughts of self-

harm perhaps through overdose during a regularly scheduled individual counseling session would constitute a crisis if it were determined that the client is at imminent threat of relapse. If the counselor were to receive a phone call from the client who states that he or she has just been kicked out of the home and is reporting thoughts and plans to relapse, this would be considered a crisis. It would now require the counselor to stop what he/she/they may be doing to address this situation and de-escalate the client to prevent relapse. Another type of situation may be where the counselor is called out to the client's place of residence because the client has relapsed. The activities involved with obtaining information necessary to prevent ongoing use would be considered crisis intervention activities.

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

At this time, crisis intervention is billed using the individual counseling code.

For Residential levels of care: Crisis intervention falls under individual counseling and is part of the daily bundled rate. However, time spent providing crisis intervention services that include the client can count towards the required number of clinical hours needed each week. For the time to count towards the clinical hours for the week, there must be documentation on file to support that this service was provided.

For Withdrawal Management levels of care: Crisis intervention falls under individual counseling and is part of the daily bundled rate. It cannot be claimed as a standalone service.

Who can provide Crisis Intervention?

Crisis intervention services can be provided by a non-LPHA or LPHA.

How can Crisis Intervention be provided?

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

Where can Crisis Intervention be provided?

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

Crisis Intervention FAQ

1. ***During our session, my client discloses thoughts of harm to others. Is this a crisis?*** Not necessarily. Thoughts of harm to others does not, by itself, necessitate a crisis intervention. Additionally, since it happened during the course of a regular session, the risk assessment is just a part of that session. Standard procedures for assessing risk would be followed (i.e., determining the lethality based on whether there is intent, a plan, and means). Obviously, if the client is truly a danger to others based on assessment, your agency's protocol for getting immediate help will need to be followed. If this is related to the substance use because it

poses "an imminent threat of relapse," it is billable as crisis intervention. "Imminent threat of relapse," means that relapse is likely within the next few hours if there is no intervention. If this is completely unrelated to substance use or a potential relapse (perhaps more mental health related), the service would be non-billable. It does not mean that we cannot address the issue; however, it will need to be coded accordingly.

2. ***I went to the client's house because his mom said he was relapsing, but when I got there, he was not experiencing a relapse. Is this still a crisis note?*** Currently, crisis intervention falls under individual counseling so there is no separation of services based on activity for a situation like this. However, if we were to specify the breakdown for an encounter like this, it may look as follows: Crisis intervention can be billed up to the point that the counselor determines that the situation is no longer a crisis because the intent of this service is to stabilize the situation. The frantic call from the mother of the client, travel to the client's home to address the potential crisis, and the assessment to determine the nature of the crisis would be billed as crisis intervention. Upon assessment of the client, where the counselor decides that the situation is no longer a crisis (i.e., no actual relapse and/or no imminent threat of relapse), the billing for this service would stop. Additional work done after this point (for example, speaking with the mother and the client together to process the situation and work on effective communication around potential relapse issues or triggers) would become a different type of service (in the prior example, it may be an individual counseling or family therapy session at this time).

Care Coordination

What is Care Coordination?

The following are billable care coordination activities:

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

The focus of care coordination is on treating the whole person, to not just address SUD, but to integrate primary care and other systems of care that impact the client's SUD treatment. For example, our clients with a chronic substance use disorder who are involved with the criminal justice system are likely going to need greater care coordination services.

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

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

For Residential levels of care: Care coordination is a standalone, billable service. There must be documentation on file to support the billing of this service. Since it is a separate billable service, care coordination cannot count towards the required number of clinical hours for the week.

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

Residential			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
Residential 3.5 Care Coordination	90899-677	90899-678	90899-679
Residential 3.5 Recovery Care Coordination	90899-686	90899-687	90899-688
Residential 3.5 Perinatal Care Coordination	90899-695	90899-696	90899-697
Residential 3.5 Perinatal Recovery Care Coordination	90899-704	90899-705	90899-706
Residential 3.3 Care Coordination	90899-847	90899-848	90899-849
Residential 3.3 Recovery Care Coordination	90899-856	90899-857	90899-858
Residential 3.1 Care Coordination	90899-641	90899-642	90899-643
Residential 3.1 Recovery Care Coordination	90899-650	90899-651	90899-652
Residential 3.1 Perinatal Care Coordination	90899-659	90899-660	90899-661
Residential 3.1 Perinatal Recovery Care Coordination	90899-668	90899-669	90899-670
Intensive Outpatient Treatment (IOT)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
IOT Care Coordination	90899-569	90899-570	90899-571
IOT Perinatal Care Coordination	90899-593	90899-594	90899-595

IOT Perinatal Recovery Care Coordination	90899-602	90899-603	90899-604
IOT Recovery Care Coordination	90899-575	90899-576	90899-577
Outpatient Drug Free (ODF)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
ODF Care Coordination	90899-509	90899-510	90899-511
ODF Perinatal Care Coordination	90899-539	90899-540	90899-541
ODF Perinatal Recovery Care Coordination	90899-548	90899-549	90899-550
ODF Recovery Care Coordination	90899-521	90899-522	90899-523
Withdrawal Management (WM)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
WM 3.2 Care Coordination	90899-782	90899-783	90899-784
OTP/NTP			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
OTP/NTP Care Coordination	90899-611	90899-612	90899-613
OTP/NTP Recovery Care Coordination	90899-623	90899-624	90899-625
Medication Assisted Treatment (MAT) Note: MAT does not have its own care coordination codes, but utilizes the same IOT/ODF care coordination codes.			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
IOT Care Coordination	90899-569	90899-570	90899-571
ODF Care Coordination	90899-509	90899-510	90899-511

Who can provide Care Coordination?

Care coordination can be provided by a non-LPHA or LPHA.

How can Care Coordination be provided?

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

Where can Care Coordination be provided?

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

Same Day Billing

Transitioning clients from one level of care to another

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

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

Only one provider may claim for treatment services on any given day.
This means that a program where the client has been receiving services at and is still open cannot bill for treatment (i.e., individual or group counseling) if the provider that the client is transitioning to wants to bill a treatment service (i.e., individual or group counseling).
When the transition is from Intensive Outpatient to Outpatient Drug Free at a different provider, there is typically no conflict because the former program is billing care coordination (to facilitate the smooth handover), while the receiving program is likely billing individual counseling for intake/assessment.
However, the issue is complicated when a Residential program is involved because of the daily, bundled billing. Residential programs are billing the State a "treatment day rate" that includes all individual and group counseling services provided on that day. This is separate from the "bed day rate" which is solely room and board and is not DMC funded. Therefore, for transitions from Residential to Outpatient, the Residential program cannot claim a treatment day rate on the same day that the client is being assessed and admitted to an Outpatient program. The Residential treatment day rate (that includes individual and group services) and the Outpatient individual counseling needed to assess/intake the client is considered the same type of treatment service, which equates to the client receiving two treatment services on the same day from different providers. This is not allowed because it is considered duplicative.

There needs to be greater coordination between the Residential and Outpatient provider so it is clear when one will stop billing and the other will begin. Ideally, the day the client discharges from Residential (when a treatment day rate will not be billed because they are leaving) will coincide with the day the client admits to Outpatient. If a Residential program must keep a client beyond his/her/their admission to the new program, they are not able to bill for any

treatment days. Once the client admits to a new program, they no longer meet medical necessity for the Residential level of care.

Care coordination billing continues to be permitted at both LOC concurrently.

Review of Documents

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

A few examples of activities that may be considered billable as review of documents:

- Discharge paperwork from medical/psychiatric hospitalization
- Physical exam
- Discharge paperwork from previously attended treatment programs
- Assessments, re-assessments, and problem lists received from the client's former provider
- LPHA review of the assessment document in preparation for consultation with non-LPHA
- Court or legal documents
- Psychological evaluations

Consultations

In addition to being able to bill for the consultation between a non-LPHA and LPHA for the purposes of establishing a diagnosis or for completing the assessment process so the LPHA can formalize the Case Formulation, there are other consultations that can be billed.

Peer-to-peer consultations within your agency may be a billable consultation. Oftentimes, there is a need to coordinate the client's care by discussing the client's functioning and his/her/their needs with others on your team. Most commonly, this occurs for a primary counselor and a group facilitator to relay information about a possible change in behavior or need. Other situations might be for the transfer of clients from one primary counselor to another. In such instances, if the consultation is a necessary activity that is relevant to the client's treatment, it can be billed as care coordination. As with other consultations discussed earlier, it can be billed by both parties involved. There may be instances where a consultation needs to take place with a non-clinical staff member, who is not authorized to bill. For example, at the Residential programs a counselor may need to consult with a non-DMC certified support staff who is assigned the night shift at the home and had a noteworthy encounter with the client. In such cases, only the certified DMC provider may claim for the time. In the documentation, it will be important to clearly write the purpose of the consultation, who was involved, and how the exchange is related to the client's treatment. If the consultation or discussion leads to a change

in course of treatment or any actions that need to be taken to assist the client, this should also be noted. Please be mindful that consultations that appear as appropriate for clinical supervision are not billable.

Sample: Care Coordination Progress Note

SAMPLE

PROGRESS NOTE

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

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

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

Narrative: Counselor met with the client's sober living manager (see ATD on file) in an effort to coordinate services to help client to improve relationships with other residents and prevent loss of housing that could threaten recovery efforts. Client was not present for this service. Counselor spoke with sober living manager about client's recent verbal altercation with another resident. Also inquired about his general observations of client's behaviors and potential risks to sobriety. Sober living manager reported that client is particularly agitated around one of the residents and sees that he often avoids interacting with him. He acknowledged that he does need to intervene at times to prevent escalation of conflicts between the two, but on most recent encounter, client seemed to be instigating. Sober living manager expressed frustration with client and possibility that he may not be a good fit for the house. Sober living manager shared that client seems to need help managing his anger and impulsivity, saying that he has some concern that these may prompt client to return to using. Next steps include follow up with sober living manager over the next few weeks in order to monitor changes in client's behaviors and interactions with peers. Plan for next session with client is to develop strategies for maintaining a conflict-free home environment and discuss its benefits to his recovery. Ongoing coordination of care needed to help support client in reducing interpersonal conflicts that perpetuate behaviors associated with use and impact ability to maintain housing.

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

Care Coordination FAQ

1. ***What is the difference between collateral and care coordination?*** Collateral involves the client's family or significant individuals in the client's life who may be part of their treatment. Although we may be collaborating with these individuals, this activity is separate from care coordination. Care coordination is specific to professionals or those of other systems of care involved in the client's treatment, such as law enforcement, court, social services, education, medical/physical health care, mental health services, etc.
2. ***I have to transport the client to their psychiatrist appointment. Can I bill this as care coordination?*** No. Even though we provide care coordination for mental health needs

that impact a client's SUD, this does not mean that we can bill for the transportation provided to access such services. Transportation is not billable under the DMC-ODS.

3. ***My client has a telehealth appointment with their medical specialist. Can I bill care coordination for facilitating this?*** No. If, by "facilitating," this is to provide the client with access to a confidential space where a computer can be utilized for a telehealth service, then this is not a clinical service that is billable. If you must be involved in the meeting with the outside provider in a clinical manner, it may be billable depending on the medical necessity for the activity.

Group Counseling

What is Group Counseling?

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

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

More than one therapist or counselor is allowed in the group; however, this does not allow for changes to the maximum number of clients allowed in the group or overall group billing amount.

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

For Residential levels of care: Group counseling services are part of the daily bundled rates, but can count towards the required number of clinical hours needed each week. For the time to count towards the clinical hours for the week, there can be no more than twelve (12) clients present in the group, the content must be clinical in nature, and there must be documentation on file to support that this service was provided.

Residential **(Billed by the day – includes group counseling)**			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
Residential 3.5	90899-674	90899-675	90899-676
Residential 3.5 Perinatal	90899-692	90899-693	90899-694

Residential 3.3	90899-844	90899-845	90899-846
Residential 3.1	90899-638	90899-639	90899-640
Residential 3.1 Perinatal	90899-656	90899-657	90899-658
Residential 3.5 Recovery Group Counseling	90899-683	90899-684	90899-685
Residential 3.5 Perinatal Recovery Group	90899-701	90899-702	90899-703
Residential 3.3 Recovery Group Counseling	90899-853	90899-854	90899-855
Residential 3.1 Recovery Group Counseling	90899-647	90899-648	90899-649
Residential 3.1 Perinatal Recovery Group	90899-665	90899-666	90899-667
Intensive Outpatient Treatment (IOT)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
IOT Group Counseling	90899-563	90899-564	90899-565
IOT Patient Education Group	90899-789	90899-790	90899-791
IOT Perinatal Group Counseling	90899-590	90899-591	90899-592
IOT Perinatal Patient Education Group	90899-792	90899-793	90899-794
IOT Perinatal Recovery Group Counseling	90899-599	90899-600	90899-601
IOT Recovery Group	90899-572	90899-573	90899-574
Outpatient Drug Free (ODF)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
ODF Group Counseling	90899-512	90899-513	90899-514
ODF Perinatal Group Counseling	90899-536	90899-537	90899-538
ODF Perinatal Recovery Group Counseling	90899-545	90899-546	90899-547
ODF Recovery Group	90899-518	90899-519	90899-520
OTP/NTP			

Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
OTP/NTP Group Counseling	90899-608	90899-609	90899-610
OTP/NTP Perinatal Group Counseling	90899-798	90899-799	90899-800
OTP/NTP Recovery Group	90899-617	90899-618	90899-619
Withdrawal Management (WM) (Billed by the day – includes group counseling)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
WM Residential Withdrawal Management 3.2	90899-779	90899-780	90899-781

Who can provide Group Counseling?

Groups can be provided by a non-LPHA or LPHA. Interventions must be within the scope of practice of the provider.

How can Group Counseling be provided?

Group counseling services must be provided face-to-face or by telehealth.

Where can Group Counseling be provided?

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

Patient Education

What is Patient Education?

According to the State, it means "providing research-based education on addiction, treatment, recovery and associated health risks." Typically, these are conducted in lecture-style formats. For the County clinics, an example of such a group is the HIV Education group offered by a Registered Nurse at the Intensive Outpatient and Outpatient Drug Free levels of care.

A few examples of Patient Education Groups…

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

For all levels of care, *except* Residential and Intensive Outpatient, Patient Education Groups cannot exceed twelve (12) people.

For Residential levels of care: Patient Education Groups can exceed twelve (12) and will be counted as part of the *structured hours* for the daily bundled rate. Be sure there is documentation on file to support that this service was provided.

For Intensive Outpatient Treatment (IOT) level of care: Patient Education Groups at IOT can exceed twelve (12) clients and is billable using the Patient Education Group code.

Patient Education at Outpatient Drug Free (ODF)

Patient Education at the ODF level of care can be billed using the billable group counseling code.

Although we are able to bill for Patient Education at ODF, there are some important considerations:

- Patient Education Groups at ODF are limited to twelve (12) clients in order to bill using the group counseling code. Patient Education Groups at ODF that exceed the twelve (12) clients, should be coded as non-billable.
- Patient Education can be provided by non-LPHA and LPHA.
- Patient Education provided by Registered Nurses (RNs) must be within scope of practice! *This is particularly important:* Just because Patient Education is billed as group counseling does not mean that an RN is now able to provide all group counseling services.

List of Participants for Groups

Group Sign-In Sheets with the participants' signatures are no longer required. Instead, please be sure that each group provided has a corresponding participant list that includes the names of all attendees for the group. The group topic or name, date and time should continue to be noted so that it can be matched up with the respective progress note. The provider's signature is not required, but recommended to demonstrate that the provider conducted the group session as documented. The provider's printed name, credentials, and date of signature should also be included with the signature. This is applicable for all groups, regardless of level of care.

Sample: Group Counseling Progress Note

SAMPLE

GROUP COUNSELING SERVICE PROGRESS NOTE

Client Name: Patrick Star

MRN: 1000-12-3456

Date of Service: 11/01/22

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

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

Narrative: Writer conducted group, "Honesty in Recovery," to encourage discussion around the behavior of lying during substance use and allow the group to reflect on its effects and what it means to live a more honest life in order to help client maintain sobriety. This writer explored with the group the importance of honesty in recovery. Client was more withdrawn in this session than usual, but participated with prompting. The group was encouraged to give input on what honesty in recovery means for them. Client seemed to be listening and reflecting on what his peers shared. This writer helped normalize common thoughts and feelings surrounding the act of lying during use and how it changes with the stopping of use. Group members were asked to share personal experiences of what has helped them to break out of the cycle of lying after use and manage feelings of guilt that may remain after use has stopped. Client was able to share that he continues to feel guilty for lying to his family during his use. In closing, this writer had group members identify what new opportunities and positive outcomes have come about from embracing honesty in their recovery journey. Client was more engaged towards the end of the session and verbalized that he wished to continue to work on being honest with himself and others, but that it was still difficult at times to face the feelings without using so that he does not have to feel difficult emotions. Plan is for client to continue to engage in groups and work towards increasing self-awareness and verbalization of thoughts and feelings. Client seems to be making adequate progress toward enhancing communication to express his needs so that he does not bottle up emotions, which is a prominent trigger for him to use.

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

Group Counseling FAQ

1. ***Are all types of groups billable?*** This depends on what the group is addressing. According to the regulations, only "clinical" groups are billable to Medi-Cal. This means that the group content must address a need related to the substance use that helps the client make progress in his/her/their recovery.
   Groups such as house meeting would not be considered "clinical" groups. However, we know that part of the purpose of the Residential setting is to provide structure for the clients to begin learning and practicing sober life skills in a safe and contained environment. Therefore, if the purpose is to build skills necessary to prepare for reintegration back into the larger community, time spent may count towards the daily

required number of hours as long as it is clear on the documentation that such activities are intended to build skills and not simply to occupy the client. It is helpful to focus on what the intention of the activity is and ask ourselves, "how is this relevant to the client's substance use treatment?" or "how might this be beneficial for the client's recovery?" Additionally, be sure the documentation makes clear what the result or benefit of the client participating in this activity is.

2. ***What happens if there are more than twelve (12) clients in the group?*** Groups will be limited to twelve (12) participants only. If it ever happens that a person is overbooked and there are more than twelve (12) people present (even 1 extra), then it is recommended that the program pull other staff and split up the group into two (2) groups. Alternatively, one client can be seen individually for a one-on-one session. Non-Medi-Cal participants in the group will still count toward the twelve (12) maximum and at least one (1) Medi-Cal client needs to be present. If there is a pattern across any one provider or the agency/organization, where groups exceeding the maximum of twelve (12) clients are found during reviews, the services may be disallowed and result in recoupment due to the potential for fraud, waste, and/or abuse.
3. ***What if there is no corresponding group participant list for the group progress note?*** A single instance where a group progress note documented does not have a matching group participant list may not result in disallowance and/or recoupment. However, a pattern across any one provider or the agency/organization would be examined further for the potential of fraud, waste, and/or abuse.

Clinician Consultation

Previously known as Physician Consultation

What is Clinician Consultation?

DMC-ODS LPHAs consulting with other LPHAs to support the client's care.

"Other LPHAs" may be addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists either within or outside of the network.

The client is not present and involved in this service.

How is this different from consultations under care coordination?

Clinician consultation is intended for use in special circumstances where there is a complex case that may need to be discussed to address issues such as medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It is designed to allow DMC-ODS clinicians the ability to seek expert advice on treatment needs specific to DMC-ODS clients.

Who can provide Clinician Consultation?

Only LPHAs.

How is Clinician Consultation billed?

Only the rendering provider can bill. This means that the primary clinician assigned to the client's case is the only provider who can bill clinician consultation.

Please be aware that this is different from consultations under care coordination where both providers can bill.

This code is currently being built into the billing system and will be available for use soon!

13. DISCHARGE

Discharge Plan

What is the discharge plan?

The discharge plan is a document (separate from a progress note), that is to be worked on collaboratively with the client that must include, at minimum, the following information:

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

The State does not dictate how the discharge plan needs to look or what format is used. As long as it meets the requirements, the format or document can be tailored to the specific needs of each program.

Except for those clients whose contact is lost, all clients will have a discharge plan. If a counselor loses contact with the client (e.g., client being discharged due to client not showing up for sessions and being unable to be reached by phone, etc.), there is no expectation that a discharge plan be completed.

Who can complete the discharge plan?

The discharge plan can be completed by a non-LPHA or LPHA counselor.

When does the discharge plan need to be completed by?

At minimum, it must be completed within thirty (30) days prior to the scheduled date of the last face-to-face session with the client.

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

DISCHARGE PLANNING STARTS AT ADMISSION! No matter the level of care the client is at, the eventual goal is to help the client on his/her/their path to returning to the larger community as a productive member without the need for the support of treatment services. Within each level of care, we are working to help improve the client's functioning enough to prepare the client for the transition to a less restrictive setting. Therefore, as soon as the client enters treatment, we should be looking at how we are going to help them transition out of treatment. Working collaboratively with the client on this mentality will also serve to help the client become more self-sufficient and avoid treatment dependence when the time does come for a planned discharge. Additionally, the reality is that we never know when our last contact with

our client will be. The client may leave prematurely after two months of treatment or two days. It is good practice to start the work of preparing for discharge in the early stages of treatment. It should be an ongoing discussion and having a document that the client can reference is a great tool for them.

Sample: Discharge Plan

Today's Date: 12/28/17	Admission Date: 9/29/17	Planned Discharge Date: 12/28/17
Name: Doe, Joe		Current Level of Care: Intensive Outpatient Treatment

SAMPLE

My Counselor's Name: Mary Sunshine, CADC II Contact: (714) 987-6543

Why I Want To Stay Sober:
"I want to go back to being like how I was before the accident."

My Treatment Goals:
1. To get help for my back pain
2. Learn how to deal with triggers and cravings
3. Go back to working

My Relapse Triggers:	Things I Can Do When I Get Triggered:
1. Back pain	1. Deep breathing, meditation
2. Not having a job	2. Positive self-talk (remind myself that I am working towards it), go to a meeting
3. Not having own place to live	3. Positive self-talk (remind myself that I am working towards it), making a gratitude list, go to a meeting
4. Conflict with family	4. Talking to my sponsor, go to a meeting, listen to music

SUPPORT PLAN:

People I Can Contact For Support When I Get Triggered:
1. Name: David Goodguy Relationship: Sponsor Contact: (310) 222-1515
2. Name: James Peach Relationship: Friend Contact: (714) 111-2323
3. Name: _____ Relationship: _____ Contact: _____

Community Resources I Can Access For Support:
1. Name of Organization: OC Narcotics Anonymous Contact: (714) 590-2388
   Address: _____
2. Name of Organization: First United Methodist Church Contact: (714) 542-2322
   Address: 609 N. Spurgeon St., Santa Ana, CA 92701
3. Name of Organization: Orange County Rescue Mission Contact: (714) 247-4300
   Address: 1 Hope Drive, Tustin, CA 92782

Additional Resources To Help Me With My Treatment Goals:
1. Name of Organization: One-Stop Center, Santa Ana Contact: (714) 565-2600
   Address: 1000 E. Santa Ana Blvd., Ste. 200, Santa Ana, CA 92701
2. Name of Organization: Orange County Housing Authority Contact: (714) 480-2700
   Address: 1770 N. Broadway, Santa Ana, CA 92706
3. Name of Organization: _____ Contact: _____
   Address: _____

Client's Name: John Doe Signature: John Doe Date: 12/28/17

Counselor's Name: Mary Sunshine, CADC II Signature: Mary Sunshine, CADC II Date: 12/28/17

☒ Copy of Discharge Plan provided to client; if no, provide reason: _____

Discharge Plan FAQ

1. ***What is considered a "last face-to-face?"*** This must be a service that can be entered into the County's electronic health record (EHR) and billing system (IRIS). Therefore, it must be an activity that can be provided by a non-LPHA counselor or LPHA. This does not include activities by Community Health Workers or front office staff. It also does not include drug testing, regardless of who performs it. The service must be provided in-person.
2. ***Is working on the discharge plan billable as individual counseling or care coordination?*** Consider the required elements of a discharge plan and what the service or session is primarily focusing on. If the bulk of the session pertains to the discussion of the client's relapse triggers and a plan to assist the client to avoid relapse when confronted with each trigger, the interventions are more appropriate as individual counseling. However, if the service or session is predominantly about setting up the external resources necessary to assist the client post-discharge, such as through linkages and referrals, the interventions are more appropriate as care coordination.
3. ***My client had a planned discharge, but we did not complete a discharge plan. What happens?*** There is no disallowance or recoupment associated with a missing discharge plan. However, be mindful that the inclusion of a discharge plan is important for assisting the client with transitioning out of services, whether or not the client goes to another level of care or program. At minimum, documentation in the progress notes should clearly show that there was a discussion with the client to prepare for discharge, which is the standard of care for termination of clients.

Discharge Summary

What is required for the discharge summary?

The State does not dictate the format that needs to be used for a discharge summary. Providers may use the County's Transfer/Discharge Summary form or any other document that would fulfill the requirements.

The discharge summary should include, at minimum, the following information:

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

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

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

Who can complete the discharge summary?

The non-LPHA or LPHA counselor can complete it.

When does the discharge summary need to be completed?

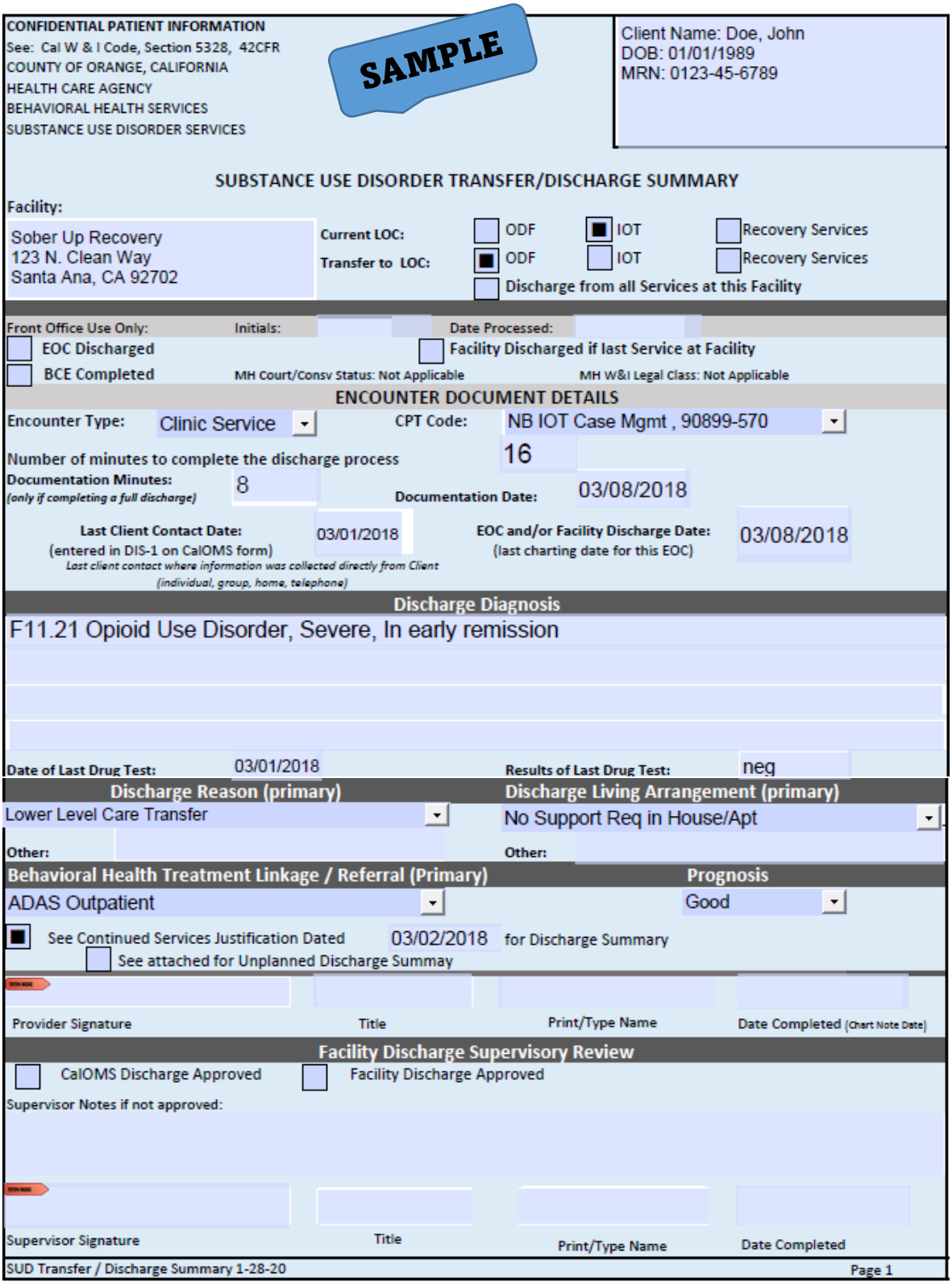
The discharge summary is to be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the client.

Can we bill for completing the discharge summary?

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

TYPE OF DISCHARGE	TYPE OF NOTE
Unplanned discharge	Billable Care Coordination
Planned discharge	Non-Billable Care Coordination

Sample: Discharge Summary



CONFIDENTIAL PATIENT INFORMATION
See: Cal W & I Code, Section 5328, 42CFR
COUNTY OF ORANGE, CALIFORNIA
HEALTH CARE AGENCY
BEHAVIORAL HEALTH SERVICES
SUBSTANCE USE DISORDER SERVICES

SAMPLE

Client Name: Doe, John
DOB: 01/01/1989
MRN: 0123-45-6789

SUBSTANCE USE DISORDER TRANSFER/DISCHARGE SUMMARY

Facility:
Sober Up Recovery
123 N. Clean Way
Santa Ana, CA 92702

Current LOC: ☐ ODF ☒ IOT ☐ Recovery Services
Transfer to LOC: ☒ ODF ☐ IOT ☐ Recovery Services
☐ Discharge from all Services at this Facility

Front Office Use Only: Initials: Date Processed:
☐ EOC Discharged ☐ Facility Discharged if last Service at Facility
☐ BCE Completed MH Court/Consv Status: Not Applicable MH W&I Legal Class: Not Applicable

ENCOUNTER DOCUMENT DETAILS

Encounter Type: Clinic Service CPT Code: NB IOT Case Mgmt , 90899-570
Number of minutes to complete the discharge process 16
Documentation Minutes: 8 (only if completing a full discharge)
Documentation Date: 03/08/2018
Last Client Contact Date: 03/01/2018 (entered in DIS-1 on CalOMS form)
Last client contact where information was collected directly from Client (individual, group, home, telephone)
EOC and/or Facility Discharge Date: 03/08/2018 (last charting date for this EOC)

Discharge Diagnosis
F11.21 Opioid Use Disorder, Severe, In early remission

Date of Last Drug Test: 03/01/2018 Results of Last Drug Test: neg

Discharge Reason (primary): Lower Level Care Transfer
Other:
Discharge Living Arrangement (primary): No Support Req in House/Apt
Other:

Behavioral Health Treatment Linkage / Referral (Primary): ADAS Outpatient
Prognosis: Good

☒ See Continued Services Justification Dated 03/02/2018 for Discharge Summary
☐ See attached for Unplanned Discharge Summay

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

Facility Discharge Supervisory Review
☐ CalOMS Discharge Approved ☐ Facility Discharge Approved
Supervisor Notes if not approved:

Supervisor Signature | Title | Print/Type Name | Date Completed

SUD Transfer / Discharge Summary 1-28-20 Page 1

CONFIDENTIAL PATIENT INFORMATION See: Cal W & I Code, Section 5328, 42CFR COUNTY OF ORANGE, CALIFORNIA HEALTH CARE AGENCY BEHAVIORAL HEALTH SERVICES SUBSTANCE USE DISORDER SERVICES	Client Name: Doe, John DOB: 01/01/1989 MRN: 0123-45-6789

Discharge Summary Details: **(summary must include a description of services including the current alcohol/drug usage, vocational/educational achievements, legal status, reason for discharge and whether discharge was involuntary or successful completion, etc.)**

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

After Care Recommendations

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

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

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

SUD Transfer / Discharge Summary 1-28-20 Page 2

Discharge Summary FAQ

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

2. ***What about a transition to a new level of care?*** Transitions to a new level of care at a different provider is considered a planned discharge. It is recommended that a discharge summary be completed to assist with any continuity of care needs, however, it is not required and is not billable. A discharge plan to help the client prepare for the transition is sufficient. For transitions from one level of care to another within the same provider, the completion of the discharge summary is not billable to DMC because it is not considered an unplanned discharge. Please use the non-billable care coordination code for completing the discharge summary and any additional discharge-related activities when documenting. For the County clinics, this is the administrative step required to end one EOC and to start another at a different LOC.
3. ***What happens if it is completed after the thirty (30) days?*** For completing discharge summaries of unplanned discharges beyond the thirty (30) calendar days from the last face-to-face with the client, you may continue to bill care coordination. However, since the timeline is thirty (30) days from that last service, please make efforts to complete it in a timely manner. A pattern of discharge summaries completed outside of the timeframe may result in disallowance and/or recoupment due to the potential for fraud, waste, and/or abuse.
4. ***What is the "Number of Minutes to Complete the Discharge Process?"*** If using the County Transfer/Discharge Summary form, please remember that the "Number of Minutes to Complete the Discharge Process" is equivalent to Service Minutes. This is the time it takes to research the client's chart for information to complete the treatment summary narrative and complete any other aspects of closing a client's case. Just as we need to justify the amount of time claimed for any progress note with Service Minutes, we must also include a brief explanation as to how the time was spent for "Number of Minutes to complete the Discharge Process." This can be included as part of the narrative section with the client's treatment summary. The "Documentation Minutes" will be the amount of time it takes to complete the discharge summary (since the progress note is embedded into the form). The "Documentation Date" and the "Facility and EOC Discharge Date" should be the same since the chart will be closed as of the last date of charting.
5. ***What's the difference between the discharge plan and the discharge summary?***

Discharge Plan	Discharge Summary
*Must be completed for all clients who have a planned discharge. *Must be completed within thirty (30) calendar days prior to the scheduled date of the last face-to-face session with the client. *During the counselor's last face-to-face session with the client*, the counselor and the client will need to sign and date the discharge plan. A copy is to be provided to the client and the original placed in the chart.	* At minimum, must be completed for every unplanned discharge. *Must be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the client. *Must include: 5. The client's length of stay in treatment (date of admission to date of discharge) 6. Reason for discharge

*Must include: 4. A description of the client's relapse triggers 5. A plan to assist the client to avoid relapse when confronted with each trigger 6. A support plan (including referrals)	7. Narrative summary of the treatment episode (include current alcohol/drug use, vocational/educational achievements, transfers/referrals provided) 8. The client's prognosis

14. OTHER LEVELS OF CARE & PROGRAMS

Recovery Services

What is Recovery Services?

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

We are now able to utilize Recovery Services as an ancillary service to other treatment services to help supplement the clients' efforts towards relapse prevention and self-management of their recovery. According to the State, clients may enroll simultaneously in Recovery Services while receiving treatment services at another level of care, including NTP and MAT.

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

A few key things to note about Recovery Services:

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

Services that may be provided at Recovery Services:

- Assessment
- Care Coordination
- Counseling: Individual and Group
- Family Therapy

- Recovery Monitoring (Includes recovery coaching and monitoring for maximum reduction of SUD).
- Relapse Prevention (Includes interventions designed to teach how to anticipate and cope with the potential for relapse).

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

Recovery Services at Residential			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
Residential 3.5 Recovery Individual	90899-680	90899-681	90899-682
Residential 3.5 Recovery Group	90899-683	90899-684	90899-685
Residential 3.5 Recovery Care Coordination	90899-686	90899-687	90899-688
Residential 3.5 Recovery Monitoring	90899-689	90899-690	90899-691
Residential 3.5 Perinatal Recovery Individual	90899-698	90899-699	90899-700
Residential 3.5 Perinatal Recovery Group	90899-701	90899-702	90899-703
Residential 3.5 Perinatal Recovery Care Coordination	90899-704	90899-705	90899-706
Residential 3.5 Perinatal Recovery Monitoring	90899-776	90899-777	90899-778
Residential 3.3 Recovery Individual	90899-850	90899-851	90899-852
Residential 3.3 Recovery Group	90899-853	90899-854	90899-855
Residential 3.3 Recovery Care Coordination	90899-856	90899-857	90899-858
Residential 3.3 Recovery Monitoring	90899-859	90899-860	90899-861
Residential 3.1 Recovery Individual	90899-644	90899-645	90899-646
Residential 3.1 Recovery Group	90899-647	90899-648	90899-649
Residential 3.1 Recovery Care Coordination	90899-650	90899-651	90899-652
Residential 3.1 Recovery Monitoring	90899-653	90899-654	90899-655

Residential 3.1 Perinatal Recovery Individual	90899-662	90899-663	90899-664
Residential 3.1 Perinatal Recovery Group	90899-665	90899-666	90899-667
Residential 3.1 Perinatal Recovery Care Coordination	90899-668	90899-669	90899-670
Residential 3.1 Perinatal Recovery Monitoring	90899-671	90899-672	90899-673
Recovery Services at Intensive Outpatient Treatment (IOT)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
IOT Recovery Individual	90899-566	90899-567	90899-568
IOT Recovery Group	90899-572	90899-573	90899-574
IOT Recovery Family	90899-761	90899-762	90899-763
IOT Recovery Care Coordination	90899-575	90899-576	90899-577
IOT Recovery Monitoring	90899-578	90899-579	90899-580
IOT Perinatal Recovery Individual	90899-596	90899-597	90899-598
IOT Perinatal Recovery Group	90899-599	90899-600	90899-601
IOT Perinatal Recovery Family	90899-767	90899-768	90899-769
IOT Perinatal Recovery Care Coordination	90899-602	90899-603	90899-604
IOT Perinatal Services Recovery Monitoring	90899-605	90899-606	90899-607
Recovery Services at Outpatient Drug Free (ODF)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
ODF Recovery Individual	90899-515	90899-516	90899-517
ODF Recovery Group	90899-518	90899-519	90899-520
ODF Recovery Family	90899-749	90899-750	90899-751
ODF Recovery Care Coordination	90899-521	90899-522	90899-523
ODF Recovery Monitoring	90899-524	90899-525	90899-526

ODF Perinatal Recovery Individual	90899-542	90899-543	90899-544
ODF Perinatal Recovery Group	90899-545	90899-546	90899-547
ODF Perinatal Recovery Family	90899-755	90899-756	90899-757
ODF Perinatal Recovery Care Coordination	90899-548	90899-549	90899-550
ODF Perinatal Recovery Monitoring	90899-551	90899-552	90899-553
Recovery Services at OTP/NTP			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
OTP/NTP Recovery Individual	90899-614	90899-615	90899-616
OTP/NTP Recovery Group	90899-617	90899-618	90899-619
OTP/NTP Recovery Family	90899-773	90899-774	90899-775
OTP/NTP Recovery Care Coordination	90899-623	90899-624	90899-625
OTP/NTP Recovery Monitoring	90899-626	90899-627	90899-628

Who can provide Recovery Services?

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

How can Recovery Services be provided?

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

Where can Recovery Services be provided?

Recovery Services may be provided in the home or anywhere in the community.

Recovery Services Scenarios

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

1. A client may be receiving Recovery Services as a standalone service, meaning that he/she/they are only involved in Recovery Services and no other service.
2. A client may also be enrolled simultaneously within one program and receiving treatment (such as ODF, for example) as well as Recovery Services.
3. A client may be enrolled in treatment at one provider while receiving Recovery Services at another provider.

The sections below will detail more on each scenario.

Recovery Services as a Standalone Service

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

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

CalOMS is not required for standalone Recovery Services.

Initial assessment reminders for Recovery Services as a standalone service:

- Initial assessments should be completed within thirty (30) calendar days from the date of the client's admission. It needs to clearly document the client's need for Recovery Services. Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) should be looked at closely for areas that may compromise a client's sobriety. Documentation in this area will help to highlight how Recovery Services can help lower the risk and address beneficial relapse prevention supports.
- Establish how the client meets criteria for the DSM-5 diagnosis/diagnoses.

Recovery Services Problem List

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

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

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

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

The treatment provider would continue to provide treatment services and the Recovery Services provider would follow the same process as a client enrolled in a standalone Recovery Services program (see above in the prior section). Since each provider has their own EOC, timeliness of completing the assessment and problem list will be specific to each EOC. Both providers should coordinate care with each other to ensure duplicative services are not being offered and to offer the best care for the client. The treatment provider and the Recovery Services provider should be providing and documenting different services. For coordination of care, both providers must secure a valid Authorization to Disclose (ATD).

Recovery Services and Treatment Provided at the Same Provider

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

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

If the client has been enrolled in treatment for some time and it is determined that the client would now benefit from the addition of Recovery Services, this should be documented in a progress note for the encounter with the client where this was discussed. The documentation should clearly indicate the client's need for Recovery Services at this time. Be sure to update the problem list accordingly. If your program is required to follow the SABG (including residential programs), Adolescent SUD Best Practices Guide (formerly Youth Treatment Guidelines), or Perinatal Treatment Guidelines, please continue with the treatment plan until further notice. Likewise, if any other accrediting

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

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

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

All treatment closing activities must occur, including completing CalOMS discharge, discharge plan, discharge summary and/or any other documentation required. A new EOC for Recovery Services only must be opened. Timelines will be re-set to match the newly opened Recovery Services EOC. Please follow the requirements for Recovery Services as a standalone service in the section above. If your program is required to follow the SABG (including residential programs), Adolescent SUD Best Practices Guide (formerly Youth Treatment Guidelines), or Perinatal Treatment Guidelines, please continue with the treatment plan until further notice. Likewise, if any other accrediting bodies are monitoring your program, you will need to continue to abide by those requirements. CalOMS is not required for standalone Recovery Services.

Withdrawal Management (WM)

Withdrawal Management (WM)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
WM Residential Withdrawal Management 3.2	90899-779	90899-780	90899-781
WM 3.2 Care Coordination	90899-782	90899-783	90899-784

The focus at the WM level of care is on stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided. Aspects of care at the WM level include assessment, care coordination, medication services, and observation (monitoring the client's withdrawal and health status).

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

Assessments at WM

A full ASAM based assessment is not required for a client's admission to WM. The County's Brief SUD Level of Care Screening is sufficient to use for this purpose. If the assessment or screening at WM was completed by a non-LPHA, a consultation needs to take place between the non-LPHA and LPHA, since the LPHA is the only provider who can diagnose and determine

whether a client meets the access criteria. Following the consultation, the LPHA must document his/her/their clinical impressions in regards to the client meeting the access criteria and appropriateness for WM within twenty-four (24) hours of the client's admission. Please be mindful that the consultation needs to take place after sufficient assessment information has been obtained by the non-LPHA so that the LPHA has all of the relevant information.

To facilitate an appropriate care transition, a full ASAM assessment or brief screening/tool such as the Brief SUD Level of Care Screening to support referral to additional services is appropriate.

There is no explicit guidance on requirements for WM from the State. However, due to the short duration of time that clients will likely be in the WM level of care, best practice would be for the primary counselor to create a client's problem list within forty-eight (48) hours of the client's admission.

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

NTP/OTP			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
OTP/NTP Methadone Dosing	90899-632	90899-633	90899-634
OTP/NTP Courtesy Methadone Dosing	90899-786	90899-787	90899-788
OTP/NTP MAT Antabuse Administration	90899-719	90899-720	90899-721
OTP/NTP MAT Narcan (2-pack Nasal Spray)	90899-722	90899-723	90899-724
OTP/NTP MAT Probuphine Administration	90899-725	90899-726	90899-727
OTP/NTP MAT Suboxone Administration	90899-728	90899-729	90899-730
OTP/NTP MAT Subutex Administration	90899-731	90899-732	90899-733
OTP/NTP MAT Courtesy Subutex Administration	90899-838	90899-839	90899-840
OTP/NTP MAT Suboxone (Film) Administration	90899-862	90899-863	90899-864
OTP/NTP MAT Sublocade Injectable Administration	90899-865	90899-866	90899-867
OTP/NTP MAT Vivitrol Injectable Administration	90899-868	90899-869	90899-870
OTP/NTP MAT Disulfiram Administration	90899-635	90899-636	90899-637
OTP/NTP MAT Buprenorphine (oral) Administration	90899-734	90899-735	90899-736

OTP/NTP MAT Courtesy Buprenorphine (oral) Administration	90899-841	90899-842	90899-843
OTP/NTP MAT Buprenorphine w/ Naloxone (oral) Administration	90899-737	90899-738	90899-739
OTP/NTP MAT Buprenorphine (implant) Administration	90899-740	90899-741	90899-742
OTP/NTP MAT Naloxone (2-pack Nasal Spray)	90899-743	90899-744	90899-745
OTP/NTP MAT Buprenorphine w/ Naloxone (Film) Administration	90899-871	90899-872	90899-873
OTP/NTP MAT Buprenorphine Injectable Administration	90899-874	90899-875	90899-876
OTP/NTP MAT Naltrexone Injectable Administration	90899-877	90899-878	90899-879
OTP/NTP Individual Counseling	90899-620	90899-621	90899-622
OTP/NTP Group Counseling	90899-608	90899-609	90899-610
OTP/NTP Family Counseling	90899-770	90899-771	90899-772
OTP/NTP Care Coordination	90899-611	90899-612	90899-613
OTP/NTP Perinatal Methadone Dosing	90899-804	90899-805	90899-806
OTP/NTP Perinatal Courtesy Methadone Dosing	90899-808	90899-809	90899-810
OTP/NTP Perinatal MAT Antabuse Administration	90899-811	90899-812	90899-813
OTP/NTP Perinatal MAT Narcan (2-pack Nasal Spray)	90899-814	90899-815	90899-816
OTP/NTP Perinatal MAT Suboxone Administration	90899-817	90899-818	90899-819
OTP/NTP Perinatal MAT Subutex Administration	90899-820	90899-821	90899-822
OTP/NTP Perinatal MAT Suboxone (Film) Administration	90899-880	90899-881	90899-882
OTP/NTP Perinatal MAT Disulfiram Administration	90899-823	90899-824	90899-825
OTP/NTP Perinatal MAT Buprenorphine (oral) Administration	90899-826	90899-827	90899-828
OTP/NTP Perinatal MAT Buprenorphine w/ Naloxone (oral) Administration	90899-829	90899-830	90899-831
OTP/NTP Perinatal MAT Naloxone (2-pack Nasal Spray)	90899-832	90899-833	90899-834
OTP/NTP Perinatal MAT Buprenorphine w/ Naloxone (Film) Administration	90899-883	90899-884	90899-885
OTP/NTP Perinatal Individual Counseling	90899-795	90899-796	90899-797
OTP/NTP Perinatal Group Counseling	90899-798	90899-799	90899-800

OTP/NTP Perinatal Family Counseling	90899-801	90899-802	90899-803
OTP/NTP Recovery Individual	90899-614	90899-615	90899-616
OTP/NTP Recovery Group	90899-617	90899-618	90899-619
OTP/NTP Recovery Family	90899-773	90899-774	90899-775
OTP/NTP Recovery Care Coordination	90899-623	90899-624	90899-625
OTP/NTP Recovery Monitoring	90899-626	90899-627	90899-628

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

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

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

NTPs/OTPs conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS. The medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) must be conducted in-person.

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

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

NTP/OTP and the ASAM Assessment

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

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

information from the six (6) ASAM Criteria dimensions justifies the client's need for NTP/OTP. There are two methods in which this may be completed:

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

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

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

NTP/OTP and the Treatment Plan

Treatment Plans are still required in accordance with Title 9.

Medications for Addiction Treatment or Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT)			
Level of Care/Type of Service:	*CDM/CPT Billable Code:*	*CDM/CPT Non-Billable Code:*	*CDM/CPT Non-Compliant Code:*
IOT MAT	99499-506	99499-507	99499-508
IOT Perinatal MAT	99499-509	99499-510	99499-511
IOT MAT Vivitrol Administration	90899-713	90899-714	90899-715
ODF MAT	99499-500	99499-501	99499-502
ODF Perinatal MAT	99499-503	99499-504	99499-505
ODF MAT Vivitrol Administration	90899-707	90899-708	90899-709

Residential 3.5 MAT	99499-521	99499-522	99499-523
Residential 3.5 Perinatal MAT	99499-524	99499-525	99499-526
Residential 3.3 MAT	99499-518	99499-519	99499-520
Residential 3.1 MAT	99499-512	99499-513	99499-514
Residential 3.1 Perinatal MAT	99499-515	99499-516	99499-517
WM Withdrawal Management 3.2 MAT	99499-527	99499-528	99499-529

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

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

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

MAT and the Treatment Plan

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

1. MAT must be determined to be medically necessary by an LPHA within his/her/their scope of practice. Due to the scope of practice restrictions, only the physician or MD (or physician extender) can make this determination.
2. A non-LPHA or non-MD LPHA is limited to referring the client for a MAT evaluation. This can be identified in Dimension 1 and/or 2 of the ASAM Assessment to refer the client for a MAT evaluation. The non-LPHA and non-MD LPHA cannot authorize MAT or state that the client needs MAT. This must be done by the physician or physician extender.
3. If MAT services are offered by the same provider (such as MAT in a Withdrawal Management program, for example), the MD or physician extender should review the initial assessment developed by the non-LPHA or non-MD LPHA to indicate concurrence of the need for the client to be medically evaluated for MAT. If the MD determines that the client is appropriate for MAT services, he /she/they must clearly document how the client meets medical necessity for MAT and what the plan will be for administering the medication as it relates to the specific individual (i.e., MAT specific

treatment plan). This would include information such as medication name, dosage, frequency, etc.

For information specific to documentation within a MAT program, please refer to the MAT Documentation Manual accessible at: https://www.ochealthinfo.com/providers-partners/authority-quality-improvement-services-division-aqis/quality-assurance-quality-1

Peer Support Services

An optional benefit as of July, 1, 2022 that the County has elected to offer.

As of January 2023, the County is currently working with the State to begin taking the next steps necessary to be able to implement these services within our network. Specific guidance about documenting Peer Services will be released once it is available.

Some general information about what it will entail:

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

Peer support services may be provided with the client or significant support person(s) and may be provided in a clinical or non-clinical setting.

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

Peer support services are based on an approved plan of care and can be delivered and claimed as a standalone service.

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

Peer support services include the following service components:

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

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

More information is forthcoming!

Contingency Management

The County has elected and the State has approved, to pilot this new benefit for eligible DMC-ODS clients. Involvement in this pilot will provide the State with information to assess the effectiveness of such a benefit before determining whether it should be made available statewide. The pilot will be for the duration from Fall of 2022 through December 2026.

Only provider sites that have been approved by DHCS for the pilot phase will be participating in Contingency Management. As of January 2023, this is only the County operated outpatient clinics.

Some general information:

- Only non-residential DMC-ODS providers can provide this service.
- Contingency management benefit consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash or cash equivalents, e.g., gift cards of low retail value, consistent with evidence-based clinical research for treating a SUD. These motivational incentives are central to contingency management, based on the best available scientific evidence for treating a SUD and not as an inducement to use other medical services.
- Utilizing an evidence-based approach, it recognizes and reinforces individual positive behavior change consistent with non-use or treatment/medication adherence.
- To qualify for a contingency management motivational incentive, a client must demonstrate treatment/medication adherence or non-use of substances through evidence (e.g., negative drug test).

The following providers may offer the contingency management service through activities, such as administering point-of-care urine drug tests, informing clients of the results of the evidence/urine drug test, entering the results into the mobile or web-based application, providing educational information, and distributing motivational incentives:

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

In order to mitigate the risk of fraud, waste or abuse associated with the motivational incentive:

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

More information to come!

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

Breakdown of the ICD-10 codes of Z55-Z65

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

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

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

Problems related to education and literacy

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

Problems related to employment and unemployment

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

Occupational exposure to risk factors

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

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

Problem related to physical environment

Z58.6 Inadequate drinking water supply

Problems related to housing and economic circumstances

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

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

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

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

Problems related to the social environment

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

Problems related to negative life events in childhood

Problems related to upbringing

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

Other problems related to primary support group, including family circumstances

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

Problems related to certain psychosocial circumstances

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

Problems related to other psychosocial circumstances

Z65.0 Conviction in civil and criminal proceedings without imprisonment
Z65.1 Imprisonment and other incarceration
Z65.2 Problems related to release from prison
Z65.3 Problems related to other legal circumstances
Z65.4 Victim of crime and terrorism
Z65.5 Exposure to disaster, war, and other hostilities
Z65.8 Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Z65.9 Problem related to unspecified psychosocial circumstances

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

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

			CRITERIA:
			1. Substance is taken more or for longer than anticipated
			2. Have wanted to use less or stop or have tried to, but could not
			3. A lot of time and energy going towards trying to get, use, or recover from the use
			4. Craving to use
			5. Not following through or taking care of responsibilities at home, school, or work because of use
			6. Keep using even though responsibilities at home, school, or work are neglected
			7. Less or stopped involvement in social, work, or pleasurable activities
			8. Continuing to use even though there have been instances of it being physically dangerous
			9. Knowing that the use is causing physical or psychological problems, but continuing anyway
			10. Signs of tolerance – needing more than you used to in order to get the same feeling OR using the same amount you used to does not achieve the effect it used to
			11. Signs of withdrawal – specific to substance or substance is taken to avoid withdrawal

TOTAL:

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