2023

Clinical Documentation Guide

CalMHSA
California Mental Health Services Authority

Introduction to this Guide

The California Medi-Cal system is undergoing a significant transformation to reform the program in service of improving the quality of life and health outcomes of Medi-Cal members. This person-centered approach, operationalized by the Department of Health Care Services (DHCS), through its California Advancing and Innovating Medi-Cal (CalAIM) initiative, streamlines processes and documentation in order to better address the needs of persons in care while improving access to and coordination among the delivery systems responsible for providing care. DHCS aims to provide Californians with access to equitable, integrated, cost-effective, and high-quality health care.

The intent of this documentation guide is to support the implementation of DHCS guidance concerning care coordination efforts between the Mental Health Plan (MHP) and Managed Care Plan (MCP) services delivery systems (e.g., screening, transition of care and service referrals), and the essential documentation requirements for specialty mental health services clinical documentation and claims reimbursement. Specifically, this guide provides guidance to Licensed Practitioner of the Healing Arts (LPHA)[1] staff in an MHP setting that claims outpatient Medi-Cal services. This documentation guide will cover many relevant topics and concepts that support your work with children, youth, adults, and families. The audience for this guide includes both those licensed, registered and waivered practitioners who are new to documentation of services, as well as those practitioners who have experience with pre-CalAIM documentation standards. Individuals receiving treatment will be referred to as "people" or "people in care", rather than "clients", "patients", or "beneficiaries".

Health Care Systems

Health care systems are intended to help people improve or maintain their health and wellness within their community. For this to happen, people need to have the ability to access not just physical health care, but quality behavioral health care, in a way that is responsive to their particular needs and situation, respects their choices and authentically centers their voice.

We know from research that care is not always accessible, available, or responsive in an equitable way. Research further shows that access to and engagement in quality health care is affected by a number of factors, including race, ethnicity, socioeconomic status, and other social drivers. Social drivers of health (SDOH) play a huge part in people's health and wellness. SDOH are the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH are grouped into five domains (CDC)[2].

1. Economic stability (ability to access and maintain food, clothing, shelter, and mobility as well as other basic needs within their community)
2. Education (opportunities to learn and build skills)
3. Health care access and quality (to prevent and treat illness and injury)
4. Neighborhood and built environment (safe, free from pollutants and access to nature)
5. Social and community context and connectedness

SDOH contribute to health disparities and inequities simply by limiting access to fundamental resources aimed at supporting health and wellness. For example, if behavioral health services are offered in one part of town that is difficult to get to, those who live far away or have transportation challenges may not receive the services they need in a timely fashion. Or perhaps the same clinic does not employ direct service staff who speak the language or understand the culture of the person seeking care. This again impacts the ability of a person in care to access care that meets their individualized needs. Lastly, we have witnessed the harsh realities of inequities revealed by the COVID-19 pandemic, with stark differences in outcomes including mortality seen along racial/ethnic lines, socioeconomic status, and educational attainment[3].

Although there are efforts aimed at addressing health disparities, there is still a lot of work to be done. As practitioners, we have a responsibility to look within our organizations and advocate for changes that help reduce or eliminate disparities within health systems. Through this diligent attention, systems can transform to best meet the needs of

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1 Licensed Practitioner of the Healing Arts" in this context means licensed, registered or waivered psychologists, clinical social workers, marriage and family therapists or professional clinical counselors. Psychiatrists and nurses are also LPHAs; however, they have different scopes of practice.

2 Social Determinants of Health | CDC; Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [May 2022], https://health.gov/healthypeople/objectives-and-data/social-determinants-health

3 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786466

the people they are intended to serve. One of the monumental ways that CalAIM supports our systems in addressing health disparities is in the acknowledgment of the impact of trauma on health and wellness. We can streamline access to treatment services, especially for youth, when a substance SUD is suspected but not yet diagnosed, or due to trauma. Details on this access criteria will be addressed later in this manual, as it cues practitioners that treatment services can be initiated while assessment is occurring concurrently.

Social Drivers of Health

Education Access and Quality

Health Care Access and Quality

Economic Stability

Neighborhood and Build Environment

Social and Community Context

Medi-Cal Programs

In California, the Department of Health Care Services (DCHS) is the state agency responsible for the administration of the state's Medicaid program. In California, we refer to Medicaid as "Medi-Cal." The Medi-Cal program is a mix of federal and state regulations serving approximately 14 million people, or 1/3 of all Californians. Medi-Cal covers 40% of children and youth and half of individuals with disabilities in California.

Medi-Cal behavioral health services are "carved out" meaning that they are delivered though separate managed care delivery systems, each of which is responsible for delivering different sets of services to individuals depending on their care needs.

To keep it simple, we will look at these three plans: Mental Health Plans (MHP) operated by county behavioral health departments, Drug Medi-Cal Plans (DMC or DMC-ODS) administered respectively by the state or the county behavioral health departments, and Managed Care Plans (MCP), which are the physical healthcare plans. The MCPs, which are either publicly run or commercial entities, administer the Non-Specialty Mental Health Services (NSMHS)benefit, while the counties administer the Specialty Mental Health Services benefit.

County				State
MCP	MCP	MHP	DMC-ODS/DMC	Dental
Physical Healthcare	Mild to Moderate Mental Health	Serious Mental Illness/Serious Emotional Disturbance	Substance Use Treatment Services	Dental

Mental Health Plans

Specialty Mental Health Services (SMHS) are managed locally by county Mental Health Plans (MHPs). Fifty-six county MHPs are contracted with DHCS to administer the Medi-Cal SMHS benefit. In addition to managing the benefit, MHPs directly deliver and/or contract with Community-Based Organizations (CBOs) or group/individual providers to deliver an array of services designed to meet the needs of individuals with Medi-Cal who have significant and/ or complex care needs. This array includes intensive services and programs, including therapy, community-based services, wraparound, and intensive case management programs. The term "case management" is used at different points since this service type is defined in federal regulation for SMHS. However, it is important to remember that each person in care is not a "case" to be managed, but rather a human being with care needs. (See Appendix II for a list of covered services.)

Substance use treatment services are provided to persons with substance use disorders that require intervention to support the person's ability to safely participate in their communities and achieve wellbeing. Substance use treatment services are provided to persons with substance use disorders that require intervention to support the person's ability to safely participate in their communities and achieve wellbeing. The Medi-Cal populations served by county MHPs include low-income individuals across the lifespan - elderly, adults, youth and children. Individuals living at or below federal poverty levels can experience complex psychosocial issues, such as being unhoused, being involved in the child welfare system, being justice-involved, or having experienced trauma, to name a few examples. In short, MHPs serve some of the most vulnerable individuals living in our state.

Drug Medi-Cal and Drug Medi-Cal Organized Delivery System

California has two main types of Drug Medi-Cal Plans: A State Drug Medi-Cal Plan (DMC) and a Drug Medi-Cal Organized Delivery System (DMC-ODS). Both Plans are administered by the Counties, however, they each have a unique array of covered benefits and follow somewhat different rule sets. Further details regarding covered services for each Plan are provided in Appendix II. Drug Medi-Cal State Plan services include Narcotic Treatment Program (NTP), Outpatient Drug Free (ODF) treatment services, Intensive Outpatient (IOP), Perinatal Residential and Naltrexone Treatment. To receive Drug Medi-Cal State Plan services, an individual must have Medi-Cal, and meet criteria suggesting they would benefit from substance use treatment services.

Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS.[4] Counties participating in the DMC-ODS program provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Drug Medi-Cal (DMC) program. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control over and accountability for services, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care. To receive services through the DMC-ODS, a person must be enrolled in Medi-Cal, reside in a participating county, and meet the criteria for substance use treatment services.

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4 https://www.chcf.org/publication/2021-edition-medi-cal-facts-figures/

Managed Care Plans

Managed Care Plans (MCPs) are responsible for the majority of the medical (physical health care) benefits and NSMHS for individuals. The MCPs provide mental health services to those with less significant or complex care needs, and therefore may provide a lower frequency/intensity of mental health services. In terms of mental health treatment, MCPs provide medication evaluation and treatment, group and individual therapy, psychological testing, as well as prescription medications, including psychotropic medications (See Appendix II for a list of covered services). MCPs may operate within one county, or across an entire region, and deliver services across a managed network of providers (hospitals, Federally Qualified Health Centers [FQHCs] and other organizations). Some counties may have multiple MCPs in one county and individuals with Medi-Cal can choose which MCP they would like to belong to. In other counties, there may be a single MCP providing coverage to all individuals with Medi-Cal. To find out which MCPs provide coverage in your county, check the DHCS website, linked here for convenience.

All three plan types discussed here - MHPs, DMC State Plan/DMC-ODS and MCPs administer and/or deliver an array of services to Medi-Cal members. Given the complexity of the systems, it can be difficult for individuals seeking services to understand which plan would best treat their behavioral health care needs and where/how to access SMHS, DMC or NSMHS. To make navigating this complex system easier for people seeking services, CalAIM has provided new guidelines for accessing medically necessary care.

Definition of Medical Necessity

All Medi-Cal services provided to persons in care need to meet the standard of being "medically necessary". The definitions of medical necessity are somewhat different, based upon the age of the person in care. For individuals aged 21 and older, an SUD service is considered "medically necessary" when it is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." For individuals under age 21, the definition of whether an SUD service is considered "medically necessary" falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT) Services language under Section 1396d(r) of Title 42 of the United States Code.[5] This section requires provision of all Medicaid (Medi-Cal)-coverable services necessary to correct or ameliorate substance misuse and SUDs discovered by a screening service, whether or not the service is covered under the State Plan. These services need not be curative or completely restorative, and can be delivered to sustain, support, improve or make more tolerable substance misuse or an SUD condition.

ASAM Criteria

Providers of DMC and DMC-ODS services are required to use the American Society of Addiction Medicine (ASAM) Criteria®, formerly known as the ASAM patient placement criteria, for all service types. The ASAM Criteria® is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcomes-oriented and results-based care in the treatment of substance use disorders (SUDs). The ASAM Criteria® relies on a comprehensive set of guidelines for level of care placement, continued stay, and transfer/discharge of patients with addiction, including those with co-occurring conditions. The ASAM Criteria® uses a multidimensional patient assessment to direct medical management and the structure, safety, security, and intensity of treatment services. Detailed information about the ASAM Criteria® is available on the ASAM website.[6]

Access to the DMC/DMC-ODS System

In a previous section, we described covered services under the DMC/DMC-ODS Medi-Cal benefit. Next, we will discuss the criteria for accessing SUD services after assessment. While we will be discussing the technical criteria, we encourage practitioners to continue to review the information from the perspective of the person in care with empathy and centering the person's voice regarding their health care decisions.

The criteria we will discuss in this section are for two distinct age cohorts: individuals aged 21 years and older[7] and individuals under 21 years of age.[8] Each of these cohorts have distinct criteria due to their developmental needs. It is important to point out early that a person may begin to receive clinically appropriate outpatient services, so long as

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5 Section 1396d(r) of Title 42 of the United States Code.

6 https://www.asam.org/asam-criteria/about-the-asam-criteria

7 W&I Section 14059.5(a

8 Section 1396d(r) of Title 42 of the United States Code

the person would benefit from the SUD services, even before a diagnosis has been fully articulated and a full ASAM assessment has been completed.

Overview of criteria for adults aged 21 year and older

To qualify for DMC and DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older must meet one of the following criteria:

- Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorder (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, OR

- Have had at least one diagnosis from the DSM 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, determined by substance use history.

Overview of criteria for persons under 21 years of age

- Beneficiaries under age 21 qualify to receive all medically necessary DMC and DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan.

- Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

Access to medically necessary services, including all Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder, cannot be denied to persons in care if they meet criteria for substance use services as per the ASAM criteria. DHCS has also alerted counties that individuals seeking substance use treatment cannot be placed on wait lists.[9]

Screening	Assessment	Problem Lists	Care Coordination	Treatment	Care Transitions	Discharge

Screening

The aim of screening is to get the person the right care. DMC and DMC-ODS systems are not required to use a standard screening tool across programs. Persons in care may be referred to substance use treatment services if a provider within the MHP or MCP completing a mental health screening tool identifies a need for substance use treatment services. If we keep the person's care needs at the forefront of treatment decisions, there is no wrong door by which the person may enter. The goal is to ensure that individuals seeking care have access to the right care in the right place at the right time, regardless of what door they come to initially.

Screening may or may not be completed by an LPHA when screening occurs in DMC/DMC-ODS systems. An abbreviated

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9 BHIN 23-001 (ca.gov)

ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. Please note that no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria® assessment. The screening tools are used to help identify behavioral health needs, symptoms, and/or diagnoses. Once the screening by the MHP or MCP is complete, there may be a referral for an ASAM multi-dimensional assessment by an LPHA to develop a clinical understanding regarding the person's care needs, including diagnosis, and to confirm the appropriate level of care and what services are medically necessary. Because humans are complex, the assessment may take more than one session to fully determine the overall care needs. For many individuals and/or in some circumstances, assessment may also include the collection of information from collateral sources including, but not limited to, family members, prior service providers and/or system partners. Please note, it is necessary to obtain consent from the person in care prior to arranging to obtain collateral information from others, including other agencies where the person may have previously received care. While the assessment is in process, the person in care may also receive clinically appropriate outpatient services simultaneous to the assessment services.

Clinically appropriate services include prevention, screening, assessment, and treatment services (e.g., individual, group, recovery services) and are covered and reimbursable under Medi-Cal even when[10].

1. Services are provided prior to determination of a diagnosis, during the assessment process, or prior to determination of whether DMC or DMC-ODS access criteria are met.

While a person may access necessary services prior to determining a diagnosis, an ICD-1011[12] code must be assigned to submit a service claim for reimbursement.

a. In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA in the CMS approved ICD-10 diagnosis code list, which may include Z codes. LPHA may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified disorders," or "Factors influencing health status and contact with health services."

b. ICD-10 Code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during the assessment phase of a person's treatment when a diagnosis has yet to be established.

c. ICD-10 codes Z55-Z65 "Persons with potential health hazards related to socioeconomic and psychosocial circumstances12[13]" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a LPHA.[14]

· As appropriate, LPHAs and non-LPHAs alike may use ICD-10 codes Z55-Z65 "Persons with potential health hazards related to socioeconomic and psychosocial circumstances[15].

2. The person in care has a co-occurring mental health condition and substance use disorder (SUD); or

3. Non-specialty mental health services (NSMHS) and specialty mental health services (SMHS) are provided concurrently, if those services are coordinated and not duplicative.

For DMC and DMC-ODS, covered and clinically appropriate services (except residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a LPHA or registered/certified counselor, or up to 60 days if the person in care is under age 21 or experiencing homelessness and, therefore, requires additional time to complete the assessment.

We should note that the responsibility for covered services by each of the service delivery systems remains in place, with each delivery system responsible for providing covered services per its contract with DHCS. This remains true even when persons in care are receiving services from multiple services delivery systems, as each delivery system has separate and distinct services for which it provides coverage.

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10 BHIN 22-013 (ca.gov)

11 BHIN 22-013 and https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

12 BHIN 22-013 and https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

13 BHIN 22-013

14 BHIN 22-013 and https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

15 BHIN 22-019 (ca.gov)

Screening	Assessment	Problem Lists	Care Coordination	Treatment	Care Transitions	Discharge

Assessment

The goal of a multi-dimensional assessment is to understand the person's needs and circumstances, in order to recommend the best care possible and help the person recover. The assessment must be completed under the guidance of an LPHA. An assessment using the American Society of Addiction Medicine (ASAM) Criteria is used to evaluate the person's substance use and considers the person's needs, obstacles, and liabilities, as well as their strengths, assets, resources, and support structure. The ASAM Criteria® is used to determine a person's level of care needs for placement, continued stays, transitions of care, and discharge. The ASAM Criteria® uses six dimensions of care for planning and treatment across levels of care. An assessment may require more than one session to complete and/or may require the practitioner to obtain information from other relevant sources, referred to as "collateral information," such as previous health records or information from the person's support system to gather a cohesive understanding of the person's care needs. Services to support the person's ability to remain safe and healthy in the community are of utmost importance. Therefore, it is important that practitioners ensure that the assessment process begins with risk and safety discussions, then moves on to discuss other matters of urgency to the person in care and completes assessment activities by gathering background information that impacts the primary concerns of the person in care.

- DHCS requires practitioners to complete an assessment using ASAM Criteria® for persons of all ages for the determination of level of care placement with the following exceptions:

  - The delivery of prevention and early intervention services (ASAM level 0.5) for persons under 21; a brief screening ASAM Criteria® tool is sufficient for these services. Assessments must include a typed or legibly printed name, and include the signature of the service provider, as well as the date of the signature15.

  - The delivery of Withdrawal Management (WM) Level 1, Level 2, Level 3.2, Level 3.7, and Level 4.0 services provided as part of a continuum of care for persons experiencing withdrawal in outpatient, residential, and inpatient settings. These services are considered urgent and provided on a short-term basis. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing WM services.

  - For all levels of care except narcotic treatment programs (under both DMC and DMC-ODS), the assessment may be completed face to face (in an office, community location or at the home of the person in care), by phone or by telehealth. A full ASAM assessment should be repeated when the condition of a person in care changes.

  - Narcotic Treatment Programs (NTP), also referred to as Opioid Treatment Programs (OTP), are considered an outpatient program. NPT/OTP programs shall conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to an NTP qualifies for the purpose of determining medical necessity.

Central to the completion of a comprehensive assessment is collaboration with the person in care. Centering the voice of the person in care and remaining curious and humble about the person's experiences, culture and needs during the assessment process is crucial to building this collaboration. When assessments are conducted in this manner, they function as an important intervention and relationship building opportunity. Focusing on strengths, culture, and resiliency, in addition to challenges, creates a setting where the person in care feels seen as a whole person. Assessments must be approached with the knowledge that one's own perspective is full of assumptions, so that one can maintain an open mind and respectful stance towards the person in care.

Curiosity and reflection indicate humility and a deep desire to truly understand the person in care and to help them meet their needs. A key outcome of the assessment process is the generation of shared agreement on the strengths and needs of the person in care, as well as how to best address those needs. The assessment process generates a hypothesis, developed in collaboration with the person in care, that helps to organize and clarify service planning.

The assessment using ASAM Criteria® serves to identify the level of care needs and outline recommendations for service

provision. For both DMC16[16] and DMC-ODS providers[17], the assessment can be completed by an LPHA or a registered/certified Alcohol and Other Drug (AOD) counselor when that counselor consults with an LPHA. In these scenarios, the LPHA is responsible for evaluating the assessment in consultation with the counselor. Consultation can occur in person, via live telephone or via live telehealth video chat and documentation of the consultation should be included in the assessment documentation. LPHAs are responsible for determining and documenting initial diagnoses, as this is outside the scope of practice for an AOD counselor. For narcotics treatment programs (under both DMC or DMC-ODS), the history and physical exams completed by an LPHA can justify medical necessity for people in care at that level of care.

Assessment Requirements

Initial assessment periods for non-residential DMC and DMC-ODS services are as follows, with the first date of service counting as "day 1"[18]:

· Up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established OR

· Up to 60 days if the person in care is under age 21 OR

· Up to 60 days if a provider documents that the person in care is experiencing homelessness and, therefore, requires additional time to complete the assessment

Assessment Dimensions

The assessment contains universally required domains (ASAM Criteria) that should not vary from county to county or CBO to CBO. Below is information on the standardized ASAM Criteria comprising the assessment for understanding the person's care needs. While each of the dimensions are required and must be addressed, information may overlap across dimensions. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure a clear and ideally chronological account of the person's current and historical need is accurately documented. Include the perspective of the person in care and, whenever possible, quote their own words within the document.

Below are the dimension categories19, key elements and guidance on information to consider under each dimension. The information in the outline below is not meant to be an exhaustive list. The practitioner should always consider the person within the context of their developmental growth and their larger community, including cultural norms or expectations when completing and documenting an assessment. Information within the assessment should come from the person seeking care, in their own words, whenever possible. Particularly for youth and those with disabling impairments, this may also include information from collateral sources.

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16 BHIN 21-071 (ca.gov)

17 BHIN 23-001

18 BHIN 22-019, BHIN 23-001, BHIN 21-071

19 Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013. Copyright 2013 by the American Society of Addiction Medicine.

Acute Intoxication and/or Withdrawal Potential	Biomedical Conditions and Complications	Emotional, Behavioral or Cognitive Conditions and Complications	Readiness to Change	Relapse, Continued Use or Continued Problem Potential	Recovery/ Living Environment

Acute Intoxication and/or Withdrawal Potential (Dimension 1)

Dimension 1 assesses the need for stabilization of acute intoxication and the type and intensity of withdrawal management services that may be needed.

- **Substance Use (past and current) –** Explore the past and current experiences of substance use and withdrawal of the person in care.

- **Risk Related to Substance Use –** Identify risks associated with the person's current level of acute intoxication and what intoxication management services are needed.

- **Withdrawal –** Include current signs of withdrawal and/or significant risk of severe withdrawal symptoms, seizures or other medical complications (based on history and amount/frequency/chronicity and recency of discontinuation), including scoring of any standardized withdrawal rating scales used. Identify if there are sufficient supports available for ambulatory withdrawal management, if that would be safe.

Biomedical Conditions and Complications (Dimension 2)

Dimension 2 involves information on medical and health factors that may complicate treatment.

- **Health Factors –** Explore individual's health history, chronic conditions, communicable diseases, current illnesses and current physical condition.

- **Medical Stabilization –** Review ongoing disease management or medical treatment needs for chronic conditions.

- **Pregnancy –** For female individuals, identify pregnancy status and pregnancy history, particularly if she has an opioid use disorder.

Emotional, Behavioral or Cognitive Conditions and Complications (Dimension 3)

Dimension 3 focuses on history of mental health needs and the need for mental health treatment. Dimension 3 also includes a review of co-occurring disorders, the connection of mental health symptomology to substance use, risks and functioning.

- **Mental Health History –** Explore the person's thoughts, emotions and mental health issues, including current or chronic psychiatric illnesses or psychological, behavioral, emotional or cognitive conditions, and how they create risk or interfere with/complicate treatment.

- **Connection to Substance Use –** Identify if any emotional, behavioral or cognitive symptoms appear to be part of SUD or if they appear autonomous and, even if connected to the substance use disorder, whether the symptoms require specific mental health treatment. Include how course of illness and how mental health recovery efforts may be complicated by addiction challenges.

- **Coping and Social Functioning–** Explore how the person in care copes with any emotional, behavioral or cognitive conditions and the degree to which the individual's relationships are impacted by substance use and/

or mental health challenges

- **Activities of Daily Living** – Review individual's ability to manage activities of daily living.

- **Risk** – Exploration of risk for suicide, homicide or other forms of self-harm, including impulsivity, ideation, plans and behaviors.

Readiness to Change (Dimension 4)

Dimension 4 integrates the need for motivational interventions as part of the recovery process. Understanding where a person in care is related to the stages of change provides important context for understanding the needs of the people we serve and the interventions needed to assist them.

- **Change Interest –** Explore individual readiness, willingness and interest in changing behaviors, as well as their feelings about their ability to change.

- **Awareness –** Review individual's awareness of the relationship between substance use/behaviors, reward/ relief and negative life consequences.

- **Control –** Explore how much the individuals feels (or doesn't feel) in control of their treatment services.

Relapse, Continued Use or Continued Problem Potential (Dimension 5)

Dimension 5 assesses the need for relapse prevention services and potential for continued use. It is important for providers to give equal weight to historical relapses and historical periods of sobriety to determine what works to help the person in care healthy.

- **Relapse Relationship –** Explore the individual's unique relationship with relapse or continued use or problems with substances, including the individual's recognition, understanding and ability to cope with challenges to prevent relapse or cope with protracted withdrawal, cravings or impulses.

- **Relapse Risk –** Determine if the individual is in immediate danger of continued substance use and/or mental health distress.·

- **Relapse Prevention –** Identify if addiction and/or psychotropic medications have assisted in recovery in the past and how the individual copes with negative effects, peer pressures and stresses to avoid relapse. Include the individual's awareness of relapse triggers and skills to control impulses

Recovery and Living Environment (Dimension 6)

Domain 6 provides clinicians an opportunity to clearly articulate a working theory about how the person in care's Dimension 6 supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

- **Living Situation –** Explore the person in care's recovery or living situation and the surrounding people, places and things.

- **Support and Risk –** Identify if any family members, significant others, school, work or other settings/ situations pose a threat to the individual's safety or treatment engagement and, conversely, if the individual has resources that increase the likelihood of recovery including supportive friendships, financial resources, educational or vocational resources.

- **Mandates –** Explore legal, vocational, regulatory, criminal justice or social service mandates that may enhance motivation for treatment.

- **Environmental Factors –** Identify transportation, childcare, housing, employment or other environmental factors that may need to be addressed to increase recovery likelihood.

Diagnosis

While SUD treatment is allowable prior to the determination of a diagnosis, the responsibility to provide a diagnosis has not changed. Information for the determination of a diagnosis is obtained through a clinical assessment. Information may come directly from the person in care or through other means, such as collateral information or health records. A diagnosis captures clinical information about the person's behavioral health needs and other conditions based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). Diagnoses are determined by an LPHA commensurate with their scope of practice. Diagnoses are used to communicate with other team members about the person's substance use disorders, mental health symptoms, and other conditions and may inform level of distress/impairment. Moreover, and most importantly, diagnoses may help practitioners advise the person in care about treatment options.

Diagnoses should not remain static. For example, the person's clinical presentation may change over time and/or the practitioner may receive additional information about the person's symptoms and how the person experiences their symptoms(s) and conditions. As a practitioner, it is your responsibility to document all diagnoses, including preliminary diagnostic impressions and differential diagnoses as well as to update the health record of the person in care whenever a diagnostic change occurs.

While there is no longer a limited set of diagnosis codes that are allowable in relation to the provision of SMHS, the covered benefits and services responsibilities of the MHPs and MCPs remain unchanged. For example, MHPs are not required to provide Applied Behavior Analysis (ABA), a key intervention in the treatment of autism spectrum disorder (ASD), as the responsibility for providing that service remains with the MCP. However, a person in care who has ASD is able to additionally receive treatment from the MHP if their service needs require it and services are not duplicative with the other care they are receiving.

Providers may use the following options during the assessment phase of a person's treatment when a diagnosis has yet to be established[20]:

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate, including an MHRS or other qualified staff, during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA).

- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during the assessment phase of a person's treatment when a diagnosis has yet to be established.

- In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA in the CMS approved ICD-10 diagnosis code list, which may include Z codes. LPHAs may use any clinically appropriate ICD-10[21] code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

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20 BHIN 22-013 (ca.gov)

21 BHIN 22-013 and https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

| Screening	Assessment	Problem Lists	Care Coordination	Treatment	Care Transitions	Discharge

The Problem List

In the previous section we explored the assessment and how it informs care recommendations. Next, we will explore how the diagnosis and problem list intersect. Below you can see how different members of the care team can add to the list to fully capture the issues needing attention.

The use of a Problem List has largely replaced the use of treatment plans[22], except where federal requirements mandate a treatment plan be maintained. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the problem list. The providers responsible for the person's care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by Mental Health Rehabilitation Specialists, Peer Support Specialists, and other treatment team members. The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person's care needs, including current diagnoses and key health and social issues.
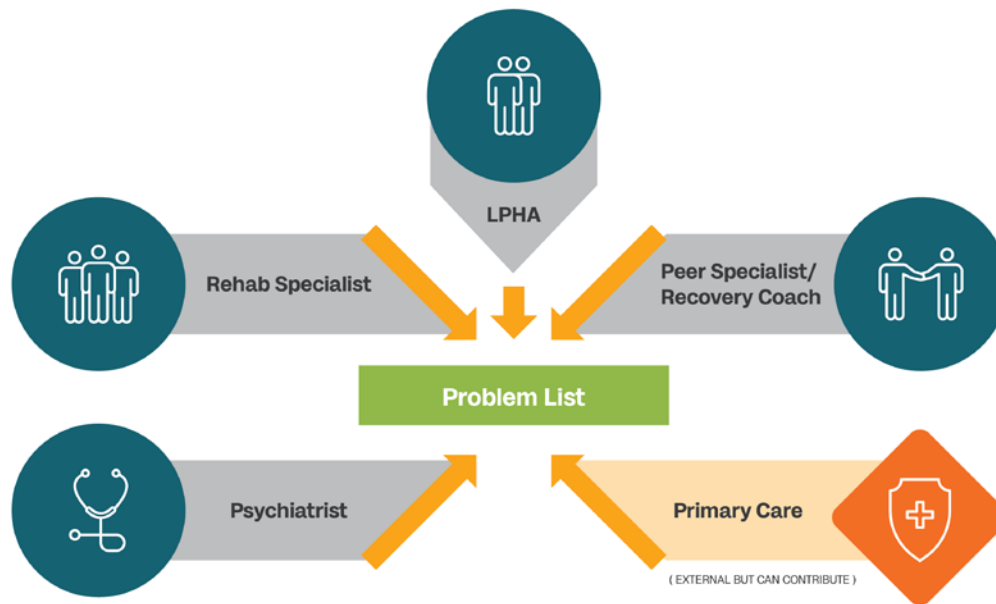
When used as intended, treatment teams can use the problem list to quickly gain necessary information about a person's concerns, how long the issue has been present, the name of the practitioner who recorded the concern, and to track the issue over time, including its resolution. The problem list is a key tool for treatment teams and should be kept up to date to accurately communicate a person's needs and to support care coordination.

Problem lists will have ICD-10 codes and or Systematized Nomenclature of Medicine (SNOMED) codes, including Z codes, as well as SDOH codes[23]. DHCS has identified a list of priority SDOH codes to facilitate the collection of reliable SDOH information for the Medi-Cal population. These codes are found in Appendix IV.

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22 Treatment or Care Plans remain in place for some specialty programs, per BHIN 22-019, Attachment 1

23 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

Problem List Requirements

The problem list shall be updated on an ongoing basis to reflect the current presentation of the person in care. Providers shall add to or remove problems from the problem list when there is a relevant change to a person's condition.

The problem list shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice.
  - Include diagnostic specifiers from the ICD-10 if applicable.
- Problems identified by a provider acting within their scope of practice.
- Problems or illnesses identified by the person in care and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

DHCS does not require the problem list to be updated within a specific time frame or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

Accuracy of the diagnoses and problem list are necessary for appropriate treatment services to a person, and to support claiming for services. Inconsistencies in either can lead to poor coordination of care across teams and treatment as well as inadequate documentation of the medical necessity of services, which can lead to rejected claims.

Treatment Plan Requirements

In the past, treatment plans were static and complicated documents with strict start and end dates. If services were provided that were not documented on the treatment plan, they could not be claimed. Persons in care had to sign the treatment plans or they were not considered valid. Over time it has become clear that effective treatment planning involves a more dynamic process since the person's needs can evolve and change rapidly. As part of CalAIM, treatment plans for many types of services are moving from standalone documents to being embedded in the "plan section" of progress notes. Exceptions to these changes can be found in Attachment 1 of BHIN 22-019[24].

A. Peer Support Services

Peer support services must be based on an approved plan of care.[25] The plan of care shall be documented within the progress notes in the person's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

B. Additional Treatment and Care Plan Requirements

Requirements for treatment/care planning for additional service types are found in Attachment 1 of BHIN 22-019 [26].

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24 https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf

25 State Medicaid Director Letter #07-011; California State Plan, Supp. 3 to Att. 3.1-A, pp. 4, 5, 6h, 6i (substance use disorder); p. 2m.1 (SMHS)

26 BHIN 22-019 (ca.gov)

Example of a Problem List for a Person in Care:

Code	Description	Date Added	Date Removed	Added or Removed by	Provider Title*
Z65.9	Problem related to unspecified psychosocial circumstances	07/01/2022	07/19/2022	Name	Mental Health Rehabilitation Specialist
Z59.02	Unsheltered homelessness	07/01/2022	Current	Name	AOD Counselor
Z59.41	Food insecurity	07/01/2022	Current	Name	Peer Support Specialist
Z59.7	Insufficient social insurance and welfare support	07/01/2022	Current	Name	Peer Support Specialist
F33.3	Major Depressive Disorder recurrent, severe with psychotic features	07/19/2022	Current	Name	Psychiatrist
F10.99	Alcohol Use Disorder, unspecified	07/19/2022	Current	Name	Clinical Social Worker
I10.	Hypertension	07/25/2022	Current	Name	Primary Care Physician
Z62.819	Personal history of unspecified abuse in childhood	08/16/2022	Current	Name	Clinical Social Worker

*Name and provider title may be automatically populated by your Electronic Health Record.

| Screening | Assessment | Problem Lists | Care Coordination | Treatment | Care Transitions | Discharge |

Care Coordination

In previous sections we explored social drivers of health and how access to resources contributes meaningfully to quality of life. Access to health care is an important driver of quality of life and health outcomes, and one that we can directly impact. We know far too well that accessing and navigating healthcare systems can be a challenge for anyone. This may be especially true in behavioral health because care can involve treatment providers across multiple disciplines and organizations. Although care coordination can only be billed in DMC-ODS counties, the concept of coordinating care on behalf of the person in care is important to consider and integrate into practice for DMC State Plan counties as well.

Appropriate access to healthcare requires not only that services be available and accessible at the time the person needs the services, but also that care is coordinated, streamlined, and non-duplicative, even when it is provided by multiple entities. Care that is not coordinated runs the risk of being ineffective, wasteful of healthcare resources, and onerous for the individuals it is designed to help. As a whole, the disparate practitioners that are providing care can benefit from coordination so they can act in concert, as a team, with the person in care having a central voice and role.

Care coordination was previously referred to as case management. Care Coordination as a service is only available within DMC-ODS counties. Care coordination necessitates that a point person is identified who is accountable for coordination, bringing the person in care, natural supports/family, other service providers and system partners to the table. To ensure smooth coordination of care, practitioners should request authorization to share information (also known as releases of information) for all others involved in the care of the person in treatment during the intake process and throughout the course of treatment.

Care coordination also meets federal requirements designed to ensure that each person in care has an ongoing source of care appropriate to their needs. One person or entity must be formally designated as primarily responsible for coordinating the services accessed by the person in care, and the person in care must be provided information on how to contact their designated person or entity[27].

The Care Coordinator may be you, a treatment team member from your organization, or a treatment provider from another organization or delivery system. This role may have different names within various organizations, such as case manager, care manager, team facilitator, or the function of care coordination may be incorporated into the role of a clinician or other staff. The main goal of the Care Coordinator is to meet the person's care needs by using treatment information in a deliberate way and sharing necessary information with providers and the person in care, to guide the delivery of appropriate and effective care. Care Coordinators work to build teams and facilitate partnerships, creating formal and informal networks of support that enhance treatment for persons in care and allow for sustainable support long after treatment ends. Care coordination serves as a key element of service planning, ensuring that treatment across the team is meeting the needs of the person in care, that plans are updated as needed and that barriers to success are overcome. Within the team, communication is a key element of success, along with empowering the person in care to guide the team to meet their own needs. When referring or transitioning a person in care, the practitioner should discuss the reason for referral or transition and ensure the person understands, not only the reason for referral or transition, but also the expected outcome of the referral or transition. When transitioning care between MHP and MCP providers, be aware that DHCS has launched a Transition of Care tool to assist with care coordination and communication during transitions.

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27 42 CFR §438.208

Screening	Assessment	Problem Lists	Care Coordination	Treatment	Care Transitions	Dischar

Treatment

Treatment in behavioral health refers to a range of interventions designed to address and improve the mental health of a person in care. Treatment can involve a variety of evidence-based practices, such as motivational interviewing or Seeking Safety. Treatment approaches should be tailored to meet the unique needs of the person in care to alleviate mental health symptoms, enhance coping skills, and foster overall mental wellness. Treatment involves the use of a variety of Medi-Cal services, such as individual or group therapy, individual or group rehabilitation, medication services, or targeted case management to provide supportive interventions. By taking a comprehensive and holistic approach to the treatment needs of the person in care, providers can help individuals navigate their challenges, develop resilience, and work towards achieving optimal mental wellness and quality of life.

Evidence-Based Practices

Providers working within the DMC-ODS system are required to implement at least two of the following evidenced-based treatment practices (EBPs) based on their county's implementation plan[28]. The two EBPs are per provider and per service modality, and fidelity is monitored by the county to ensure practices are well implemented within programs. Please check in with your county SUD administrator or program director to confirm which modalities are currently being used. The evidenced-based practices approved for use are:

- **Motivational Interviewing –** A person in care-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on the past successes of people in care.

- **Cognitive-Behavioral Therapy –** Based on the theory that most emotional reactions, thought processes and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

- **Relapse Prevention –** A behavioral self-control program that teaches individuals with SUD how to anticipate and cope with triggers and/or the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial SUD treatment.

- **Trauma-Informed Treatment –** Services must take into account an understanding of trauma and place priority on trauma survivors' safety, choice, and control.

- **Psycho-Education –** Psycho-educational groups are designed to educate people

The hallmark of EBP service delivery's effectiveness is fidelity to the model, i.e., providing treatment that research has shown to be effective. Research shows us that after initial training, it is imperative that the service provider continue to receive supervision, consultation or mentorship to ensure fidelity to the model.

Level of Care Determination

Placement and level of care determination must be provided in the least restrictive level of care that is clinically appropriate to treat the person's condition, based on the results of the ASAM-based multidimensional assessment[29]. Covered services are based on recommendations by an LPHA, within their scope of practice, and must be provided by DMC-certified practitioners. Services shall be "medically necessary," as justified by the assessment, diagnosis and problem list. More information on the below services can be found in the ASAM manual, as well as in BHIN 23-001. See Appendix III for the ASAM Level of Care Crosswalk. While all the below levels of care are required for DMC-ODS Plans, DMC State Plans may not incorporate every level of care outlined in this guide. Please see Appendix II for a list of services that are provided in DMC-ODS and DMC State Plan counties.

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28 BHIN 23-001

29 W&I Code 14184.402(e)

ASAM Level 0.5 - Screening, Brief Intervention, Referral to Treatment and Early Intervention Services

Early intervention services are those that explore and address risks and problem behaviors that appear to be related to substance use in order to help the person in care recognize negative consequences of substance use. Services are aimed to support individuals who may be at risk for developing substance use problems.

Any person in care under age 18 who is screened and determined to be at risk of developing an SUD may receive early intervention services. Early intervention services are provided under the outpatient treatment modality and may be provided in a variety of settings via in person, telehealth or telephone intervention. For this level of care, a full assessment utilizing ASAM Criteria® and an SUD diagnosis are not required, and an abbreviated ASAM screening tool may be used to justify service. If the screening indicates that a person under age 21 meets criteria for an SUD, then a full ASAM assessment must be performed and the person in care referred to the appropriate level of care based on the assessment.

However, the Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) (formerly known as Brief Intervention, and Referral and Treatment [SBIRT]) are not DMC-ODS benefits. This is a benefit in the MCP delivery system for individuals aged 11 years and older.

ASAM Level 1 - Outpatient Treatment Services (often referred to as Outpatient Drug Free)

Outpatient treatment services are organized services that provide addiction treatment to support ongoing recovery through regularly scheduled sessions that include fewer than nine hours of service a week for adults and less than six hours of service a week for individuals under age 18. Services are individualized to the needs of each person in care and are designed to create change in substance use and other addictive behaviors. Services are delivered in a wide variety of locations but are typically found in an office-based setting. Services are provided in person, via telehealth and by phone. Outpatient treatment services include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Medication for Addiction Treatment (MAT) for Opioid Use Disorder (OUD) MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

ASAM Level 2.1 – Intensive Outpatient Treatment Services

Intensive Outpatient Program (IOP) services are structured services that provide intensive counseling and psychoeducation to individuals related to addiction and mental health needs. Psychiatric and medical services are typically addressed through consultation and referral arrangements through thoughtful care coordination at this level of care. IOP programs typically are not designed to provide treatment to individuals with significant and unstable medical or psychiatric conditions. IOP services are provided based on medical necessity for the individual in care within ASAM guidelines of 9-19 hours per week for adults and 6-19 hours per week for adolescents. Services can occur in person, by telephone or via telehealth. Intensive outpatient treatment services include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy

- Medication Services
- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

ASAM Level 2.5 - Partial Hospitalization Services

Partial Hospitalization Program (PHP) services (sometimes referred to as "day treatment") are provided in a clinically intensive programming environment designed to address the treatment needs of individuals in care with severe SUD requiring more intensive treatment services than can be provided at lower levels of care. PHPs typically have direct access to psychiatric, medical, and laboratory services and, for programs serving adolescents, educational services are also typically provided or arranged for. PHPs are designed to meet the identified needs that warrant daily monitoring or management, but that can be appropriately addressed in a structured outpatient setting. This level of care is optional for counties within the DMC-OSD system. The PHP level of care requires 20 or more hours of week of intensive service programming that can be provided in person, by telephone or via telehealth. Treatment services include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for opioid use disorder (OUD)
- MAT for alcohol use disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

ASAM Levels 3.1, 3.3, & 3.5 - Residential Treatment

Residential Treatment is a highly structured treatment modality within a 24-hour care setting. Facilities are community-based rather than hospital based, though they may be housed within a hospital setting. Services are provided in a short-term residential program of any size through one of the following levels:

- Level 3.1 - Clinically Managed Low-Intensity Residential Services
- Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
- Level 3.5 - Clinically Managed High Intensity Residential Services

Residential programs may require additional licensure beyond DMC certification, depending on the specific facility type, and be designated regarding the specific level of residential treatment provided (3.1, 3.3 or 3.5). Level designations are based primarily on the functional limitations of the person in care, with the individuals with the highest level of need receiving support within a higher-level residential treatment program. Additionally, treatment intensity is a factor in determining the appropriate level; where a 3.1 designation is assigned to a supportive 24-hour living environment and a 3.3 or 3.5 designation provides 24-hour treatment.

Residential treatment is designed to address functional challenges related to substance use disorders and to restore, maintain and practice interpersonal and independent living skills, along with access to community support systems. Services support people in care to develop practice and demonstrate recovery skills needed to avoid immediate

relapse and/or high-risk behaviors. Self-help groups are often brought on site and integrated within the treatment schedule at this level of care.

All services are individually tailored to the person in care based on their needs, and individuals are to be transitioned to lower levels of care when clinically appropriate to be moved to a less restrictive setting, aligned with the statewide goal of a 30-day or less length of stay. This length of stay is not a rigid limit or intended to represent a hard cap on service provision, nor has the state provided further guidelines regarding length of stay. Most services must be in person; however, telehealth and telephone services can be used to supplement the in-person treatment and therapeutic milieu on site. Service components include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

ASAM Levels 3.7 - Medically Monitored Inpatient Services - & 4.0 - Medically Managed Intensive Inpatient Services

Medically Monitored and Medically Managed Inpatient Services are designed to provide inpatient residential treatment to people in care who require support to restore, improve or maintain interpersonal and independent living skills in order to thrive in the community. Such programs are typically provided in a hospital setting and include the direction from a medical professional for direct evaluation, observation and medical monitoring. Medically Monitored and Medically Managed programs are intended to meet the needs of people in care with significant functional challenges in Dimensions 1, 2 and/or 3 of the ASAM assessment. Individuals in Medically Managed programs require primary medical and nursing care where treatment is medically directed by a physician and in locations where the full resources of a general acute care of psychiatric hospital are available. Programs require additional licensure beyond DMC certification. Per DHCS[30], these levels of care are optional for counties participating in the DMC-ODS system, though the counties that do not opt to provide this level of treatment must have a clearly defined referral mechanism and care coordination for these levels of care.

Services are typically delivered by an interdisciplinary staff of credentialed treatment professionals. Services occur in person and within the on-site therapeutic milieu. Telephone and telehealth services may be used to supplement in person and milieu services. All services are individually tailored to the person in care based on their needs and individuals are to be transitioned to lower levels of care when clinically appropriate to be moved to a less restrictive setting, aligned with the statewide goal (not a strict limit) of a 30-day or less length of stay. Service components include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD

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30 DHCS All-Plan Letter 1801

- MAT for AUD and other non-opioid SUDs

- Patient Education

- Recovery Services

- SUD Crisis Intervention Services

Narcotic Treatment Program

Narcotic Treatment Program (NTP)[31], also described in the ASAM Criteria® as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to people who are covered under the DMC-ODS formulary, including:

- Methadone

- Buprenorphine (transmucosal and long-acting injectable)

- Naltrexone (oral and long-acting injectable)

- Disulfiram

- Naloxone

If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the person in care to a provider capable of dispensing the medication.

In addition, NTPs provide a variety of psychosocial services in order to support the use of pharmacotherapy to treat SUDs. Counseling (individual or group) must be offered to the person in care for at least 50 minutes per calendar month either in person, by telephone or by telehealth. Medical evaluation must be conducted in person[32]. Service components include:

- Assessment

- Care Coordination

- Counseling (individual and group)

- Family Therapy

- Medical Psychotherapy

- Medication Services

- MAT for OUD

- MAT for AUD and other non-opioid SUDs

- Patient Education

- Recovery Services

- SUD Crisis Intervention Services

- Medical evaluation for methadone treatment, including medical history, laboratory tests, physical exam

Treatment Services

Assessment

Assessment consists of activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable state and federal laws, regulations, and standards. Assessment may be initial and periodic

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31 NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

32 BHIN 23-001, page 15

and may 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 beneficiary. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.

- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing.

- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.

Care Coordination

Care coordination consists of activities, previously referred to as case management, to provide coordination of SUD care, mental health care, and medical care, and to support the person in care with linkages to services and supports designed to restore the person in care to their best possible functional level. Care coordination must be provided in conjunction with all levels of treatment. Care coordination may also be delivered and claimed as a standalone service in a DMC-ODS county but cannot be claimed for in DMC State Plan counties.

Care coordination occurs in person, by telephone and via telehealth in a variety of clinical and non-clinical settings, including in the community. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a person-centered and whole-person approach to wellness33[33]. Service components include one of more of the following:

- Coordination between medical and behavioral health care providers to monitor and support comorbid health conditions.

- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.

- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

Clinician Consultation

Clinician consultation is not a direct service provided to a person in care. Clinician consultation replaces and expands on the previous "Physician Consultation" service and is designed to support DMC-ODS licensed clinicians with complex cases. Clinical consultation may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. Clinician consultation includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for a specific person in care. These consultations consist of DMC-ODS LPHAs consulting with other LPHAs to support the provision of care. Counties contract with one or more physicians, clinicians or pharmacists specializing in addiction in order to provide consultation services in person, by telehealth, via telephone or by asynchronous telecommunication systems (e.g., email or text messaging).

Contingency Management Services

DHCS implemented a new contingency management benefit for eligible DMC-ODS beneficiaries with a stimulant use disorder (StimUD) in DMC-ODS counties that elect and are approved by DHCS to pilot the benefit. The pilot will allow California to evaluate and assess the effectiveness of a contingency management benefit before determining whether

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33 DMC-ODS counties shall have an executed memoranda of understanding to support care coordination

it should be available statewide. Under the pilot, the contingency management benefit will be available in participating DMC-ODS counties that opt for and are approved by DHCS to provide this service. Only non-residential DMC-ODS providers can provide contingency management services. To participate in the contingency management pilot, DMC-ODS counties must submit an application to DHCS. The pilot will begin in fall 2022 and will end December 31, 2026. For more information, please refer to the DMC-ODS Billing Manual published June 2023.

Family Therapy

Family therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

Group Counseling

Group counseling consists of contacts with multiple beneficiaries at the same time. Group Counseling shall focus on the needs of the participants.

Individual Counseling

Individual counseling consists of contacts with a beneficiary. 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 beneficiary by supporting the achievement of the beneficiary's treatment goals.

Medical Psychotherapy

Medical psychotherapy is a counseling service conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.

Medication Services

Medication services includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication.

Medications for Addiction Treatment

Medications for Addiction Treatment (previously also known as Medication-Assisted Treatment or MAT) is a service that provides people in care with medications that treat substance use conditions. The required MAT medications were expanded to include all medications and biological products Food and Drug Administration (FDA)-approved to treat opioid use disorders (OUD) and Alcohol Use Disorders (AUD)[34]. Medications to be provided include:

· Methadone

· Buprenorphine (transmucosal and long-acting injectable)

· Naltrexone (oral and long-acting injectable)

· Disulfiram

· Naloxone

MAT may be provided in clinical or non-clinical settings and may be delivered as a standalone service or as a component of another level of care. People in care needing or using MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a person in care who declines counseling services. Service components include:

· Assessment

· Care Coordination

· Counseling (individual and group)

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34 On December 29, 2020, DHCS obtained a one-year extension for DMC-ODS 115 waiver.

- Family Therapy
- Medication Services
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

DMC-ODS providers, at all levels of care, must demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT service for the person in care with SUD diagnoses that are treatable with medication or biological products. These referrals include facilitating access to MAT off-site if the program does not include MAT on-site within the program and DHCS has determined that providing a person in care, the contact information for a treatment program is not considered sufficient. To align with DHCS expectations, providers should ensure that all referrals are made using a "warm hand-off" method where one provider directly introduces the person in care to a second provider, providers ensure that persons in care attend their first appointment with the new provider and/or engagement in a face-to-face meeting with the individual in care and both providers to discuss the needs of the person in care.

For people in care with a lack of connection to psychosocial services, numerous, varied and more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g., telehealth), different staff, and/or different services (e.g., peer support services) to fully engage with individuals based on their existing motivation for change. If the DMC-ODS provider is not capable of continuing to treat the person in care, the DMC-ODS provider must assist the person in care in choosing another MAT provider, support continuity of care and facilitate a warm hand-off to ensure engagement.

DMC-ODS counties have the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit. This means the county pays the cost for MAT medications purchased by providers and administered or dispensed on site or in the community and billed to the county DMC-ODS plan. If the DMC-ODS county elects this option, it could reimburse providers for the medications, such as naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities and non-clinical or community settings.

DMC-ODS counties that do not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit are still required to cover the drug product costs for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a standalone service.

All medications and biological products utilized to treat SUDs, including long-acting injectables, continue to be available through the Medi-Cal pharmacy benefit without prior authorization and can be delivered to provider offices by pharmacies.

Mobile Crisis Services
Community-based mobile crisis intervention services provide rapid response, individual assessment and community-based stabilization for Medi-Cal beneficiaries who are experiencing a mental health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques that reduce the immediate risk and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restore the beneficiary to the highest possible functional level. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate, and in a manner that is consistent with all federal and state laws related to minor

consent, privacy and confidentiality.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the beneficiary a behavioral health crisis. Locations may include, but are not limited to the beneficiary's home, school or workplace, on the street, or where a beneficiary socializes. Mobile crisis services cannot be provided in hospitals or other facility settings. Mobile crisis services shall be available to beneficiaries experiencing behavioral health crises 24 hours per day, seven days per week, 365 days per year.

Patient Education

Patient education is education for the beneficiary on addiction, treatment, recovery and associated health risks.

Peer Support Services

Peer support services are a new service implemented as a County Option effective July 1, 2022. Services are provided by Certified Peer Support Specialists[35], who are individuals in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification. Certified Peer Support Specialists must meet all other applicable California state requirements, including ongoing education requirements[36].

Peer support services must be provided under the direction[37] of a behavioral health professional[38] [39]. An individual directing a service is not required to be physically present at the service site to provide direction. The licensed professional directing a service assumes ultimate responsibility for the service provided. Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements[40].

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

People in care may concurrently receive Peer Support Services and services from other levels of care. Services may include contact with family members or other people supporting the person in care (defined as "collaterals") if the purpose of the collateral's participation is to focus on the treatment needs of the person in care by supporting the treatment goals of the person in care. Services are delivered and claimed as a standalone service and may be provided in a clinical or non-clinical setting. Service components include:

- **Educational Skill Building Groups -** providing a supportive environment in which people in care and their families learn coping mechanisms and problem-solving skills in order to help the person in care achieve desired outcomes. These groups promote skill building for the people in care in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

- **Engagement Services -** activities and coaching led by Peer Support Specialists to encourage and support people in care to participate in behavioral health treatment. Engagement may include supporting people in care in their transitions between levels of care and supporting people in care in developing their own recovery goals and processes.

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35 Behavioral Health information Notice 21-041

36 Further guidance forthcoming regarding certification requirements for Peer Support Specialists.

37 "Under the direction of" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval and signing of client plans

38 Services are provided under the direction of a physician; a licensed or waivered psychologist; a licensed, waivered or registered social worker; a licensed, waivered or registered marriage and family therapist; a licensed, waivered or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner). Behavioral Health Professionals must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC-ODS or Specialty Mental Health Services

39 Supplement 3 to Attachment 3.1-A of the California State Plan. DMC-ODS services are described in the "Expanded SUD   Treatment Services" section

40 Requirements outlined in BHIN 22-018

- **Therapeutic Activity -** a structured non-clinical activity provided by Peer Support Specialists 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 treatment of the person in care to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the person in care; promotion of self-advocacy; resource navigation; and collaboration with the people in care and others providing care or support to the person in care, family members, or significant support persons.

Peer support services are billable services that must be based on a treatment care plan approved by a behavioral health professional (see definition of behavioral health professional above; this term is specific to the administration of peer support services).

Recovery Services

Recovery services are designed to support recovery and prevent relapse with the objective of restoring the person in care to their best possible functional level with emphasis on the person in care as the central role in managing their health, using effective self-management support strategies, and organizing internal and community resources to provide ongoing self-management. Services are provided based on the person in care's self-assessment or provider assessment of relapse risk, and a diagnosis of "remission" is not required to receive recovery services. Services can occur in person, by telephone or via telehealth and may be provided concurrently with any level of care, including with MAT and NTP services. Services may be provided immediately after incarceration with a prior diagnosis of SUD. Recovery services can be delivered and claimed as a standalone service, concurrently with the other levels of care described. Service components include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the SUD of the person in care
- Relapse Prevention, which includes interventions designed to teach people in care with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the SUD of the person in care

SUD Crisis Intervention

Crisis intervention services consists of contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance, which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation and be provided in the least intensive level of care that is medically necessary to treat the condition.

Withdrawal Management Services

Withdrawal management (WM) services are provided as a part of a continuum of care to people in care experiencing withdrawal in outpatient, residential, and inpatient settings. Persons in care shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.

A full ASAM Criteria® assessment is not required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where the person in care can receive comprehensive treatment services. Service components include:

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD

- MAT for AUD and other non-opioid SUDs
- Observation
- Recovery Services

Withdrawal Management occurs across the ASAM levels of care and treatment settings as follows:

- Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision).
- Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non- residential setting).
- Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).
- Level 3.7-WM: Medically managed inpatient withdrawal management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits).
- Level 4.0-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability).

Treatment Team

SUD services are often provided through a team-based approach. While the precise composition of teams varies in each individual situation, it is not uncommon to have treatment teams with some combination of LPHAs, AOD counselors, Peer Support Specialists, medical providers and others who work with the person in care. It is critical that treatment teams include the person in care and center their voice and priorities as the treatment team collaborates to support the person in care in meeting their goals. Teaming should be a seamless part of treatment, and all members should work collaboratively to ensure that work is highly coordinated and aligned across providers. Doing this well takes intentional partnership, information sharing, and focus. Treatment teams are highly encouraged to use consensus-building decision making techniques and to solicit and explore viewpoints across the team.

Co-Occurring Treatment

Co-occurring treatment, also known as dual diagnosis treatment, refers to an integrated approach to addressing both mental health and substance use disorders that present simultaneously. Co-occurring treatment recognizes that mental health and substance use disorders often coexist and interact, influencing each other's severity and progression.

Co-occurring treatment is based on the understanding that treating one condition while ignoring the other can lead to incomplete recovery and an increased risk of relapse. By providing co-occurring treatment, providers can deliver comprehensive and coordinated care that addresses both the mental health and substance use aspects of the well-being of a person in care.

Under CalAIM, the No Wrong Door policy aims to ensure that beneficiaries have access to the right care at the right time[41]. No Wrong Door specifies that clinically appropriate SMHS are covered and reimbursable even when the person in care has a co-occurring substance use disorder. Similarly, clinically appropriate and covered DMC and DMC-ODS services are covered by DMC and DMC-ODS plans even when the person in care has a co-occurring mental health disorder. Co-occurring diagnoses can interact and influence each other, leading to more complex treatment. By recognizing and understanding the interplay between co-occurring diagnoses, providers can provide more effective treatment tailored to the person in care's needs.

Progress Notes

In previous sections, we explored the use of the screening tools, assessment, diagnosis, and problem lists to best identify the person's care needs and treatment options. Now, we will explore the use of progress notes for documenting services

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41 BHIN 22-011

as practitioners work with individuals to address their needs. Please note, NTP/OTP programs continue to adhere to federal requirements; however, the characteristics and tips in the information below may be relevant for quality documentation.

Progress notes have multiple functions. First and foremost, progress notes are used to document the treatment that has occurred (the intervention), and the intended next steps (the plan). Progress notes can also serve as communication tools to alert other practitioners (or the person in care themselves) of the status of treatment. For these reasons, each progress note should be understandable when read independently of other progress notes, providing an accurate picture of the person's condition, treatment provided, and response to care at the time the service was provided. To facilitate clear and accurate communication, abbreviations should be avoided, unless universally recognized, so that they will be accessible to a range of practitioners with whom you may wish to coordinate care. Keep in mind that progress notes can be used in legal proceedings and may also be accessed by the person in care themselves. People in care should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

Given the communication aspect of progress notes, they should be completed as soon as reasonable after a service has occurred – generally within 24 hours for a crisis service, and within three days for most other services (more below).

Appendix V provides sample note narratives demonstrating sufficient documentation of the intervention.

The following list are characteristics of a progress note that supports quality documentation. Consider the following characteristics when documenting[42]:

- ☐ Clear
- ☐ Consistent
- ☐ Descriptive
- ☐ Reliable
- ☐ Accurate/Precise
- ☐ Timely

Required Progress Note Service Information

- ☐ The type of service rendered
- ☐ A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
- ☐ The date that the service was provided to the beneficiary.
- ☐ Duration of the service, including travel and documentation time, which should be documented separately [43].
- ☐ Location of the person in care at the time of receiving the service[44].
- ☐ A typed or legibly printed name, signature for the service provided and date of signature.
- ☐ ICD 10 code.[45]
- ☐ Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- ☐ The plan, or next steps, including but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate.

Group Progress Notes

The information above remains consistent for services provided in a group setting, with the following additional requirements:

- ☐ For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners can be used to document the group service provided.

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42 Hess, Pamela Carroll. Clinical Documentation Improvement: Principles and Practice. Chicago: AHIMA Press, 2017.

43 Under Payment reform, rates include the costs of travel and documentation time which supports streamlined claims processing. However, travel time and documentation time should still be documented separately in progress notes to support future rate setting efforts.

44 Per BHIN 22-019 the location of the beneficiary at the time of the service shall be identified, regardless of whether the beneficiary was present for the service.

45 https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

Progress notes need to contain the information as noted above and modifications and additional information as noted below:

☐ Information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity. Travel and documentation time should be captured separately[46] .

☐ A list of group participant names needs to be maintained. Please note, due to confidentiality standards, the full list of group participants must **not** be kept in any single participant's personal health records: instead the MHP or practitioner must maintain the full participant list outside of any participant's health records.

Progress Notes Timeliness

As noted above, each progress note should stand alone and be clear, complete, accurate, and free of jargon and local abbreviations. Documentation should be completed in a timely manner to support the practitioner's recall of the specifics of a service. Progress notes should never be completed in advance of a service. Below are timeliness expectations determined by DHCS:

·   **Routine outpatient services:** Documentation should be completed within three (3) business days. If a note is submitted outside of the 3 business days, it is good practice to document the reason the note is delayed. Late notes remain billable and should not be withheld from the claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations[47]), stricter note completion timelines may be required by state regulation.

·   **Crisis services**: Documentation should be completed within 24 hours.

·   **A daily note** is required for documentation of some residential services, day treatment, and other similar settings that use a daily rate for billing. In these programs, weekly summaries are no longer required.

  Narcotic Treatment Programs: No changes to this requirement. Federal requirements remain in effect.

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and abuse[48] within the service provision and claiming system. Disallowances in audits will occur when there is evidence of fraud, waste, or abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this guide are necessary steps to promote compliance.

Screening	Assessment	Problem Lists	Care Coordination	Treatment	Care Transitions	Discharge

Care Transitions

Given the multiple healthcare delivery systems and resources that a person in care can be served in, there is a need for care coordination to successfully transition between providers and care settings. We should think about care as occurring across a continuum with an understanding that people's needs change over time. Given that individual needs can also be addressed concurrently by providers in different agencies or systems, coordination of care is a necessary element of service provision. The goal of care coordination is to meet the person's needs though proactive and deliberate activities that include the person in care and to organize or coordinate with other service providers to facilitate the appropriate delivery of services across providers, treatment settings, and healthcare systems. It is likely that the coordination of services may include other treatment team members to help carry out activities, with each provider identifying what roles and activities they are taking on that support the overarching wellness of the person in care.

As noted earlier in this guide, there are multiple service delivery systems that cover distinct Medi-Cal services, with some not covered under the DMC/DMC-ODS program or best provided by another delivery system. Although a person may receive care from more than one delivery system or provider, the practitioner or care coordinator must ensure this is done without duplication.

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46 Under Payment reform, rates include the costs of travel and documentation time which supports streamlined claims processing. However, travel time and documentation time should still be documented separately in progress notes to support future rate setting efforts.

47 https://www.dhcs.ca.gov/Documents/STRTP-Regulations-version-II.pdf

48 Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual.

Screening	Assessment	Problem Lists	Care Coordination	Treatment	Care Transitions	Discharge

Discharge Planning

Behavioral health treatment should always commence with the understanding that recovery is possible. Appropriate treatment and supports benefit people with a wide variety of conditions; lessening disability and improving the ability to live full and fulfilling lives. For this reason, the discussion about discharge planning should begin at the time of initial assessment (as clinically appropriate) and continue throughout the course of treatment. Routinely asking yourself and the person in care how you will know when they are ready to discontinue treatment and what they imagine their life will look like after treatment is a valuable discussion that enhances engagement and instills hope for the future.

Discharge planning must include the person in care and their social support as full partners in the planning process and should be done as far in advance as practical. If the person in care is being discharged to a different kind of treatment, including other treatment providers in the process can help pave the way to successful transitions from one care setting to another. Detailed information on discharge planning should be clear, concise, and accurately communicated and documented.

A successful discharge discussion includes a review of how the person can continue to receive any necessary support and how those needs may be addressed post-discharge from the program. Information contained in discharge plans and shared with the person in care includes how the person's needs may be addressed, information on prescribed medications, the type of care the person is expected to receive and by whom, information on crisis supports, and available community services, to name a few.

Claiming for Services

Code Sets for Claiming Services

In an earlier section we explored the importance of identifying needs, assessing conditions and/or diagnoses to recommend medically necessary services and initiate care planning and treatment. Here, we will explore the intersection of progress notes with code sets for submitting claims for reimbursement. But first, let us talk about the different code sets and their uses.

- **DSM Diagnosis:** Captures clinical information about the person's behavioral health needs and other conditions (clusters of symptoms) based on the DSM-5. The selection of appropriate treatment interventions is informed by the diagnosis, assessed need and problem list.

- **International Classification of Diseases - Clinical Modification (ICD-10-CM) Codes:** Captures detailed information about the disorder (granular information) and is used in claiming. The ICD is a standard transaction code set for diagnostic purposes under the Health Insurance Portability and Accountability Act (HIPAA).

- **Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes:** These codes are used to capture uniform information for claiming for medical services and products. Specialty Mental Health Services primarily used HCPCS codes for claiming services prior to July 2023. Following July 2023, as an outcome of the implementation of the CalAIM initiative referred to as "payment reform", SMHS will use a combination of HCPCS codes and CPT codes to bill Medi-Cal. This change will largely impact licensed and licensed-eligible staff, who are able to claim for services using CPT codes. Please see Appendix VI for a list of commonly used HCPCS/CPT codes by practitioner type.

The above code sets are used throughout healthcare settings and offer standardization and uniformity for data collection, claims processing, and evaluation of disease prevalence and service provision.

Conclusion

We hope that this guide has given you useful tools to implement the service delivery system transformation,

documentation redesign and payment reform concepts foundational to CalAIM. Achieving the goals of CalAIM requires transformation across our service delivery system, by all types of practitioners and staff. Through coordination of care and strong engagement with the person in care, clinical staff can streamline documentation and provide higher quality care and further the goals of improving access for all Californians.

Appendices

Appendix I: Acronym List

- ACE: Adverse Childhood Experience

- ASAM: American Society of Addiction Medicine

- BHIN: Behavioral Health Information Notice

- BIPOC: Black, Indigenous and People of Color

- CalAIM: California Advancing and Innovating Medi-Cal

- CANS: Child and Adolescent Needs and Strengths

- CMS: Centers for Medicare & Medicaid Services

- CPT: Current Procedural Terminology

- DHCS: Department of Health Care Services

- DMC: Drug Medi-Cal

- DMC-ODS: Drug Medi-Cal Organized Delivery System

- DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

- EPSDT: Early & Periodic Screening, Diagnosis and Treatment

- HCPCS: Healthcare Common Procedure Coding System

- HIPAA: Health Insurance Portability and Accountability Act

- ICD-10: International Classification of Diseases, Tenth Revision

- LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and all sexual and gender minority identities

- LOC: Level of Care

- LPHA: Licensed Practitioner of the Healing Arts

- MAT: Medication for Addiction Treatment

- MCO: Managed Care Organization

- MCP: Managed Care Plan

- MHP: Mental Health Plan

- NSMHS: Non-specialty mental health services

- NTP: Narcotic Treatment Program

- PSC-35: Pediatric Symptom Checklist

- SMHS: Specialty Mental Health Services

- SUD: Substance Use Disorder

- TCM: Targeted Case Management

Appendix II: Medi-Cal Plans by Type

Medi-Cal Benefits		
System	Services	Service Definition
Mental Health Plan (MHP)	Specialty Mental Health Services (SMHS) – Carved out of overall Medi-Cal benefit within 1915b Waiver[49]	SMHS includes the following[50]: · Inpatient psychiatric services · Outpatient services, including intensive and community-based services, such as individual, family and group therapy, collateral, plan development and assessment · Rehabilitative skill building services in individual and/or group settings · Targeted Case Management · Medication Support Services · Day Treatment Intensive or Rehabilitation · Crisis Intervention and Stabilization · Adult and Crisis Residential Treatment · Intensive Care Coordination · Therapeutic Foster Care · Intensive Home-Based Services · Therapeutic Behavioral Services · Peer Support Services · Mobile Crisis Services
Managed Care Plan (MCP)	Non-Specialty Mental Health Services (NSMHS) and Physical Healthcare	NSMHS include the following: · Mental health evaluation and treatment, including individual, group and family psychotherapy · Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition · Outpatient services for purposes of monitoring drug therapy · Psychiatric consultation · Outpatient laboratory, drugs, supplies and supplements

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49 https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx

50 https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Boilerplate_2017-2022_MHP_Contract-Exhibits_A_B_and_E.pdf

Medi-Cal Benefits (cont.)		
System	**Services**	**Service Definition**
County Drug Medi-Cal Organized Delivery System (DMC-ODS)	Substance Use Treatment Continuum of Care modeled after ASAM Criteria	Continuum of Care modeled after the American Society of Addiction Medicine (ASAM) criteria[51] including: · Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5) · Outpatient (ASAM Level 1) · Intensive Outpatient (ASAM Level 2.1) · Partial Hospitalization (ASAM Level 2.5) · Residential Treatment (ASAM Levels 3.1, 3.3, 3.5) · Inpatient (ASAM Levels 3.7 and 4.0) (Medically Monitored or Medically Managed) · Narcotic Treatment Program · Withdrawal Management Services (ASAM Level 1-WM, Level 2-WM, Level 3.2-WM, Level 3.7-WM, Level 4-WM) · Medications for Addiction Treatment · Peer Support Services · Contingency Management · Recovery Services · Care Coordination · Clinician Consultation
Drug Medi-Cal (DMC)	Substance Use Treatment	Includes the following[52]: · Narcotic Treatment Programs · Outpatient drug free treatment, including medication services, treatment planning, crisis intervention, collateral, individual counseling, and group counseling. · Day Habilitative services · Perinatal residential · Naltrexone treatment

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51 ASAM LOC Criteria

52 https://govt.westlaw.com/calregs/Document/I12C91B008DA411E4A0F094BBA3CAFB62?transitionType=Default&contextData=%28sc.De-fault%29

Appendix III: ASAM Levels of Care Crosswalk[53]

ASAM Criteria - Adult Levels of Care

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to Change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/ Living Environment
Level 0.5 Early Intervention	No withdrawal risk	None or very stable	None or very stable	Willing to explore how current alcohol, tobacco, other drug or medication use and/or other high-risk behaviors may affect personal goals	Needs an understanding of skills, or skills to change, current alcohol, tobacco, or other drug or medication use patterns and/or high-risk behavior	Social support system or significant others increase the risk of personal conflict about alcohol, tobacco or other drug use
OTP – LEVEL 1 Opioid Treatment program	Physiologically dependent on opioids and requires OTP to prevent withdrawal	None or manageable with outpatient medical monitoring	None or manageable in an outpatient structured environment	Ready to change the negative effects of opioid use, but is not ready for total abstinence from illicit prescription or non-prescription drug use	At high risk of relapse or continued use without OTP and structured therapy to promote treatment progress	Recovery environment is supportive and/or the patient has skills to cope
LEVEL 1 Outpatient Services1	Not experiencing significant withdrawal, or at minimal risk of severe withdrawal. Manageable at level 1 -WM (See withdrawal management criteria)	None or very stable, or is receiving concurrent medical monitoring	None or very stable, or	Ready for recovery but needs motivating and monitoring strategies to strengthen readiness. Or needs ongoing monitoring and disease management. Or high severity in this dimension but not in other dimensions. Needs Level 1 motivational enhancement strategies	At high risk of relapse or continued use without OTP and structured therapy to promote treatment progress	Recovery environment is supportive and/or the patient has skills to cope
LEVEL 2.1 Intensive Outpatient Services	Minimal risk of severe withdrawal. Manageable at level 2-WM (See withdrawal management criteria)	None or not a distraction from treatment.	Able to maintain abstinence or control use and/	Has variable engagement in treatment, ambivalence, or lack of awareness of the substance use or mental health problems, and requires a structured program several times a week to promote progress through the stages of change	Able to maintain abstinence or control use and/	Recovery environment is supportive and/or the patient has skills to cope
LEVEL 2.5 Patient Hospitalization Services	Moderate risk of severe withdrawal. Manageable at level 2-WM (See withdrawal management criteria)	None or not sufficient to distract from treatment. Such problems are manageable at Level 2.5	Mild or moderate severity, with potential to distract from recovery, needs stabilization	Open to recovery, but needs a structured environment to maintain therapeutic gains	Understands relapse but needs structure to maintain therapeutic gains	Environment is dangerous, but recovery is achievable if Level 3.1 24-hour structure is achievable
LEVEL 3.1 Clinically Managed Low Intensity Residential Service	No withdrawal risk, or minimal or stable withdrawal. Concurrently receiving Level 1-WM (minimal) or Level 2-WM (moderate) services. (See withdrawal management criteria)	None or stable, or receiving concurrent medical monitoring	None or minimal, not distracting to recovery. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced program is required.	Open to recovery but needs a structured environment to maintain therapeutic gains.	Has little awareness and needs interventions available only at Level 3.1 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction.	Environment is dangerous and patient needs 24-hour structure to learn to cope.

53 https://www.americanhealthholding.com/Content/Pdfs/asam%20criteria.pdf

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to Change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/ Living Environment
Level 3.3 Clinically Managed Population Specific High Intensity Residential Service	At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3.2 WM. (See withdrawal management criteria)	None or stable, or receiving concurrent medical monitoring	Mild to moderate severity; needs structure to focus on recovery. Treatment should be designed to address significant cognitive deficits. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced program is required.	Has little awareness and needs interventions available at Level 3.3 to engage and stay in treatment. If there is high severity in Dimension 4 but not in any other dimension, motivation enhancement strategies should be provided in Level 1	Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences	Environment is dangerous and the patient has skills to cope outside of a highly structured 24-hour setting.
Level 3.5 Clinically Managed High Intensity Residential Service	At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3.2 WM. (See withdrawal management criteria)	None or stable, or receiving concurrent medical monitoring	Demonstrates repeated inability to control impulses, or unstable and dangerous signs/symptoms require stabilization. Other functional deficits require stabilization and a 24-hour setting to prepare for community integration and continuing care. A co-occurring enhanced setting is required for those with severe and chronic mental illness.	Has variable engagement in treatment, ambivalence, or lack of awareness of the substance use or mental health problems, and requires a structured program several times a week to promote progress through the stages of change	Intensification of addiction or mental health symptoms indicate a high likelihood or relapse or continued problems without close monitoring and support several times a week.	Recovery environment is not supportive but with structure and support and relief from the home environment, the patient can cope.
Level 3.7 Medically Monitored Intensive Inpatient Services	At high risk of withdrawal, but manageable at Level 3.7 WM and does not require the full resources of a licensed hospital. (See withdrawal management criteria)	Requires 24-hour medical monitoring but not intensive treatment	Moderate severity; needs a 24-hour structured setting. If the patient has a co-occurring mental disorder, requires concurring mental health services in a medically monitored setting	Low interest in treatment and impulsive control is poor, despite negative consequences; needs motivating strategies only safely available in a 24-hour structured setting. If there is high severity in Dimension 4, motivational enhancement strategies should be provided in Level 1.	Unable to control use, with imminently dangerous consequences, despite active participation at less intensive levels of care	Environment is dangerous, but recovery is achievable if level 3.1 24-structure is achievable
Level 4 Medically Monitored Intensive Inpatient Services	At high risk of withdrawal and requires Level 4 WM and the full resources of a licensed hospital. (See withdrawal management criteria)	Requires 24-hour medical and nursing care and the full resources of a licensed hospital	Because of severe and unstable problems, requires 24-hour psychiatric care with concomitant addiction treatment (co-occurring enhanced)	Problems in this dimension do not qualify the patient for Level 4 services. If the patient's only severity is in Dimension 4, 5, and/ or 6 without high severity in Dimensions 1, 2 and/or 3, then the patient does not qualify for Level 4.	Problems in this dimension do not qualify the patient for Level 4 services. See further explanation in Dimension 4	Problems in this dimension do not qualify the patient for Level 4 services. See further explanation in Dimension 4

ASAM Criteria
Adolescent Levels of Care

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to Change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/ Living Environment
Level 0.5 Early Intervention	No withdrawal risk	None or very stable	None or very stable. Any Dimension 3 issues are being addressed through concurrent mental health services and do not interfere with early intervention addiction treatment services.	Willingness to explore how current alcohol, tobacco, medication, other drug use, and/or high-risk behaviors may affect achievement of personal goals	Needs an understanding of, or skills to change current alcohol, tobacco, other drug or medication use patterns, and/or high-risk behaviors	Adolescent's risk of initiation of or progression in substance use and/or high-risk behaviors is increased by substance use or values about use. High-risk behaviors of family, peers, or others in adolescent's social support system
Level 1 Outpatient Services	No withdrawal risk	None or very stable, or is receiving concurrent medical services	Features one of more of the following: a) The adolescent is not at risk of harm. b) There is minimal interference. c) Minimal to mild impairment. d) The adolescent is experiencing mild to moderate difficulties with activities of daily living, but there is significant risk of deterioration. e) The adolescent is at minimal imminent risk, which predicts a need for some monitoring or interventions.	Willing to engage in treatment, and is at least contemplating change, but needs motivating and monitoring strategies	Able to maintain abstinence or control use and pursue recovery or motivational goals with minimal support	Family and environment can support recovery with limited assistance
Level 2.1 Intensive Outpatient Services	Experiencing minimal withdrawal, experiencing mild withdrawal, or is at risk of withdrawal	None are stable or distracting from treatment at a less intensive level of care. Such problems are manageable at Level 2.5	The adolescent's status in dimension 3 features one of more of the following: a) The adolescent is at low risk of harm, and he or she is safe between sessions. b) Mild interference requires the intensity of this level of care to support treatment engagement. c) Mild to moderate impairment but can sustain responsibilities. d) The adolescent is experiencing moderate difficulties with activities of daily living and requires near/daily monitoring or interventions. e) the adolescent history (combined with the present situation) predicts the need for near daily monitoring or interventions.	Requires close monitoring or support several times a week to promote progress through the stages of change because of variable treatment engagement, or no interest in getting assistance	Significant risks of relapse or continued use or continued problems and deterioration in level of functioning. Has poor prevention skills and needs monitoring or support	Adolescent environment is impeding his or her recovery, and adolescent requires close monitoring or support to overcome that barrier.

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Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to Change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/ Living Environment
Level 2.5 Partial Hospitalization Services	Experiencing mild withdrawal, or is at risk of withdrawal	None are stable or distracting from treatment at a less intensive level of carte. Such problems are manageable at Level 2.5	The adolescent's status in Dimension 3 features one of more of the following: a) The adolescent is at low risk of harm, and he or she is safe overnight. b) Moderate interference requires the intensity of this level of care to support treatment engagement. c) Moderate impairment but can sustain responsibilities d) The adolescent is experiencing moderate difficulties with activities of daily living and requires near/daily monitoring or interventions. e) The adolescent's history (combined with the present situation) predicts the need for near daily monitoring or interventions.	Requires a near daily structured programto promote progress through the stages of change because of little treatment engagement or escalating use or impairment, or no awareness of the role of alcohol, tobacco and/or other drugs play in his/her present problems	High risk of relapse or continued use, or continued problems in deterioration in level of functioning. Has minimal prevention skills and needs near daily monitoring and support	Adolescent's environment renders recovery unlikely without near/daily monitoring or support, or frequent relief from his or her home environment.
Level 3.1 Clinically Managed Low-Intensity Residential Services	The adolescent state of withdrawal (or risk of withdrawal) is being managed concurrently at another level of care	None or stable, or receiving concurrent medical monitoring as needed	The adolescent's status in Dimension 3 features one of more of the following: a) The adolescent needs a stable living environment. b) Moderate interference requiring limited 24-hour supervision to support treatment engagement c) Moderate impairment needing limited 24-hour supervision to sustain responsibilities d) Moderate difficulties with activities of daily living requiring 24-hour supervision and prompting e) The adolescent's history (combined with the present situation) predicts instability without limited f) 24-hour supervision.	Open to recovery, but needs limited 24-hour supervision to promote or sustain change	Understands the potential for continued use and/or has emerging recovery skills but needs supervision to reinforce recovery and relapse prevention skills, limited exposure to substances and/or environmental triggers or maintain therapeutic gains	Environment poses a risk to his or her recovery so that he or she requires alternative residential, secure placement or support

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to Change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/ Living Environment
Level 3.5 Clinically Managed Medium Intensity Residential Service	Adolescent is experiencing mild to moderate to severe withdrawal (or is at risk of withdrawal), but does not need pharmacological management or nursing monitoring.	None or stable, or receiving concurrent medical monitoring as needed	The adolescent's status in Dimension 3 features one of more of the following: a) Moderate but stable risk of harm b) Moderate to severe interference requiring medium-intensity residential treatment to support engagement c) Moderate to severe impairment that cannot be managed at a less intensive level of care d) Moderate to severe difficulties with activities of daily living requiring 24-hour supervision and medium-intensity staff assistance e) The adolescent's history (combined with the present situation) predicts destabilization without medium- intensity residential treatment.	The adolescent needs intensive motivating strategies in a 24-hour structured program to address minimal engagement in, or opposition to, treatment, or to address his or her lack of recognition of current severe impairment	High risk or relapse or continued use, or continued problems and deterioration in level of functioning. Has minimal prevention skills and needs near daily monitoring and support	Environment is dangerous to his or her recovery, so that he or she requires residential treatment to promote recovery goals, or for protection
Level 3.7 Clinically Managed Population Specific High Intensity Residential Service	Adolescent is experiencing moderate to severe withdrawal (or is at risk of withdrawal), but this is manageable at Level 3.7.	Requires a 24-hour medical monitoring, but not intensive treatment	The adolescent's status in Dimension 3 features one of more of the following: a) Moderate risk of harm, needing high-intensity 24-hour monitoring or treatment b) Severe interference requiring high-intensity residential treatment to support engagement c) Severe impairment that cannot be managed at a less intensive level of care d) Severe difficulties with activities of daily living requiring 24-hour supervision and high-intensity staff assistance e) The adolescent's history (combined with the present situation) predicts destabilization without high-intensity residential treatment.	The adolescent needs motivating strategies in a 24-hour medically monitored program due to no treatment engagement associated with a biomedical, emotional or behavioral condition, or because he or she actively opposes treatment, requiring secure placement remain safe; or because he or she needs high-intensity case management to create linkages that would support outpatient treatment. (because of an emotional, behavioral, or cognitive condition; severe impulse control problems; withdrawal symptoms; and the like)	Unable to interrupt high-severity or high-frequency pattern of use/ or behaviors and avoid dangerous consequences without high-intensity 24-hour interventions. Environment is dangerous to his or her recovery, and he or she requires residential treatment to promote recovery goals, or for protection, and to help him or her establish a successful transition to a less intensive level of care	Environment is dangerous to his or her recovery, and he or she requires residential treatment to promote recovery goals, or for protection, and to help him or her establish a successful transition to a less intensive level of care.

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to Change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/ Living Environment
Level 4 Monitored Intensive Inpatient Services	Adolescent is experiencing severe withdrawal (or is at risk of withdrawal) and requires intensive active medical management.	Requires 24-hour medical and nursing care and the full resources of a licensed hospital	The adolescent's status in Dimension 3 features one of more of the following: a) The adolescent is at severe risk of harm. b) Very severe, almost overwhelming interference renders the adolescent incapable of participating in treatment at a less intensive level of care. c) Very severe, dangerous impairment requiring frequent medical and nursing interventions d) Very severe difficulties with activities of daily living requiring frequent medical and nursing interventions e) The adolescent's history (combined with the present situation) predicts destabilization without medical management.	Problems in this dimension do not qualify the patient for Level 4 services. If the patient's only severity is in Dimension 4, 5, and /or 6 without high severity in Dimensions 1, 2 and/or 3, then the patient does not quality for Level 4.	Problems in this dimension do not qualify the patient for Level 4 services. If the patient's only severity is in Dimension 4, 5, and /or 6 without high severity in Dimensions 1, 2 and/or 3, then the patient does not quality for Level 4.	Problems in this dimension do not qualify the patient for Level 4 services. If the patient's only severity is in Dimension 4, 5, and /or 6 without high severity in Dimensions 1, 2 and/or 3, then the patient does not quality for Level 4.

Appendix IV: DHCS Priority SDOH Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.4	Educational maladjustment and discord with teachers and classmates*
Z55.5	Less than a high school diploma*
Z56.0	Unemployment*
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)
Z62.21	Child in welfare custody*
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
Z64.0	Problems related to unwanted pregnancy*
Z65.1	Imprisonment and other incarceration

Z65.2	Problems related to release from prison
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

*Indicates CalMHSA recommended SDOH Z-code

Appendix V: Sample Progress Note Narratives

Assessment Session

Dave was referred to the clinic by the emergency department due to a swollen abdomen (enlarged liver) and symptoms of severe nausea, fatigue, and diarrhea. Dave reported interest in services because he believes that he needs to reduce his alcohol consumption or he will die, as his father had at a young age. He has experienced some withdrawal symptoms in the past and reported being very concerned with this.

A biopsychosocial assessment was completed with clinical data entered into the ASAM six dimensions. An analysis of the six dimensions, as well as a cross-dimensional analysis, suggested highest scores in the area of Withdrawal and Biomedical although Environment was also a concern. A consideration of immediate needs and imminent danger suggest a need for withdrawal management Level 3.2. As Dave is unwilling to leave the area for residential treatment, we discussed a withdrawal management Level 2 program for a clinically monitored detox with high intensity outpatient services including attendance of 1) motivational enhancement services; 2) medications for addiction treatment (MAT); 3) individual and family therapy. Dave reported that he did not want to participate in any 12-step program but that he was concerned enough regarding his health to further develop a plan with these components.

Individual Therapy Session

Client continues to report challenges with managing cravings and triggers. We explored coping strategies to manage these situations more effectively in therapy session. Cognitive-behavioral techniques were introduced to help client identify and challenge negative thought patterns associated with substance use. We discussed the importance of creating a relapse prevention plan, which includes identifying high-risk situations and developing alternative ways to cope with stress and social pressure. Plan will be to focus on addressing triggers and exploring underlying emotional factors contributing to substance use disorder.

Care Coordination

Contact was made to Alice's Probation Officer Williams. He confirmed that Alice's last two drug screens had been random and were positive for both alcohol and marijuana. PO Williams expressed concern that Alice was not taking treatment seriously and was in danger of being remanded to Juvenile Hall if a third test is positive. PO Williams also conveyed that he has been in contact with Alice's mother, and has found her cooperative, and wanting to help Alice in any way she can. Will meet with Alice and her mom to explore a potential support role.

Group Rehabilitation Session

Group facilitators began with an open discussion about the role of coping mechanisms in recovery and prompted each participant about what coping mechanisms they've utilized in the past week to manage cravings. As part of the session, each participant was encouraged to set and share their realistic short-term and long-term goals for their recovery. Hugo actively participated in the group session, sharing that his participating in the contingency management program has acted as a coping mechanism for him by helping him to remain drug free for the past 10 days despite intense cravings. He stated that "It's nice to be rewarded for clean tests and it's helping me stay motivated to not cave into cravings. I'd like to continue it for another 2 weeks until I move into sober living house."

Perinatal Group Therapy Session

Therapist provided psychoeducation on the effects of substance use on infant development and shared evidence-based parenting strategies, like nurturing touch, positive reinforcement, and consistent routines. Therapist engaged group in discussion of underlying beliefs associated with trying new parenting strategies and normalized feelings shared by group members. Carly shared that she felt "burnt out" when learning about new parenting strategies because she often feels like a failure and cares a lot about wanting to improve her parenting skill base. Group members brainstormed ways to provide each other with positive reinforcement and creating consistent routines. Group members plan to commit to at least one contact during the next week and report back to the group.

Appendix VI: Scope of Practice Matrix

DMC-ODS Services					
	Counselors	LPHA	Medical Director of a NTP	Peer Support Specialist	Other
Assessment	Yes	Yes*			
Care Coordination**	Yes	Yes			
Crisis Intervention	Yes	Yes			
Family Therapy		Yes			
Counseling (Individual & Group)	Yes	Yes			
Medical Psychotherapy			Yes		
Medication Services	Yes	Yes			
Patient Education	Yes	Yes			
Peer Support Services				Yes*	
Contingency management	Yes	Yes		Yes	Yes
Observation	Yes	Yes***			
Recovery Services	Yes	Yes			

*Under the direct supervision of a Behavioral Health Professional.
**Certified counselors may assist with some aspects of this service; however, a licensed provider is responsible for this service component.
***All personnel performing observations must comply with applicable California State withdrawal management training requirements.

Counselor: An AOD counselor that is 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies, and 2) meets all California State education, training, and work experience requirements set forth in the Counselor Certification Regulations, Title 9, Division 4, Chapter 8.

LPHA: A LPHA includes any of the following: Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, and Licensed Marriage and Family Therapist, and licensed-eligible practitioner registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician. To be considered "license-eligible," the individual must be registered with the appropriate state licensing authority for their respective field. Interns who have not yet received their advanced degree within their specific field and/or have not registered with the appropriate state board are not considered LPHAs.

Medical director of a Narcotic Treatment Program: The medical director of a NTP is a licensed physician in the State of California.
Peer Support Specialist: A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet all other applicable California state requirements, including ongoing education requirements. Peer Support Specialists provide services under the direction of a Behavioral Health Professional. For additional guidance, please refer to BHIN 21-041.

Other: Trained staff under supervision of an LPHA. This new staffing category is specific to the contingency management pilot, referred to as the Recovery Incentives Program. This would not change existing staffing requirements for other DMC-ODS services, which may only be provided by LPHAs, registered or certified counselors, or certified peers under the new, optional peer provider type and benefit noted above.

Appendix VII: Commonly Used Service Codes

The table below identifies commonly used service codes and the disciplines allowed to bill each code. This list of codes is not comprehensive. DMC State Plan counties use fewer service codes than DMC-ODS counties. Service codes that are unique to DMC-ODS counties are marked with an asterisk (*); the codes without an asterisk apply to both DMC-ODS and DMC State Plan counties. Every county's implementation of service codes in their electronic health record (EHR) is different. For example, some EHRs use the code description set by the Centers for Medicare and Medicaid Services (CMS), whereas others use simplified code descriptions. For additional information on service codes, please refer to the CalMHSA CPT for Direct Service Providers LMS Training here.

Assessment		
Code	CMS Code Description	Allowable Discipline
G0396	Alcohol And/Or Substance (Other Than Tobacco) Abuse Structured Assessment. 15-30 Minutes (Note: Use Codes G2011, G0396 And G0397 To Determine the ASAM Criteria).	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD, *Pharm (DMC-ODS only)
G0397	Alcohol And/Or Substance (Other Than Tobacco) Abuse Structured Assessment. 30+ Minutes (Note: Use Codes G2011, G0396 And G0397 To Determine the ASAM Criteria).	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD, *Pharm (DMC-ODS only)
G2011	Alcohol And/Or Drug Testing, Abuse Structured Assessment. 5-14 Minutes. (Note: Use Codes G2011, G0396, And G0397 To Determine ASAM Criteria)	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD, *Pharm (DMC-ODS only
H0001	Alcohol And/Or Drug Assessment (Screening To Determine Appropriate Services)	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD, Pharm
H0003	Alcohol And/Or Drug Screening Laboratory Analysis	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD, *Pharm (DMC-ODS only)
H0049	Alcohol And/Or Drug Screening	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD, Pharm
90791	Psychiatric Diagnostic Evaluation, 15 Minutes	MD/DO, PA, Psy, RN, NP, Pharm
90885	Psychiatric Evaluation Of Hospital Records, Other Psychiatric Reports, Psychometric And/Or Projective Tests, And Other Accumulated Data For Medical Diagnostic Purposes, 15 Minutes	MD/DO, PA, Psy, LCSW, MFT, NP, LPCC
96130	Psychological Testing Evaluation, First Hour	MD/DO, PA, Psy, LCSW, MFT, NP, LPCC
Crisis Intervention		
Code	CMS Code Description	Allowable Discipline
H0007	SUD Crisis Intervention	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC (DMC only), AOD
Mobile Crisis		
Code	CMS Code Description	Allowable Discipline
H2011	Mobile Crisis	N/A

Care Coordination		
Code	CMS Code Description	Allowable Discipline
H1000 *	Prenatal Care, At Risk Assessment	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD, Pharm
T1017 *	Targeted Case Management, 15 Minutes	MD/DO, PA, Pharm, Psy, LCSW, MFT, RN, NP, LPCC, AOD
90889 *	Preparation Of Report Of Patient's Psychiatric Status, History, Treatment, Or Progress (Other Than For Legal or Consultative Purpose) For Other Individuals, Agencies, Or Insurance Carries	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC
96160 *	Administration Of Patient-Focused Health Risk Assessment Instrument	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC
99368 *	Medical Team Conference With Interdisciplinary Team of Health Care Professionals, Participation By Non-Physician. Patient And/Or Family Not Present. 30 Minutes Or More	PA, Pharm, Psy, LCSW, MFT, RN, NP, LPCC
Discharge Services		
Code	CMS Code Description	Allowable Discipline
T1007	Alcohol And/Or Substance Abuse Services, Treatment Plan Development And/Or Modification	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD
Group Counseling		
Code	CMS Code Description	Allowable Discipline
H0005	Alcohol And/Or Drug Services; Group Counseling By A Clinician	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD
Family Therapy		
Code	CMS Code Description	Allowable Discipline
90846 *	Family Psychotherapy (Conjoint Psychotherapy Without the Patient Present), 50 Minutes	MD/DO, PA, Psy, LCSW, MFT, NP, LPCC
90847 *	Family Psychotherapy (Conjoint Psychotherapy With Patient Present), 50 Minutes	MD/DO, PA, Psy, LCSW, MFT, NP, LPCC
90849 *	Multiple-family Group Psychotherapy, 15 Minutes	MD/DO, PA, Psy, LCSW, MFT, NP, LPCC

Recovery Services		
Code	CMS Code Description	Allowable Discipline
H0008 *	Alcohol And/Or Drug Services (Hospital Inpatient) Subacute Detoxification	MD/DO, PA, NP, RN, Pharm
H0009 *	Alcohol And/Or Drug Services (Hospital Inpatient) Acute Detoxification	MD/DO, PA, NP, RN, Pharm
H2015 (For DMC, listed under Treatment Planning)	Comprehensive Community Support Services, Per 15 Minutes	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD
H2017 *	Psychosocial Rehabilitation, Per 15 Minutes	MD/DO, PA, Psy, Pharm, LCSW, MFT, RN, NP, LPCC, AOD
H2035 *	Alcohol And/Or Other Drug Treatment Program, Per Hour	MD/DO, PA, Psy, Pharm, LCSW, MFT, RN, NP, LPCC, AOD
Treatment Planning		
Code	CMS Code Description	Allowable Discipline
H2014	Skills Training And Development, Per 15 Minutes. (Use This Code To Submit Claims For Patient Education Services)	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD
H2015 (For DMC-ODS, listed under Recovery Services)	Comprehensive Community Support Services, Per 15 Minutes	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD
H2021	Community- Based Wrap-around Services, Per 15 Minutes	MD/DO, PA, Pharm, Psy, LCSW, MFT, RN, NP, LPCC, AOD
H2027	Psychoeducational Service, Per 15 Minutes	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD
Individual Counseling		
Code	CMS Code Description	Allowable Discipline
H0004	Behavioral Health Counseling And Therapy, 15 Minutes	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD
H0050 *	Alcohol And/Or Drug Services, Brief Intervention	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD, Pharm, Peers
T1006	Alcohol And/Or Substance Abuse Services, Family/Couple Counseling	MD/DO, Psy, PA, LCSW, MFT, RN, NP, LPCC, AOD
Supplemental Services		
Code	CMS Code Description	Allowable Discipline
96170	Health Behavior Intervention, Family (Without the Patient Present), Face-to-face. 16-30 Minutes	MD/DO, PA, Psy, LCSW, MFT, RN, NP, LPCC

Appendix VIII: Documentation Guide Change Log

Section	Change Description	Revision Date
Introduction to this Guide	Edits to grammar and clarified language	7/1/2023
Health Care Systems	Edits to grammar and clarified language	7/1/23
Medi-Cal Programs	Edits to grammar, clarified and updated language specific to DMC, DMC-ODS, and MCPs	7/1/23
Screening Tools	Removed content about mental health screening processes, added information about options for Z-codes and unspecified diagnoses.	7/1/2023
Assessment	Clarified requirements for using ASAM criteria to determine level of care placement and information about abbreviated ASAM screenings for WM levels of care.	7/1/2023
Diagnosis	Clarified language and removed language about the requirement for Medical Director or LPHA to sign a diagnosis narrative document.	7/1/2023
Problem List	Clarified guidance about use of ICD-10 codes, added information about SNOMED codes in problem lists; clarified information about Treatment Plan Requirements and updated Example of a Problem List.	7/1/2023
Care Coordination	Removed information about the transition of care tool, clarified that care coordination as a service is specific to DMC-ODS, edits to language about care coordination as a clinical concept.	7/1/2023
Treatment	Removed information about Stages of Change and Motivational Interviewing, added general information about the function of treatment in behavioral health; added definitions for treatment services.	7/1/2023
Co-occurring Treatment	Added language about co-occurring treatment and information about No Wrong Door;	7/1/2023
Progress Notes	Clarified that NTP programs continue to adhere to federal requirements, clarified language about the need to separate travel and documentation time from total service time.	7/1/2023
Appendices	Updated Appendix I, II, IV, V; added VI and VII	7/1/2023
Diagnosis	Added DMC-ODS signature requirements for diagnosis narrative documentation	6/24/2022
Co-occurring treatment	Clarified language around co-occurring treatment and services during assessment	6/21/2022
Assessment	Clarified language around assessment updates	6/21/2022
Problem List	Updated Example Problem List header titles and provider types	6/21/2022
Care Coordination	Added information on federal care coordination requirements	6/21/2022
Progress Note Timeliness	Clarified language around audit disallowances	6/21/2022
Appendix	Updated Appendix I: Acronym List	6/21/2022
Multiple	Updated use of person-centered language; fixed typos / formatting issues	6/21/2022
--	Removed former Appendix III: Sample Progress Note Treatment Plan Template	6/21/2022
--	Removed former Appendix IV: DMC-ODS Staff Services Categories/ Definitions	6/21/2022

| Access | Clarified services need "not" be curative for persons under age 21 | 6/03/2022 |

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