Alameda County Behavioral Health
Mental Health & Substance Use Services

Substance Use Disorder (SUD) Documentation Training Opioid Treatment Providers

July 30, 2019

9am to 4:30pm

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Agenda

Today's Topics of Discussion
Overview of Training / Recommended Workflows
Informing Materials and Clinical Intake and Assessment(s)
ASAM Level of Care (ALOC) and Medical Necessity
Client Plans
Case Management and Progress Notes
Discharge Plan, Discharge Summary and Wrap-Up

Break Schedule

Approximate Time	Break Schedule
10:00 to 10:10 am	Break #1
11:00 to 11:10 am	Break #2
12:00 to 12:30 pm	Lunch
1:30 to 1:40 pm	Break #3
2:40 to 2:50 pm	Break #4

Introductions

- What agency/program are you with?
- What is your role/professional credential?
- What is one question you have about OTP documentation you would like answered today?

ACBH Audit Info & SUD Claims

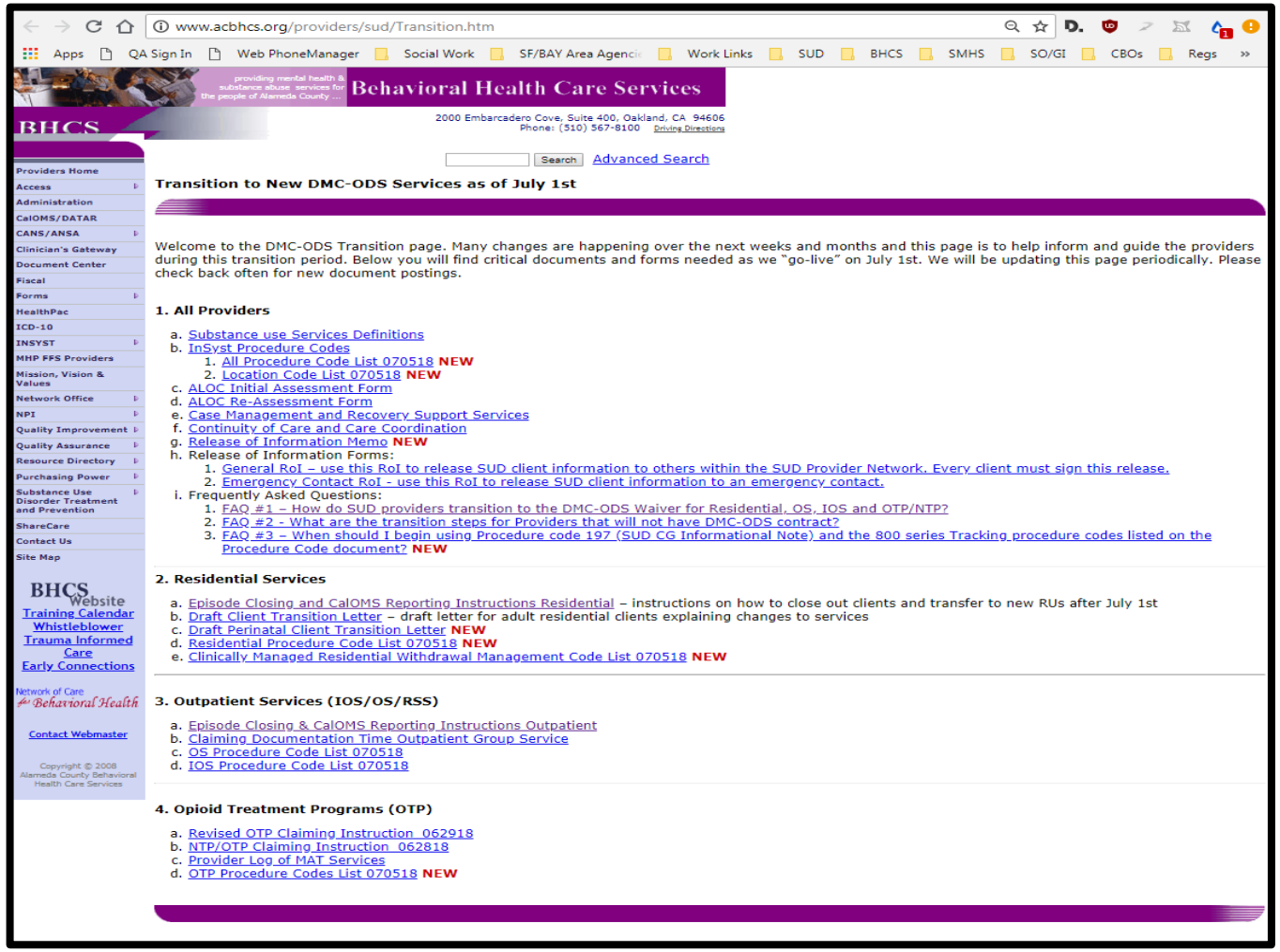
- CY 2018-2019 SUD SOC Audit is currently underway. Results will be forthcoming.
- Disallowances associated with fraud, waste, and abuse may result in recoupment of service amounts

Technical Assistance Feedback

- DHCS and other entities are conducting technical assistance and monitoring independent of ACBH
  - Please let Sharon know if DHCS or another agency contacts your agency to conduct a review
  - This will assist us in providing accurate, consistent technical assistance to all of our providers

ACBH SUD DMC-ODS Transition Website

http://www.ACBH.org/providers/sud/Transition.htm

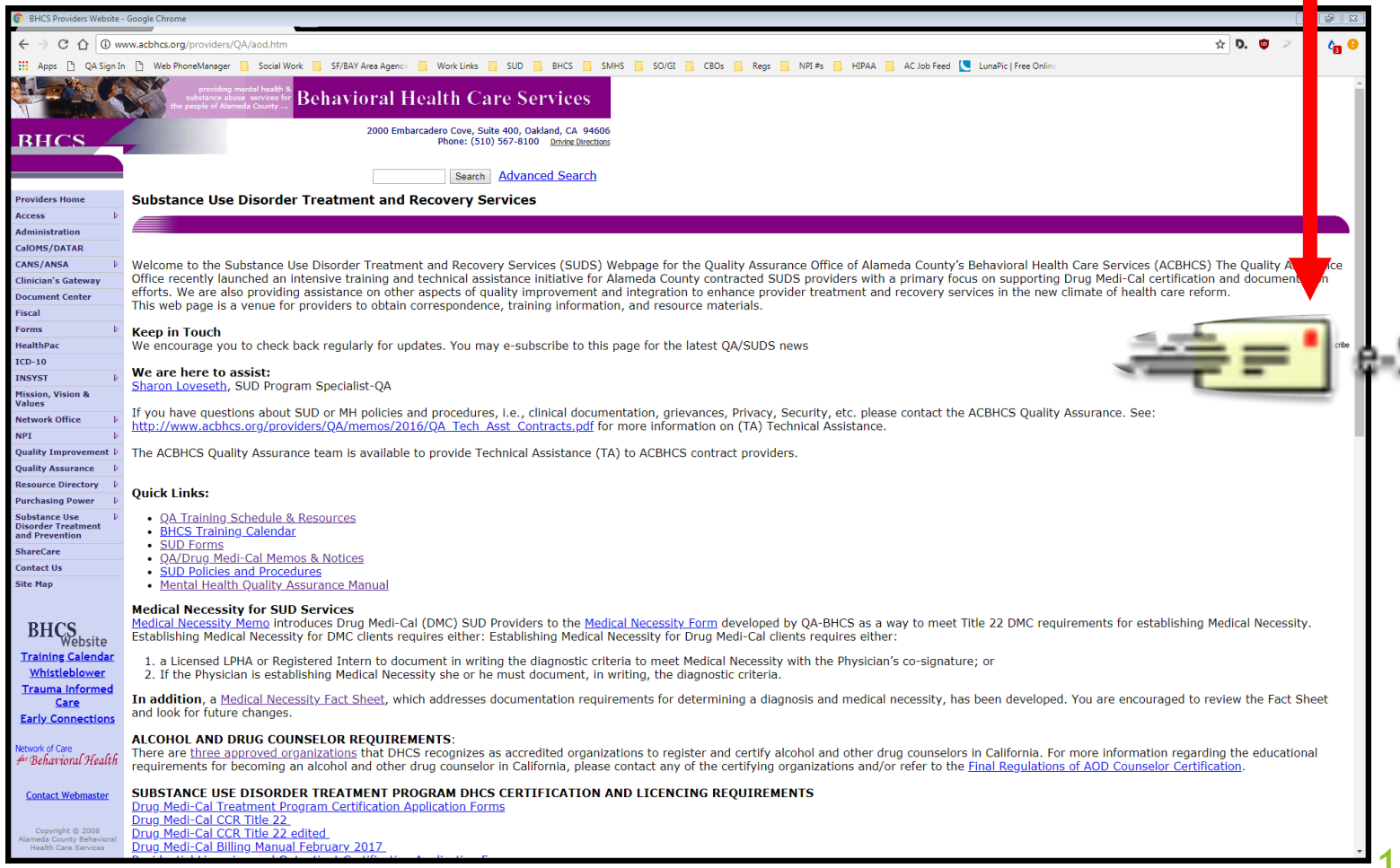


FYI

ACBH SUD QA Webpage

http://www.ACBH.org/providers/QA/aod.htm

To subscribe to ACBH email lists, click on this icon



Who is this training for?

- All Alameda County subcontracted Opioid Treatment Programs
  - Both in and out of county
- ACBH staff

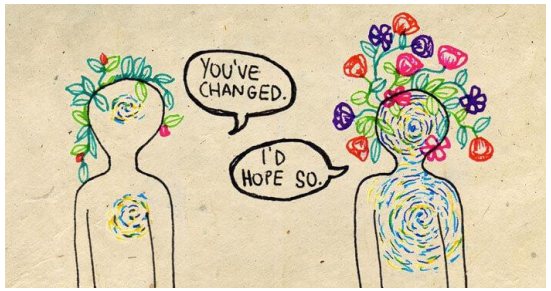
Please alert trainer if you are not employed at one of these entities

Some things to keep in mind…

- Regardless of program certification standards or contract, all subcontracted SUD providers will be audited to ACBH QA clinical documentation standards
- ACBH may have additional standards not specified in associated regulations
- All days indicated in this training are to be considered calendar days, unless specifically noted otherwise

The Changing State of SUD Services in CA

- With the implementation of the DMC-ODS, delivery of substance use treatment services in California and Alameda County are changing
- The way all SUD services operate, including service delivery, is also changing. It is changing for the state, the counties, the providers, and our clients
- For us to make this new system work, we all need to collaboratively work together and be open to change and the growth of our system



Alameda County SUD System Overview

What is the DMC-ODS Waiver?

- The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care.
- This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs.

updated 7/30/19

CALIFORNIA DEPARTMENT OF Health Care Services

Applicable Regulations and Standards Covered in this Training (others may apply)

- DMC-ODS Intergovernmental Agreement (Exhibit A, Attachment I)
- Centers For Medicare & Medicaid Services, Special Terms and Conditions
  - Note: Refer to pages 96-127 and 376-407 for the DMC-ODS system. (Updated June 7, 2018)
- Title 9 CCR, Ch. 4 and 42 CFR Part 8 - MAT for Opioid Use Disorders
- Health & Safety Code, Division 10.5, Part 2, Chapter 10
- Alameda County Behavioral Health Plan / ACBH QA Clinical Doc Standards
  - ACBH SUD DMC-ODS RFP
  - ACBH SUD DMC-ODS Implementation Plan
  - Individual provider contracts
- 42 CFR, Part 2, HIPAA (PUBLIC LAW 104-191), HITECH
- SAMHSA Block Grant Funds (SABG, SAPT)
- SAMHSA Guidelines
- Controlled Substances Act
- DATA 2000
- Additional regulations may apply

The IA, STCs, Title 22, and Title 9

- By implementing the DMC-ODS Waiver, SUD services from 7/1/18 are regulated by the DMC-ODS Intergovernmental Agreement and the CMS Special Terms and Conditions. Title 22 § 51341.1 is no longer applicable in DMC-ODS counties.
- Other regulations still apply and the higher standard must be followed
- Additional requirements may be indicated in ACBH SUD RFP Specifications, ACBH SUD DMC-ODS Implementation Plan, and individual contracts.

DHCS has stated that the broad standards outlined in the IA are intended as a minimum standard of care. Counties have been told encouraged and are expected to set higher standards of care depending on specific county needs. In all areas, SUD Providers must follow the ACBH Guidelines described herein.

AOD Certification / License Standards

- DHCS Alcohol and/or Other Drug Program Certification Standards updated 5/2017:

  http://www.dhcs.ca.gov/provgovpart/Documents/DHCS_AOD_Certification_Standards_5_._30_._17.pdf
- All residential programs, including WM 3.2, are required to have AOD Certification Standard License
- At this time, OTPs and outpatient SUD providers are not required to have an AOD Certification or License
  - Regardless, if an agency has an active AOD Certification / License, then that agency is required to follow those standards (if different or higher)
- ACBH will be requesting evidence of AOD Certification / License at the time of audits

Early Intervention Services
(ASAM Level 0.5) – contracted out services (not ODS claiming-a separate contract is required)

- Services include: screenings, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage.
- Individuals, other than at-risk youth, refer to other prevention services in the community.
- Some types of Early Intervention Services include: Educational programs for DUI, Employee Assistance Programs, community based services, Transition to Treatment, primary prevention service providers
- Bridge to Treatment - For adolescents at risk of developing a substance use disorder or those with an existing substance use disorder.
- Transition to Treatment – For adults (and their families) experiencing problems related to substance use and who need treatment services but have not yet engaged in those services
- Early Interventions Services must be specified in your contract in order to be claimed

Outpatient Services (OS)
(ASAM Level 1.0) – Outpatient contracts

Outpatient treatment services using recovery or motivational enhancement therapies and strategies. ASAM Level 1 encompasses organized services that may be delivered in a wide variety of settings. A detailed description begins on page 184 of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (2013)*

- Adults = Up to 9 hours of medically necessary services
- Adolescents = Less than 6 hours of medically necessary services
- Not limited to DMC certified sites (e.g. special population contracts – older adults, youth prevention)
- Services can be provided in-person, by telephone, by telehealth (except group), and in any appropriate setting in the community

Opioid Treatment Programs (OTPs)
ASAM Level OTP 1

- Under DMC-ODS OTPs are required to have methadone, buprenorphine, disulfiram, naloxone available.
  - Note that licensed OTPs may prescribe other non-controlled medications approved by the FDA for MAT (e.g. Naltrexone and Acamprosate)
  - Medications approved by the FDA in the future would also be allowed to be utilized by OTPs
- Services include methadone dosing, buprenorphine dosing, disulfiram dosing, and naloxone dispensing along with counseling services to beneficiaries diagnosed with an Opioid Use Disorder
- At least 50 minutes of counseling services must be provided each calendar month
- OTP services may only be provided in OTP-licensed settings
- When included in the provider contract, Case Management Services may also be provided

Health and Safety Code Section 11839.2
9 CCR, Ch. 4

Opioid Treatment Programs (OTPs)
ASAM Level OTP 1

Citizens of Alameda County have access to a comprehensive range of opioid specific treatment services:

Medi-Cal / DMC Clients

- *Short-term Detoxification Treatment*: 1 to 21 day detoxification
- *Long Term Detoxification Treatment*: 21 to 180 day detoxification
- *Maintenance Treatment*: 21+ days for maintenance treatment purposes

Non-Medi-Cal Clients

- Non-DMC Opioid Treatment Services

9 CCR, Ch. 4
ACBH OTP Contracts
ADP Bulletin 05-11

Opioid Treatment Programs (OTPs)
Detoxification Treatment

- In *Detoxification Treatment*, patients are provided with gradually reduced doses of narcotic replacement medication to prevent withdrawal symptoms. Detoxification is generally short-term, twenty-one (21) days, or long-term, up to 180 days.
- During detoxification treatment, a patient receives a narcotic replacement medication in decreasing dosages to ease adverse physical and psychological effects caused by withdrawal from the long-term use of an opiate.
- The goal of *Detoxification Treatment* is to reduce or eliminate opiate addiction
- Counseling and Case Management Services may be provided during the detoxification episode
- Clients with two or more unsuccessful detoxification episodes within a 12-month period must be assessed by the OTP physician for other forms of treatment. A program cannot admit a client for more than two detoxification treatment episodes in one year → Providers may request a DHCS exception

42 CFR § 8.2
42 CFR § 8.12.e.4
ADP Bulletin 05-11

Opioid Treatment Programs (OTPs)
Maintenance Treatment

Maintenance Treatment: This phase of treatment provides narcotic replacement medication to patients in sustained, stable, medically determined doses:

- The purpose is to reduce or eliminate chronic illicit opiate addiction, while the patient is provided a comprehensive range of additional treatment services
- Once the client is stabilized on a satisfactory dosage, it is often possible to address his/her other chronic medical and psychiatric conditions
- Client dose is determined by the treating OTP physician

42 CFR § 8.2
DHCS OTP FAQs

Opioid Treatment Programs (OTPs)
ASAM Level OTP 1

Non-Medi-Cal Clients

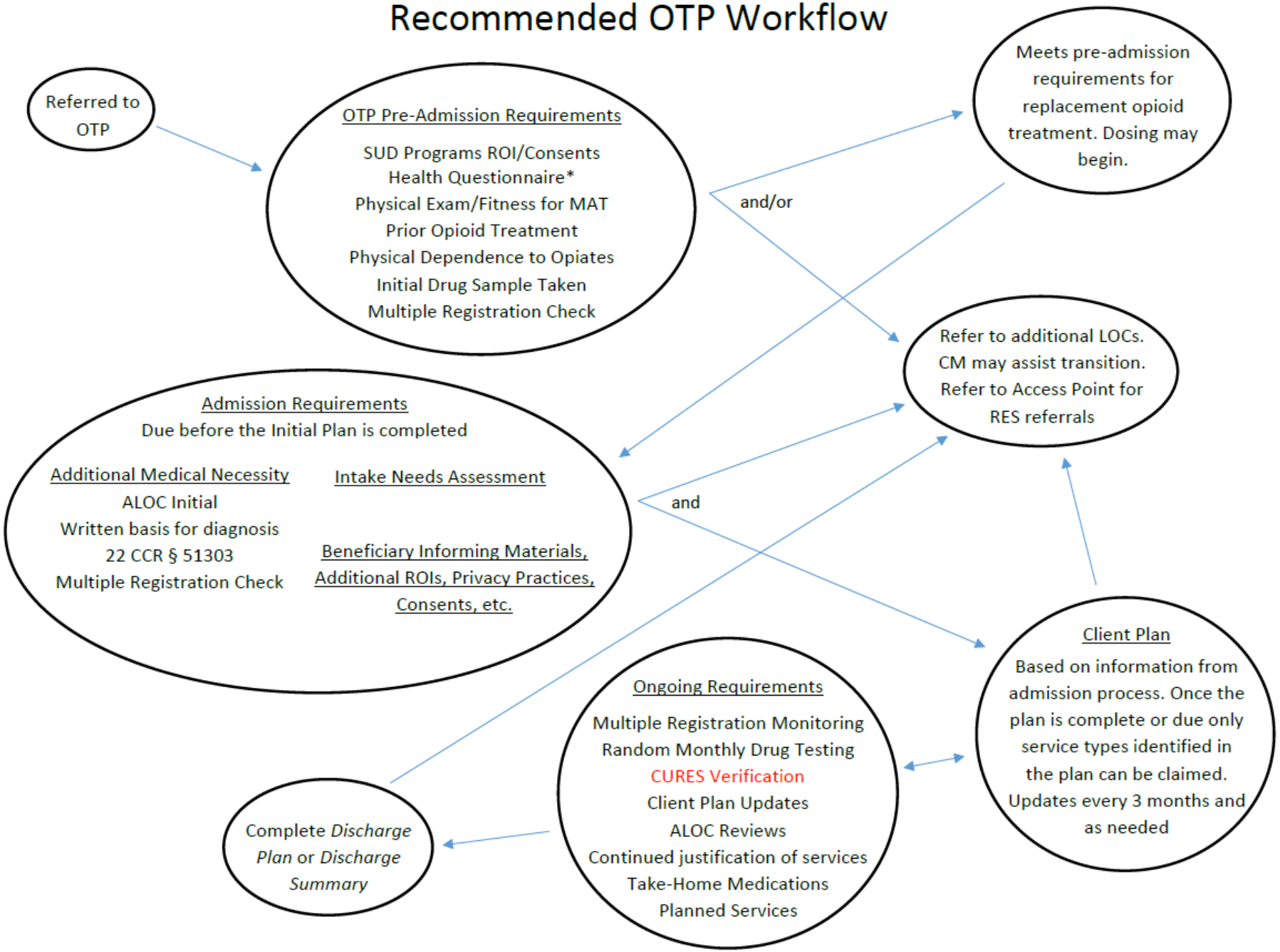
- Non-DMC Opioid Treatment Services
  - Determined by contract. More information to follow.
- Currently these are the OTP Detoxification RUs, these names may be changing

9 CCR, Ch. 4
ACBH OTP Contracts

What are the differences between OTP MAT services and non-OTP MAT services?

- OTP MAT services include methadone dosing, buprenorphine dosing, disulfiram dosing, and naloxone dispensing, along with counseling services
  - Methadone may only be dispensed at a licensed OTP
- Non-OTP MAT services are known as “Additional MAT” and must be indicated in providers’ contract
  - Additional MAT includes medication management – which reimburses the MD for medication management services and prescribing. Prescriptions are filled by a pharmacy and reimbursed through a beneficiary’s Medi-Cal pharmacy benefit

Recommended OTP Workflow



Intensive Outpatient Services (IOS)
ASAM Level 2.1

ASAM Level 2.1 encompasses services that are capable of meeting the complex needs of people with addiction and co-occurring conditions. It is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening, and/or on weekends. A detailed description begins on page 198 of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (2013)*

- Adults = min. of 9 hours, max. of 19 hours per week of medically necessary services
- Adolescents = min. of 6 hours, max. of 19 hours per week of medically necessary services

More than 19 hours per week may be provided when medically necessary. LPHA must document clinical reasoning in the chart and the client plan must be updated to reflect the need for expanded IOS hours. In these cases, if ALOC indicates a higher level of care, then the ALOC and/or progress noted must describe the clinical reason why the beneficiary is receiving services at a lower level of care.

Services can be provided in-person, by telephone, by telehealth (except group), and in any appropriate setting in the community.

updated 7/30/19

IA.III.P
IA.V.H.1.i

Components of OS/IOS Services
Allowable Services

- Intake/Assessment
- Treatment Planning
- Individual and Group Counseling
- Patient Education (Ind. or Group)
- Family Therapy (LPHAs only)
- Medication Services
  - (Medical Providers MD, DO, NP, PA ONLY)
  - More information available later in the presentation
- Case Management
- Physician Consultation
- Collateral Services
- Crisis intervention services
- Discharge planning and coordination

updated 7/30/19

Recovery Support Services (RSS)

- Only may be provided at OS or IOS providers
- Beneficiary is expected to be in remission and have a SUD remission diagnosis
- Are available after the beneficiary has completed a course of treatment and is in remission.
- Recovery Support Services emphasize the client's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to clients.
- Current RSS documentation follows stated standards for OS
- ACBH is currently updating RSS standards

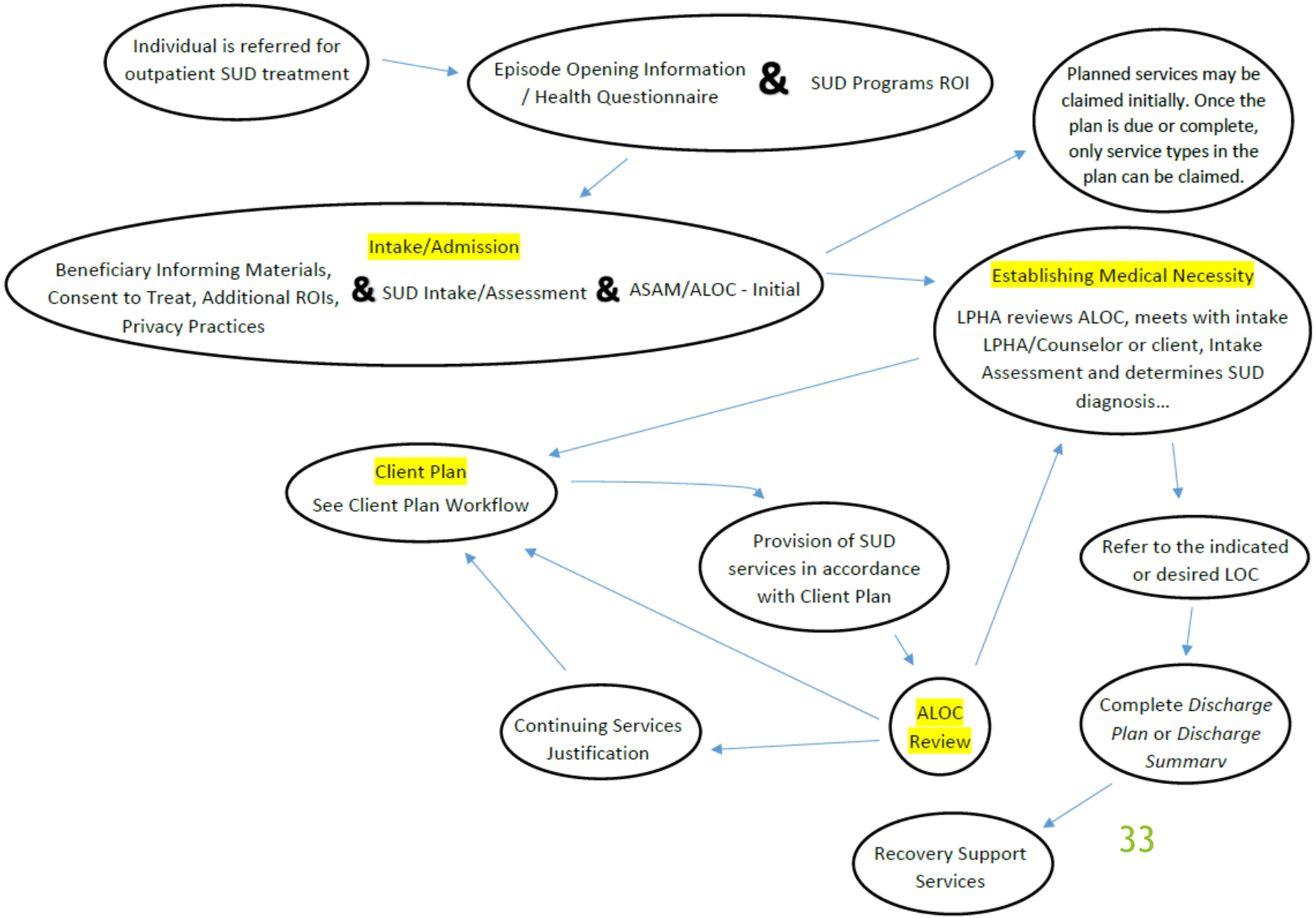
Components of Recovery Support Services

- Individual and group counseling, assessment, treatment planning, and:
- Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
- Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
- Family Support: Linkages to childcare, parent education, child development support services, family/marriage education.
- Support Groups: Linkages to self-help and support, spiritual and faith-based support.
- Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

Recovery Support Services Requirements

- Providers must attempt one (1) contact every 30 days unless LPHA clinically justifies reduced contact (in-person, telephone, or telehealth). Document this contact or attempt in the medical record.
- Medical Necessity shall be reassessed between 5-6 months from RSS episode opening date (EOD) or most recent Medical Necessity. The beneficiary must meet criteria for medical necessity to qualify for continuing services.
- Services may be delivered by an approved certified Peer Specialist (for substance abuse assistance services only) or SUD Counselor / LPHA
- Peers may not be concurrently receiving and providing SAA RSS

Recommended OS/IOS/RSS Workflow



Level 3.2-WM - Clinically Managed Residential Withdrawal Management - Currently Cherry Hill

- Services delivered by appropriately trained staff, who provide 24 –hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal.
- WM 3.2 is characterized by its emphasis on peer and social support rather than medical and nursing care. This level provides care for clients whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support.
- Individuals enter Withdrawal Management Services (Cherry Hill Detox) through the Sobering Center and may stay very briefly or as long as a few days.
- During the first 24-48 hours at Cherry Hill Detox, a assessment is completed addressing the six ASAM dimensions, and a withdrawal management plan is developed with the client. The plan addresses both withdrawal management considerations, and case management interventions for pre-discharge planning. Clients tend to stay in withdrawal management for an average of 4 days.
- Upon discharge, when determined by the ALOC, clients should be referred to an appropriate LOC within the SUD system of care

Withdrawal Management
Components of Services

- **Intake/Treatment Planning:** The process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- **Observation/Monitoring:** The process of monitoring the beneficiary's course of withdrawal. To be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.
- **Medication Services:** The prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.
- **Case Management/Care Coordination:** See CM slides.
- **Physician Consultation:** Physician consultation between agency MD and ACBH approved addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. Must be claimed separately in order to be reimbursed.
- **Discharge/Transition Services:** The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

Cherry Hill Workflow

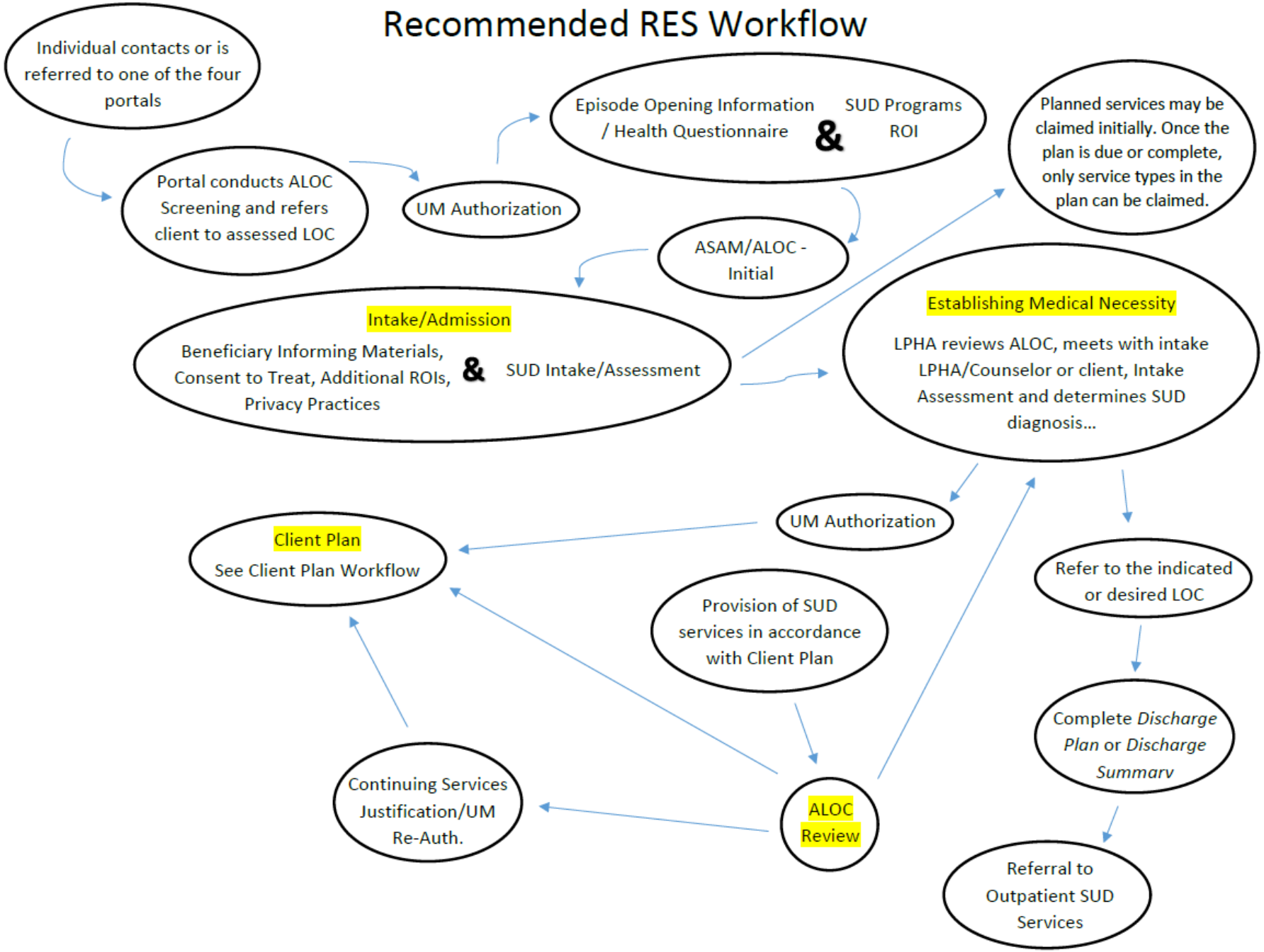
Residential Services

- Open to all populations per contract
- Based on assessed ASAM Level of Care (ALOC)
- There are limitations on length of stay
- Prior authorization required
  - Referral from portal
  - UM must authorize within 24 hours from admission, and then ongoing
- 24-hour structure
- 7 days a week

Referrals to Residential

- Beneficiaries must be referred to a residential facility through one of the SUD access points
  - CenterPoint aka Call Center → (844) 682-7215
  - CenterPoint AB109 Criminal Justice Case Management Program
  - Cherry Hill
  - Drug Court
- The ASAM Level of Care (ALOC) screening is completed at one of the portals and referral information securely sent to the referred provider
- Access points may also refer to other levels of care, depending on LOC determination

Recommended RES Workflow



updated 7/30/19

Recovery Residences

- Are abstinence-based, peer supported housing with concurrent Alameda County SUD outpatient treatment
- Based on recommended CCAAP Recovery Residence models
- Short-term housing (6 month maximum) based on ACBH criteria
- Beneficiaries must be actively participating in OS/IOS/RSS treatment in order to be eligible for Recovery Residence services
- Beneficiaries receiving OTP services must also be actively participating in OS/IOS/RSS treatment services to be RR eligible

Medical Record Requirements

Charting Requirements Individual Client Record

- Each client must have an individual record that meets 42 CFR, Part 2 Final Rule, HIPAA, & HITECH requirements → whichever is stricter
- NO other client identifying information is allowed in another client's record
  - In past audits, services were disallowed because they contained multiple client PHI information, often in the form of combined group notes or group sign-in sheets
  - As a result, the medical record was not considered unique
  - References to other clients should happen only when absolutely necessary and done anonymously (e.g. "another client")
    - Never use other clients' initials, names, nicknames, etc.

Content of Client Records 1

- A unique identifier (e.g. name, client number, InSyst ID)
- Date of admission and other admission data

- Personal Information:
  - Date of birth
  - Telephone number (or indicate “none”)
  - Gender identity/expression
  - Address (or indicate “homeless”)
  - Preferred name
  - Other pertinent personal information
  - Assigned gender at birth
  - Preferred pronoun
  - Race, cultural, and/or ethnic information
  - Next of kin or emergency contact (with ROI)
  - Sexual orientation

IA.III.PP.9
9 CCR § 10165

Content of Client Records 2

- All treatment records also must include documentation of sessions, services, and treatment provided, as well as progress notes signed by the physician, nurse, or counselor, test or analysis results for illicit drug use.
- Documentation of services and treatment provided includes, but is not limited to, such documentation as:
  - Informing Materials/Consent signature page
  - ASAMs
  - Assessments
  - Medical necessity documents
  - Treatment plans
  - Progress/Counseling notes
  - Continuing services justifications
  - Discharge plan/summary
  - Prior addiction and treatment failure
  - ROIs and ROI tracker Log
  - Physical examinations
  - Laboratory test orders and results
  - Referrals
  - Reasons for med. changes
  - CQRT and authorization forms
  - Any other information relating to the treatment services rendered to the beneficiary

9 CCR § 10165
IA.III.PP.9

Content of Client Records 3
Additional Requirements for OTPs

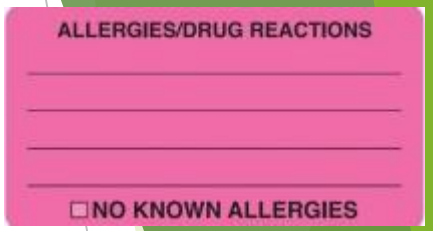
- Program's response to a test or analysis for illicit drug use which disclose the absence of both methadone and its primary metabolite (when prescribed by the medical director and program physician)
- Documentation of approval or denial of any granted exceptions to required practices
- Documentation of the reasons for changes in medications and dosage levels, when applicable
- Documentation that the beneficiary received a copy of the program rules and instructions prior to admission
- CURES verifications (Effective 10/2/18)

9 CCR § 10165
9 CCR § 10170

ACBH Medical Record Retention Policy

- Providers must maintain client records following discharge/termination with the following considerations:
  - For all clients, records (paper and electronic) must be maintained for a minimum of: 10 years after the last service OR 10 years after their 18 birthday, whichever is later.
  - Records must be retained until audit findings are resolved, potentially longer than 10 years from the last date of service
  - Records must also be retained until DHCS/ACBH finalizes cost settlement for the year in which the last service occurred
  - All records must be maintained through the end of the MHP contract in place 10 years from the date of the last service
- Also, consider that different disciplines have different record retention requirements and providers must adhere to the strictest standard
- For these reasons ACBH recommends providers maintain all records for at least 15 years from the last date of service, or the client's 18th birthday, whichever is later.
- Many hospitals and other medical services store records indefinitely

Emergency Contact and Allergy Information



- Emergency contact and allergy information must be posted in a prominent location in the medical that is easily located during an emergency situation
- Allergy Information Requirements:
  - Many providers use allergy stickers on the front of the chart
  - If no allergies indicate, No Known Allergies or NKA
- Emergency Contact Information Requirements:
  - It's impossible to predict an emergency situation so it's best to get emergency contact information at the beginning of treatment and then update periodically
  - Also have beneficiary sign an ROI for the contact and update this when the contact changes
  - InSyst must be updated with the current Emergency Contact information (see slides at the end of this presentation for instructions)

SUD Personnel

OTP Licensing Requirements

- All OTP Programs operating in the State of California must be licensed by the California Department of Health Care Services (DHCS).
- Medication Units are required to additionally have approval from the FDA
- All OTP programs must renew their DHCS Narcotic Treatment Programs operating license annually. In order to complete the license renewal process the Alameda County AOD Administrator is required to complete and submit a Certification of Need for Continued Services and a recommendation of license renewal.
  - A renewal application must be submitted to ACBH AOD Administrator and DHCS advance of license expiration as this process can take up to 3 months once all of the required elements are submitted to DHCS. It is imperative that OTP providers submit these documents in a timely manner as no services may be provided on an inactive license; regardless of when application documents were submitted. Note that DHCS assesses license fees in order to complete the license application and renewal process, applications without the required fee will be terminated.
- Additional licenses, accreditation may be required (COA, CARF, Joint Commission, DEA, NCQA, URAC, ACHC, etc.)

9 CCR § 10055, 9 CCR § 10020, 9 CCR § 10010, Licensing Requirements

OTP Certification/Accreditation

- OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body to dispense opioid treatment medications
- All OTPs also must be licensed by the state in which they operate and must register with the Drug Enforcement Administration (DEA), through a local DEA office
- Once an OTP is certified, its certification must be renewed annually or every three years depending on the accreditation type
- Accreditation is a peer-review process that evaluates an OTP against SAMHSA's opioid treatment standards and the accreditation standards of SAMHSA-approved accrediting bodies. → CARF and Joint Commission

SUD Agency Responsibilities

- Ensure that staff know and follow ALL applicable regulations
- Employ qualified staff and ensure staff work within their scope of practice!
- Develop and document procedures for admission
- Ensure medical necessity is documented in beneficiary records
- Complete a personal, medical, and substance use history upon admission
- Ensure that identified challenges are addressed in treatment plan and progress notes
- Complete discharge summary/plan upon discharge
- OTP Treatment MUST be provided under the direction of a Licensed Physician

Requirements for SUD Medical Director

- Physicians must be licensed by the *Medical Board of California* or the *Osteopathic Medical Board of California*
  - Must not be excluded from participation in any State or Federal Medicare or Medicaid program
  - Must be enrolled in Medi-Cal as a substance use disorder medical director
  - Must be acting in compliance with all laws and requirements of the Medi-Cal program

22 CCR § 51000.24.4,
22 CCR § 51000.70

SUD Medical Director Responsibilities 1

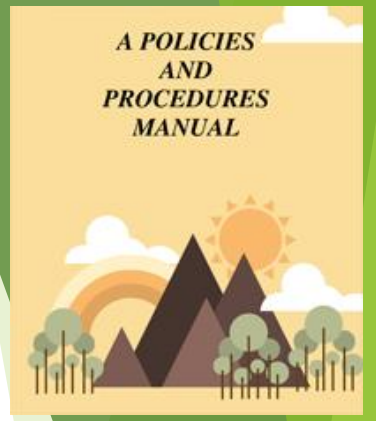
- Each program must have a medical director who is a licensed physician in the State of California. The medical director may also serve as the program director. The medical director shall assume the medical responsibility for all program clients by:
  - Documenting their services and signing their notes
  - Placing clients in treatment
  - Initiating, altering and terminating replacement narcotic therapy medications and dosage amounts
  - Supervising the administration and dispensing of medications
  - Planning and supervising provision of treatment including regular review and notes in the clients' records
- Other duties and responsibilities of the medical director shall be set forth in the protocol.
- The medical director may delegate duties as prescribed in the program protocol to another licensed program physician(s) but may not delegate his/her responsibility in above to physician extenders.

9 CCR § 10110

SUD Medical Director Responsibilities 2

- The substance use disorder medical director may delegate their responsibilities to a physician consistent with the provider's medical policies and standards; however, the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed.
- Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care
- Ensure that physicians do not delegate their duties to non- physician personnel
- Develop and implement medical policies and standards for the provider. MD P&P must be signed by the current Medical Director.
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
- Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries
- Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section

SUD Medical Policy and Standards 1
AKA Program Protocol



- Is written document which sets forth a program's treatment concept, organization, and operational procedures and approved by DHCS
- The Medical Director is required to develop program and/or agency policy and procedures
- These are common policies and procedures to guide on-site medical and related requirements. → Must be updated as necessary
- The content of the P&P is a combination required elements and elements as determined by the Medical Director
- Much of the content will be specific application of the regulations to the agency
- Current Medical Director signature must be present on the P&P

IA.III.PP.5.i,
9 CCR § 10110
9 CCR § 10175

SUD Medical Policy and Standards 2
AKA Program Protocol

- <u>Some</u> required elements include:
  - Medication Protocols, Plan for evaluating effectiveness of the program, Program administration, medical director duties/delegation of duties (physicians, physician extenders), caseload Information, multiple registration policies, program rules, emergency/disaster plan, client Identification, admission criteria, body specimen collection requirements, dosing policies, take home privileges policies, discharge/termination policies, fair hearing policies.
- Additional sections recommended by DHCS for inclusion are:
  - Disease prevention, on-site injury response, on-site injury prevention, medication dosing procedures, emergency protocols, OD procedure, medical emergency procedure, infectious disease protocols (e.g. TB, lice, MRSA, scabies, etc), requirements for physical exam, procedure for when the client is under the influence, and more…

9 CCR, Ch. 4
IA.III.PP.5.i

Staff Personnel Records
Requirements

- Opioid Treatment Programs employ a range of staff, each with distinct and overlapping responsibilities. These slides provide an overview of providers, their roles, and responsibilities. Agencies must maintain personnel records for all staff that includes at least the following information:
  - Name, address, telephone number, position, duties, and date of employment
  - Resumes, applications, and/or transcripts documenting work experience and/or education used to meet the requirements of regulations
  - When applicable, copies of licensure, certification, or registration to obtain certification for all staff who provide treatment services (including medical staff who administer medications) covering the duration of employment
  - Staff who provide counseling services must also include a copy of the code of conduct of the registrant's or certified AOD counselor's certifying organization

9 CCR § 10125.d
9 CCR § 13005

Physicians

- A program physician may delegate his/her duties under this subchapter to other appropriately licensed personnel who are members of the program staff.
- The nature and extent of such delegation of duties shall be set forth in the protocol
- Practitioners who administer and dispense approved Schedule II controlled substances (that is, methadone) for maintenance and detoxification treatment must obtain a DEA registration
- Other certifications, licenses, waivers may apply and must be followed
- Physicians at OTPs are not required to apply for a buprenorphine waiver (DATA 2000), but the OTP must be SAMHSA-certified. They also are not subject to patient limits as physicians.

9 CCR § 10115,
9 CCR § 10120,
DATA 2000,
SAMHSA Guidelines

Physician Extenders

- The term “physician extender” refers to registered nurse practitioners and physicians' assistants only
- The protocol shall contain documentation satisfactory to the Department verifying that:
  - Nurse practitioners are used as physician extenders in compliance with the licensing and scope of practice requirements listed in article 8 (commencing with section 2834), chapter 6, division 2, of the Business and Professions Code and corresponding regulations adopted by the Board of Registered Nurses, and
  - Physicians' assistants are used as physician extenders in compliance with the licensing and scope of practice requirements listed in chapter 7.7 (commencing with section 3500), division 2, of the Business and Professions Code and corresponding regulations adopted by the Medical Board of California.

Other Medical Staff
May work under physician surgeon supervision

- Registered Nurses
- Licensed Vocational Nurses
- Pharmacists
- Psychiatric Technician

Must work within their scope of practice and in accordance with regulations

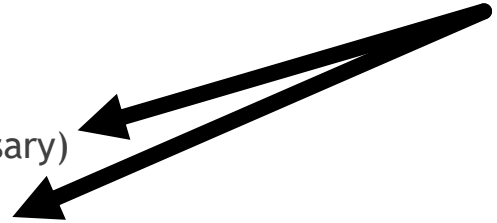
Licensed Practitioners of the Healing Arts (LPHAs)

LPHAs include:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Registered Nurses
- Registered Pharmacists (May not diagnose or conduct MSE as it is not within their scope of practice)
- Licensed Clinical Psychologists
- Licensed Clinical Social Worker
- Licensed Professional Clinical Counselor
- Licensed Marriage and Family Therapists
- License Eligible Practitioners (Registered/Waivered) working under the supervision of licensed clinicians
  - Co-signatures required by licensed LPHA on diagnoses

SUD Counselor/LPHA Responsibilities

- Each client must be assigned to a counselor
- Assessment (Intake and ongoing as medically necessary)
- ASAM/ALOC (LPHAs and Certified Counselors only)
- Collaborating with the client to develop Initial & Updated Treatment Plans
- Facilitating Individual & Group Counseling Sessions
- Completing and Monitoring Sign-In Sheets
- Providing Crisis Intervention Services
- Providing Collateral Services
- Documenting Services in Progress Notes
- Providing Case Management Services
- Discharge Planning



LPHA and Certified Counselors may conduct these

Registered Counselors with appropriate training and experience may complete Intake/Assessment and ALOCs. (See additional slides for specific training and experience requirements.)

Also, see co-signature requirements for Intake/Assessment for all SUD Counselors.

IA.III.PP.9.ii,
9 CCR § 10125

SUD Counselors
Code of Conduct Requirements

Program staff that provide counseling services are required to have a signed copy of their certifying organization's Code of Conduct in their personnel file. At a minimum, that Code of Conduct must prohibit counselors from:

- Providing counseling services, attending any program services or activities, or being present on program premises while under the influence of any amount of alcohol or illicit drugs. Drugs or medications prescribed by a physician or other person authorized to prescribe drugs, and over-the-counter medications, used in the dosage and frequency indicated, are exempt from this prohibition.
- Providing services beyond the scope of their license, registration, or certification
- Discriminating against program participants, clients, residents, or other staff members, based on race, religion, age, gender, disability, national ancestry, sexual orientation, or economic condition;
- Engaging in social or business relationships for personal gain with program participants, clients, or residents, their family members or other persons who are significant to them;
- Engaging in sexual conduct with current participants, clients, residents, their family members, or other persons who are significant to them;
- Verbally, physically, or sexually harassing, threatening, or abusing any participant, client, resident, their family members, other persons who are significant to them, or other staff members.

9 CCR § 13060

SUD Counselor Certification Organizations

SUD Counselors are required to have an active certification or registration with a DHCS approved Counselor Certification Organization when providing the service. DHCS maintains a website of the current accepted Certification Organizations:

https://www.dhcs.ca.gov/provgovpart/Pages/CounselorCertificationOrganizations.aspx

As of this training these are:

California Association of DUI Treatment Programs (CADTP)
http://www.cadtp.org/
Email: info@cadtp.org

California Consortium of Addiction Programs and Professionals (CCAPP)
https://www.ccapp.us/
Email: office@ccapp.us

California Association for Drug/Alcohol Educators (CAADE) (Must be after 3/11/19)
https://dev.caade.org/
Email: office@accbc.org

updated 7/30/19

Training Requirements

- All LPHAs, including the SUD Medical Director, must receive a minimum of five (5) hours of continuing education related to addiction medicine each year
- All staff who provide ANY treatment services must keep up with their respective board or credentialing requirements and have an active credential at the time the service is provided. Any service provided by a staff without an active credential at the time of the service is not a valid service. This includes claiming and non-claiming related treatment activities.
- Registered and certified SUD counselors must adhere to all requirements in CCR Title 9, Chapter 8
- For ASAM, at a minimum all e-modules or equivalent in-person ASAM trainings are required
- Each contracted agency must have at least one representative attend every ACBH QA training

IA.III.A.1.iv,
IA.III.GG.3.ii
9 CCR § 10105

Temporary Exceptions to OTP Regulations

Temporary Exceptions to OTP Regulations 1

DHCS may grant temporary exceptions to Title 9, Ch. 4 requirements if it determines that such action is justified and would improve treatment services or afford greater protections to the health, safety or welfare of clients, the community, or the general public. No exception may be granted if it is contrary to or less stringent than the federal laws and regulations which govern narcotic treatment programs.

Temporary Exceptions to OTP Regulations 2

Exceptions are subject to all of the following requirements:

- Such exceptions shall be limited to program licensees operating in compliance with applicable laws and regulations
- Requests for exceptions shall be formally submitted in writing to DHCS
- Exceptions are limited to a one-year period unless an extension is formally granted by DHCS
- No exception may be granted until DHCS has requested and evaluated a recommendation from the applicable County Drug Program Administrator and all applicable fees have been received
- The program applicant shall comply with all Departmental requirements for maintaining appropriate records or otherwise documenting and reporting activity
- The formal approval by DHCS must contain an accurate description of the exception(s) granted and the terms and conditions to be observed by the licensee
- Exception(s) shall be voided if the licensee fails to maintain compliance with this section or other applicable laws and regulations that govern narcotic treatment programs

Temporary Exceptions to OTP Regulations 3

The content of this training is based on the codified regulations, specific agency and individual client requirements may differ

- Providers are required to provide proof of all exceptions at the time of audits or other monitoring activities

There are several types of exceptions to Opioid Treatment Regulations:

- Statewide exceptions
- Countywide exceptions
- Agency level exceptions
- Individual client exceptions (keep DHCS exception documents in the client's record)

According to DHCS exception requests must be submitted to DHCS and SAMHSA via the SAMHSA/CSAT Opioid Treatment Program Extranet

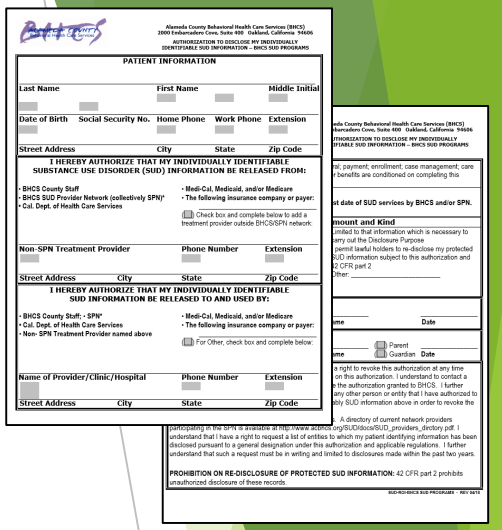
- https://otp-extranet.samhsa.gov/login.aspx?ReturnUrl=%2f

OTP Admission Process

Pre-Admission requirements (before the first dose)

ACBH SUD Programs ROI

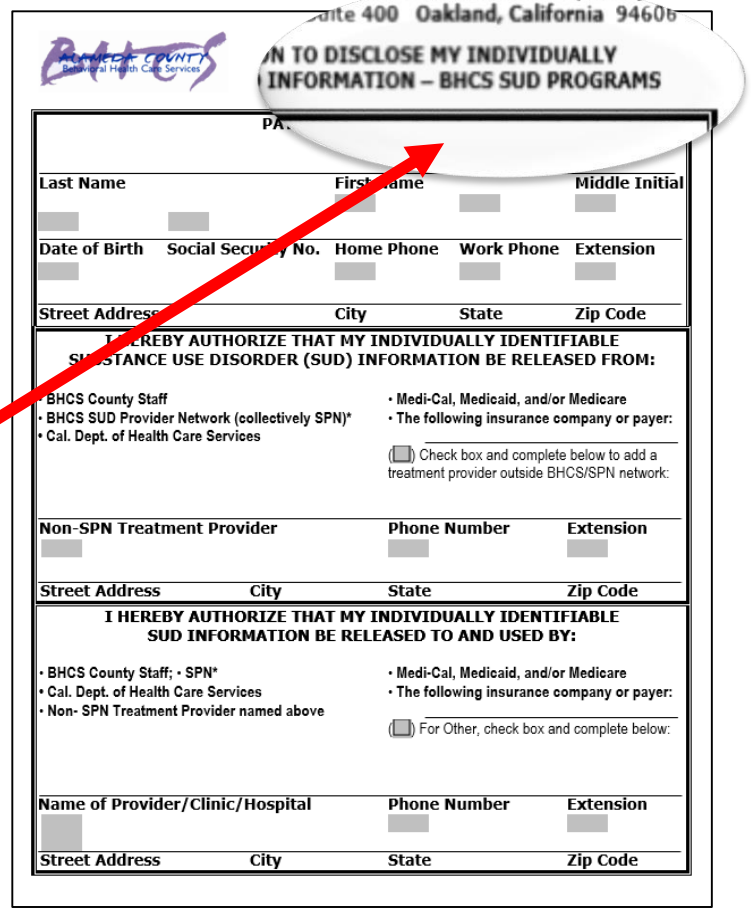
All open clients must have this signed


Alameda County Behavioral Health Care Services (BHCS)
2000 Embarcadero Cove, Suite 400 Oakland, California 94606
AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS
PATIENT INFORMATION
Last Name First Name Middle Initial
Date of Birth Social Security No. Home Phone Work Phone Extension
Street Address City State Zip Code
I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:
• BHCS County Staff
• BHCS SUD Provider Network (collectively SPN)*
• Cal. Dept. of Health Care Services
• Medi-Cal, Medicaid, and/or Medicare
• The following insurance company or payor:
Check box and complete below to add a treatment provider outside BHCS/SPN network:
Non-SPN Treatment Provider Phone Number Extension
Street Address City State Zip Code
I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY:
• BHCS County Staff: - SPN*
• Cal. Dept. of Health Care Services
• Non- SPN Treatment Provider named above
• Medi-Cal, Medicaid, and/or Medicare
• The following insurance company or payor:
For Other, check box and complete below:
Name of Provider/Clinic/Hospital Phone Number Extension
Street Address City State Zip Code
PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR part 2 prohibits unauthorized disclosure of these records

- ACBH SUD Programs ROI is required for all ACBH contracted SUD providers and must be signed prior to entering any information into Clinician's Gateway/InSyst and releasing any information to the ACBH SUD Provider Network (SPN).
- When the beneficiary signs the ACBH SUD Programs ROI, this allows communication between ACBH contracted SUD programs (collectively the SPN)
  - Regardless best practice remains to discuss and have client sign a specific ROI whenever releasing information outside of your agency
  - Use the ACBH SUD Provider Directory to determine which agencies are covered by the ACBH SUD Programs release:
    - http://www.ACBH.org/SUD/docs/SUD_providers_dirctory.pdf
- If the beneficiary declines to sign the required SUD Programs ROI, DO NOT OPEN EPISODE IN INSYST or CG. Indicate on ROI and consult with ACBH immediately.

ACBH SUD Program ROI Screenshot

SUD Programs ROI is required on day one before any beneficiary information may be inputted in to Clinician's Gateway and InSyst



N TO DISCLOSE MY INDIVIDUALLY
INFORMATION – BHCS SUD PROGRAMS

Last Name | First Name | Middle Initial

Date of Birth | Social Security No. | Home Phone | Work Phone | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

- BHCS County Staff
- BHCS SUD Provider Network (collectively SPN)*
- Cal. Dept. of Health Care Services
- Medi-Cal, Medicaid, and/or Medicare
- The following insurance company or payer:

☐ Check box and complete below to add a treatment provider outside BHCS/SPN network:

Non-SPN Treatment Provider | Phone Number | Extension

Street Address | City | State | Zip Code

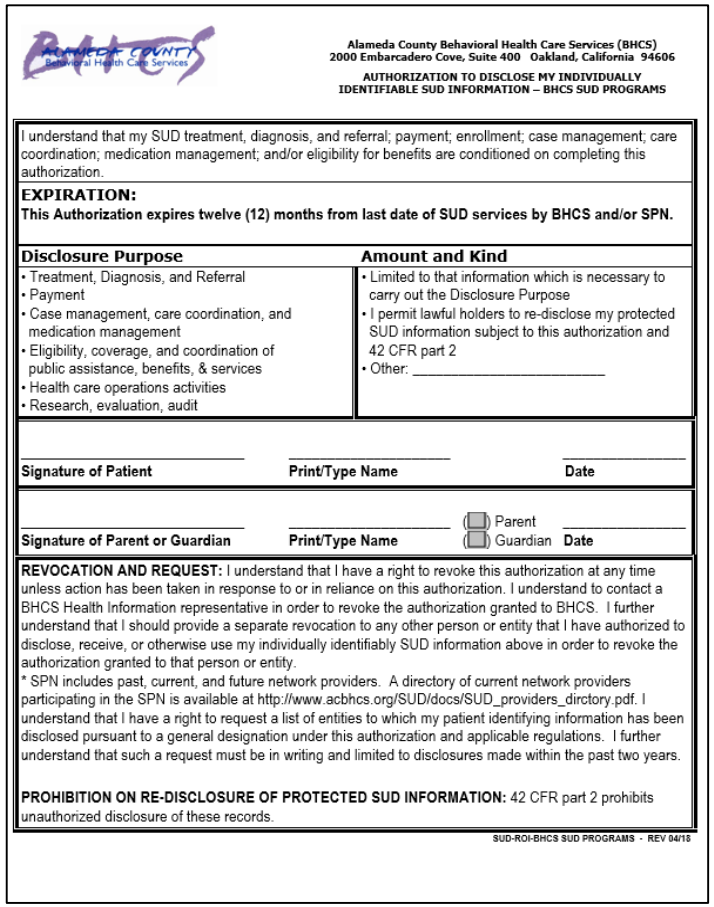
I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY:

- BHCS County Staff; • SPN*
- Cal. Dept. of Health Care Services
- Non- SPN Treatment Provider named above
- Medi-Cal, Medicaid, and/or Medicare
- The following insurance company or payer:

☐ For Other, check box and complete below:

Name of Provider/Clinic/Hospital | Phone Number | Extension

Street Address | City | State | Zip Code



Alameda County Behavioral Health Care Services (BHCS)
2000 Embarcadero Cove, Suite 400 Oakland, California 94606

AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS

I understand that my SUD treatment, diagnosis, and referral; payment; enrollment; case management; care coordination; medication management; and/or eligibility for benefits are conditioned on completing this authorization.

EXPIRATION:
This Authorization expires twelve (12) months from last date of SUD services by BHCS and/or SPN.

Disclosure Purpose	Amount and Kind
• Treatment, Diagnosis, and Referral • Payment • Case management, care coordination, and medication management • Eligibility, coverage, and coordination of public assistance, benefits, & services • Health care operations activities • Research, evaluation, audit	• Limited to that information which is necessary to carry out the Disclosure Purpose • I permit lawful holders to re-disclose my protected SUD information subject to this authorization and 42 CFR part 2 • Other: _____

Signature of Patient | Print/Type Name | Date

Signature of Parent or Guardian | Print/Type Name | ☐ Parent ☐ Guardian | Date

REVOCATION AND REQUEST: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand to contact a BHCS Health Information representative in order to revoke the authorization granted to BHCS. I further understand that I should provide a separate revocation to any other person or entity that I have authorized to disclose, receive, or otherwise use my individually identifiably SUD information above in order to revoke the authorization granted to that person or entity.
* SPN includes past, current, and future network providers. A directory of current network providers participating in the SPN is available at http://www.acbhcs.org/SUD/docs/SUD_providers_dirctory.pdf. I understand that I have a right to request a list of entities to which my patient identifying information has been disclosed pursuant to a general designation under this authorization and applicable regulations. I further understand that such a request must be in writing and limited to disclosures made within the past two years.

PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR part 2 prohibits unauthorized disclosure of these records.

SUD-ROI-BHCS SUD PROGRAMS - REV 04/18

OTP Admission/Client Selection
Admission Components

Admission to opioid treatment consists of four core elements:

1. Determination of physical fitness to receive medication
2. Determination of physical addiction/dependence to opiates
3. Informed consent for medication assisted SUD treatment
4. Prevention of multiple registrations

Dosing may not occur until the client is admitted to treatment

OTP Admission/Client Selection
1. Determination of Physical Fitness

While helpful for pain management, opioid use can have devastating side effects and are highly addictive substances. Both opioids and the medications used for treating them are powerful substances. Also, for a variety of reasons, individuals who are physically dependent on opioids, can have significant physical health related concerns. Moreover, some individuals who are addicted to opioids use other medications and street drugs. All of these factors need to be assessed and taken into consideration before a practitioner can prescribe MAT.

As a result, the regulations require that, prior to admission, a medical evaluation containing at a minimum the following components must be completed:

- A medical history which includes the applicant's history of illicit drug use
- Laboratory tests for determination of narcotic drug use, tuberculosis, and syphilis
- A physical examination (See physical examination slide for specific requirements)

9 CCR § 10270.a

OTP Admission/Client Selection
Physical Examination Requirements

The physical examination must at a minimum contain:

- An evaluation of the applicant's organ systems for possibility of infectious diseases; pulmonary, liver, or cardiac abnormalities; and dermatologic sequelae of addiction
- A record of the applicant's vital signs (temperature, pulse, blood pressure, and respiratory rate)
- An examination of the applicant's head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin, and general appearance
- An assessment of the applicant's neurological system
- A record of an overall impression which identifies any medical condition or health problem for which treatment is warranted

When a physical examination, completed in the prior 12 months, indicates a beneficiary has a significant medical illness, the client plan must include a goal that the beneficiary obtain appropriate treatment for the illness

9 CCR § 10270
IA.III.PP.12.i.a.i.9

OTP Admission/Client Selection

2. Determination of physical addiction/dependence to opiates

- Observed signs of physical dependence, must be clearly and specifically noted in the client's record
- Some of the common withdrawal effects associated with stopping the use of opioids include:
  - Physical and psychological cravings
  - Nausea
  - Stomach/Abdominal pain
  - Cold sweat / Sweating
  - Chills
  - Vomiting
  - Diarrhea
  - Dilated pupils
  - Runny nose
  - Agitation
  - Anxiety
  - Muscle tension
  - Shaking or quivering
  - Trouble sleeping
  - Enlarged pupils
  - Pain in the bones
  - Goose bumps
  - Yawning
  - Increased tearing

OTP Admission/Client Selection
Pain Management

Individuals cannot be referred to OTPs for pain management, even if the patient is physically dependent on the pain medication. The prospective client's medical doctor may continue to prescribe narcotic medication for the treatment of pain. However, if treatment is for narcotic addiction, then the patient must be referred to an OTP. The key issue is whether the doctor referred the patient to the OTP because of pain or because of an addiction.

US Dept. of Justice and DEA,
Narcotic Treatment Programs Best Practice Guidelines

OTP Admission/Client Selection
Which staff can determine admission to OTP?

- Medical Director
- Physician
- Physician's Assistant
- Nurse Practitioner

} Also known as *Physician Extenders*

Before admitting a client to treatment, the medical director must document the required elements of client selection in the medical record.

If a physician's assistant or nurse practitioner completes the medical evaluation and other requirements of admission, the medical director must also document their review and concurrence in the client's medical record.

OTP Admission/Client Selection
Maintenance Admission Requirements 1

- Confirmed documented history of at least two years of addiction to opiates
  - With prior DHCS approval, the program may make an exception to this requirement only if the program physician determines, based on their medical training and expertise, that withholding treatment constitutes a life- or health-endangering situation
- Confirmed history of two or more unsuccessful attempts in withdrawal treatment with subsequent relapse to illicit opiate use
- State regulations do not allow maintenance treatment for individuals who are under 18 years of age. DHCS will review temporary exceptions to this rule with or without written consent of their parent(s) or guardian. See Minor Consent slide for additional info.
- Certification by a physician of fitness for replacement narcotic therapy based upon physical examination, medical history, and indicated laboratory findings. Plans for correction of existing medical problems should be indicated.
- Evidence of observed signs of physical dependence

9 CCR § 10270.d
IN 18-061

OTP Admission/Client Selection
Maintenance Admission Requirements 2

Allowed exceptions when medically justified by the medical director or physician:

- An applicant who has resided in a penal or chronic care institution for one month or longer may be admitted to treatment within ~~one~~ six months of release without documented evidence of physical dependence, provided the person would have been eligible for admission before incarceration or institutionalization.
- Previously treated clients who voluntarily detoxified from maintenance treatment may be admitted to treatment without documentation of current physical dependence within six months after discharge, if the program is able to document prior maintenance treatment of 6+ months. At the discretion of the medical director or physician may be granted the same take-home step level they were on at the time of discharge.
- Pregnant clients who are currently physically dependent on opiates and have had a documented history of addition to opiates in the past may be admitted to maintenance treatment without documentation of a two-year addiction history or two prior treatment failures.

9 CCR § 10270.d.5/6
42 CFR § 8.12(e)(3)

OTP Admission/Client Selection
Detoxification Admission Requirements 1

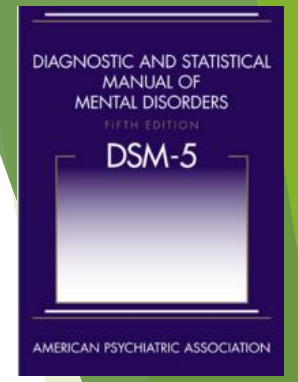
- Determination by a program physician that the client is currently physically dependent on opiates. Evidence of current physical dependence must include:
  - Observed signs of physical dependence, which must be clearly and specifically noted in the client's record.
  - Results of an initial test or analysis for illicit drug use shall be used to aid in determining current physical dependence, and must be noted in the client's record. Results of the initial test or analysis may be obtained after commencement of detoxification treatment.

OTP Admission/Client Selection
Detoxification Admission Requirements 2

- Detoxification treatment for individuals who are under 18 years of age requires written consent of their parent(s) or guardian prior to the administration of the first medication dose. OTPs may seek an exception to this requirement on an individual client basis by submitting a temporary exception request to DHCS. (see Minor Consent slide for additional information)
- The applicant may not be in the last trimester of pregnancy
- Clients with two or more unsuccessful detoxification episodes within a 12-month period must be assessed by the OTP physician for other forms of treatment. A program cannot admit a client for more than two detoxification treatment episodes in one year.

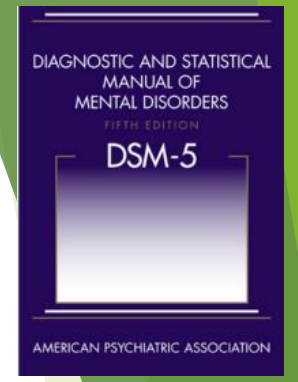
9 CCR § 10270.d.5,6
9 CCR § 10270.c.3
MHSUDS IN 18-061
42 CFR § 8.12.e.4

Establishing an Included Diagnosis
Diagnosis/Symptoms/Impairments



- Under DMC-ODS establishing a diagnosis is part of determining medical necessity
- Beneficiaries may be treated for multiple included SUD diagnoses. All SUD diagnoses to be treated must be fully established in the medical record
- An opioid SUD diagnosis must occur prior to admission by the individual conducting the medical evaluation
- The written basis for the diagnosis must be documented in the medical record by the client plan due date or completion date (whichever is earlier)
  - Must include specific, individualized signs and symptoms for each diagnosis, including timeframes
  - To be given a diagnosis, the beneficiary must meet the criteria as specified in the DSM-5 for each diagnosis given. ACBH does not determine criteria for diagnoses.
  - A good rule of thumb is that an individual reviewing the diagnosis should be able to determine the diagnosis from the written narrative alone
  - May be done by an LPHA with licensed LPHA co-signature

Included SUD Diagnoses



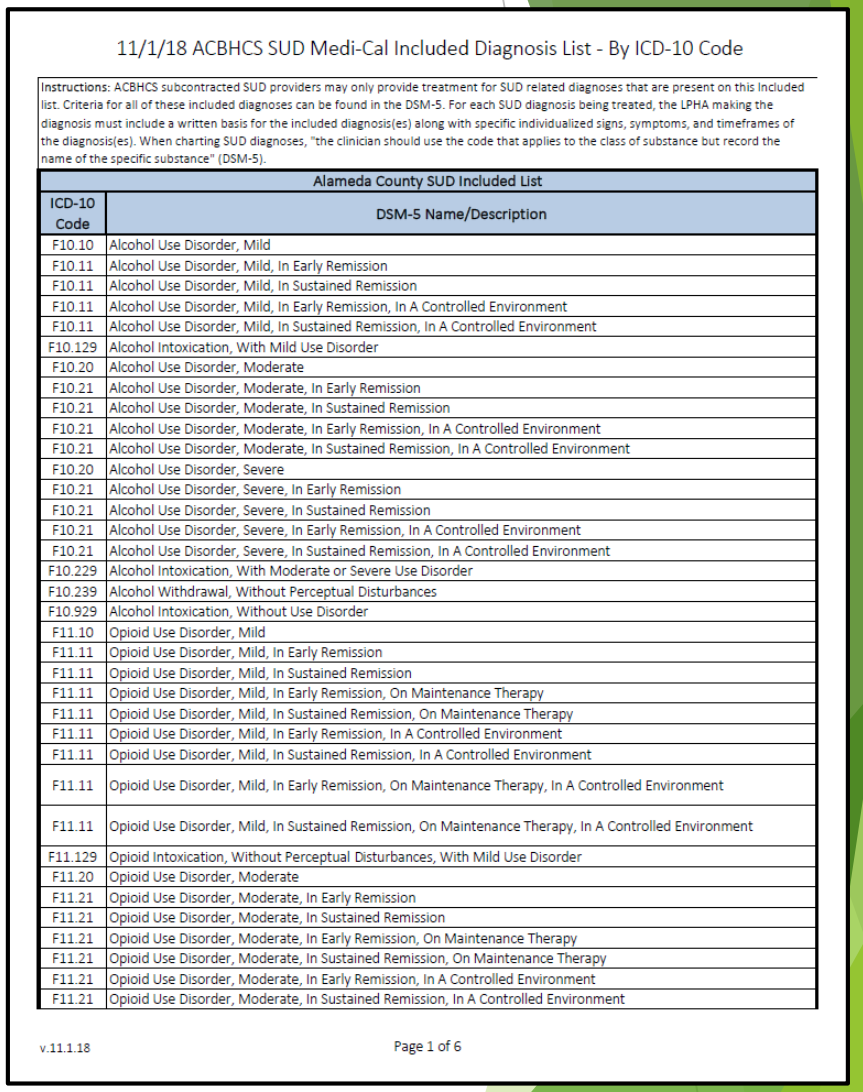
- Diagnoses that are treatable through DMC-ODS SUD treatment are indicated on the Alameda County SUD Diagnoses Included List
  - Must use the most recent list published by ACBH
  - Only the DSM-5 diagnoses on this list may be treated through SUD services
  - Beneficiaries receiving OTP services must have at least one opioid SUD diagnosis that is being treated
- Include both the ICD-10 code and DSM-5 name (including specifier)
  - e.g. In Early Remission, In Sustained Remission, In a Controlled Environment
- Differential diagnoses must be considered and documented as relevant

ACBH SUD Included Diagnosis List

Last updated on 11/1/2018 to include both DSM-5/APA coding updates and DHCS included diagnoses updates. The DSM-5 update added additional codes for remission SUD diagnoses. Alameda County's list update includes both these additional codes and all possible specifiers for all SUD included diagnoses.

Specifiers must be used accurately

Alameda County SUD providers may only provide treatment for the DSM-5 diagnoses on this list.



11/1/18 ACBHCS SUD Medi-Cal Included Diagnosis List - By ICD-10 Code

Instructions: ACBHCS subcontracted SUD providers may only provide treatment for SUD related diagnoses that are present on this Included list. Criteria for all of these included diagnoses can be found in the DSM-5. For each SUD diagnosis being treated, the LPHA making the diagnosis must include a written basis for the included diagnosis(es) along with specific individualized signs, symptoms, and timeframes of the diagnosis(es). When charting SUD diagnoses, "the clinician should use the code that applies to the class of substance but record the name of the specific substance" (DSM-5).

Alameda County SUD Included List	
ICD-10 Code	DSM-5 Name/Description
F10.10	Alcohol Use Disorder, Mild
F10.11	Alcohol Use Disorder, Mild, In Early Remission
F10.11	Alcohol Use Disorder, Mild, In Sustained Remission
F10.11	Alcohol Use Disorder, Mild, In Early Remission, In A Controlled Environment
F10.11	Alcohol Use Disorder, Mild, In Sustained Remission, In A Controlled Environment
F10.129	Alcohol Intoxication, With Mild Use Disorder
F10.20	Alcohol Use Disorder, Moderate
F10.21	Alcohol Use Disorder, Moderate, In Early Remission
F10.21	Alcohol Use Disorder, Moderate, In Sustained Remission
F10.21	Alcohol Use Disorder, Moderate, In Early Remission, In A Controlled Environment
F10.21	Alcohol Use Disorder, Moderate, In Sustained Remission, In A Controlled Environment
F10.20	Alcohol Use Disorder, Severe
F10.21	Alcohol Use Disorder, Severe, In Early Remission
F10.21	Alcohol Use Disorder, Severe, In Sustained Remission
F10.21	Alcohol Use Disorder, Severe, In Early Remission, In A Controlled Environment
F10.21	Alcohol Use Disorder, Severe, In Sustained Remission, In A Controlled Environment
F10.229	Alcohol Intoxication, With Moderate or Severe Use Disorder
F10.239	Alcohol Withdrawal, Without Perceptual Disturbances
F10.929	Alcohol Intoxication, Without Use Disorder
F11.10	Opioid Use Disorder, Mild
F11.11	Opioid Use Disorder, Mild, In Early Remission
F11.11	Opioid Use Disorder, Mild, In Sustained Remission
F11.11	Opioid Use Disorder, Mild, In Early Remission, On Maintenance Therapy
F11.11	Opioid Use Disorder, Mild, In Sustained Remission, On Maintenance Therapy
F11.11	Opioid Use Disorder, Mild, In Early Remission, In A Controlled Environment
F11.11	Opioid Use Disorder, Mild, In Sustained Remission, In A Controlled Environment
F11.11	Opioid Use Disorder, Mild, In Early Remission, On Maintenance Therapy, In A Controlled Environment
F11.11	Opioid Use Disorder, Mild, In Sustained Remission, On Maintenance Therapy, In A Controlled Environment
F11.129	Opioid Intoxication, Without Perceptual Disturbances, With Mild Use Disorder
F11.20	Opioid Use Disorder, Moderate
F11.21	Opioid Use Disorder, Moderate, In Early Remission
F11.21	Opioid Use Disorder, Moderate, In Sustained Remission
F11.21	Opioid Use Disorder, Moderate, In Early Remission, On Maintenance Therapy
F11.21	Opioid Use Disorder, Moderate, In Sustained Remission, On Maintenance Therapy
F11.21	Opioid Use Disorder, Moderate, In Early Remission, In A Controlled Environment
F11.21	Opioid Use Disorder, Moderate, In Sustained Remission, In A Controlled Environment

v.11.1.18

Page 1 of 6

OTP Admission/Client Selection
3. Informed Consent – Required Elements 1

- Each client shall attest to voluntary participation in a program by providing written documentation of his/her informed consent.
- The program shall ensure that the client reads and understands the consent form, explain program rules, and supply the client with copies of the consent form and program rules.
- If a client is admitted to a new treatment episode after a previous episode of treatment was terminated by the program physician and the discharge was noted in the client's record, the program shall reissue rules and instructions to the client and require that the client resign the consent form.

OTP Admission/Client Selection
3. Informed Consent – Required Elements 2

- The addicting nature of medications used in replacement narcotic therapy
- The hazards and risks involved in replacement narcotic therapy
- The client's responsibility to the program
- The program's responsibility to the client
- The client's participation in the program is wholly voluntary and the client may terminate their participation in the program at any time without penalty
- The client will be tested for evidence of use of opiates and other illicit drugs
- The client's medically determined dosage level may be adjusted without the client's knowledge, and at some later point the client's dose may contain no medications used in replacement narcotic therapy
- Take-home medication which may be dispensed to the client is only for the client's personal use
- Misuse of medications will result in specified penalties within the program and may also result in criminal prosecution
- The client has a right to a humane procedure of withdrawal from medications used in replacement narcotic therapy and a procedure for gradual withdrawal is available
- Possible adverse effects of abrupt withdrawal from medications used in replacement narcotic therapy
- Protection under the confidentiality requirements

updated 7/30/19

9 CCR § 10280

OTP Admission/Client Selection
3. Informed Consent – Required Elements 3

Ind. of childbearing age (~12-51 yrs)

- Knowledge of the effects of medications used in replacement narcotic therapy on pregnant individuals and their unborn children is presently inadequate to guarantee that these medications may not produce significant or serious side effects.
- These medications are transmitted to the unborn child and may cause physical dependence.
- Abrupt withdrawal from these medications may adversely affect the unborn child.
- The use of other medications or illicit drugs in addition to medications used in replacement narcotic therapy may harm the client and/or unborn child.
- The client should consult with a physician before nursing.
- The child may show irritability or other ill effects from the client's use of these medications for a brief period following birth.

OTP Admission/Client Selection
4. Prevention of Multiple Registrations 1

- Clients may only be enrolled/registered at one OTP at a time. Providers must not provide OTP services if a client has open services at another OTP
  - The only exception to this is if the client has had prior approval from their primary treatment provider to receive services on a temporary basis.
    - Both providers involved in visiting client services must follow all requirements, prior to visiting services being provided. See this slide for more specific information on this subject. (9 CCR § 10295)

9 CCR § 10205
9 CCR § 10295

OTP Admission/Client Selection

4. Prevention of Multiple Registrations 2

Prior to admission (including first dose), providers must complete the following tasks and document these in the chart:

1. Notify all clients that they cannot receive replacement narcotic treatment at multiple providers
2. Require that the client sign a written attestation they are not receiving any other replacement narcotic treatment (If the client refuses to sign this attestation, they cannot be admitted into the program)
3. Require the client provide the following demographic information: Full name and any aliases, DOB, mother's maiden name, sex, race, height, weight, color of hair, color of eyes, distinguishing markings (such as scars or tattoos).
4. Request that the client provide their Social Security number to aid in multiple registration checks
5. Request that the client sign a ROI, allowing the OTP to contact other OTPs in a 50 mile radius to complete multiple registration checks

OTP Admission/Client Selection
4. Prevention of Multiple Registrations 3

Prior to admission, a specimen must be collected for drug testing. Often these results may not be available for a few days after admission. However, when the client's initial drug analysis tests positive for Methadone or its metabolite, the program must take steps to determine the methadone's source:

- Discuss the results with the client: Have they received Methadone from another OTP or inpatient hospital (likely within the 72 hours prior to the sample collection date)?
- If the client identifies a specific OTP or inpatient hospital, have the client sign an ROI and verify that the client is no longer receiving OTP services from that program
  - OTPs must coordinate with each other to ensure only one is providing treatment
  - Clients receiving replacement therapy at another OTP must be discharged at the other OTP prior to being admitted for treatment (unless visiting client requirements are met - see Visiting Client slides)
- If the client does not identify a specific OTP, inpatient hospital, or other entity as the source of the methadone, have them sign ROIs to allow the OTP to contact all OTPs in a 50 mile radius
- Clients who refuses to sign the ROIs indicated on this slide have to be discharged immediately as there is a risk of simultaneous OTP services. No additional dosing services may be provided.

9 CCR § 10215
9 CCR § 10310

OTP Admission/Client Selection

4. Prevention of Multiple Registrations - Ongoing

To help prevent multiple registrations, DHCS has a client data system that alerts providers of potential multiple OTP registrations

- Providers report admission and discharge data to DHCS by the sixth working day of the month following the month in which the program admits or discharges a client
- DHCS will notify each program when multiple client registrations are found.
- When a program receives multiple registrations notification, they must do the following:
  - If they are still providing services, they must immediately coordinate with the other identified programs to determine the sole treating provider
  - If they are no longer providing services, the provider must notify DHCS and close any open services
- DHCS may need to help resolve situations when it is not clear who is the treatment provider

9 CCR § 10220
9 CCR § 10225

Methadone Medication Dosage Levels

- For both *Detoxification* and *Maintenance* treatment the first-day dose of methadone must not exceed 30 milligrams unless:
  - The dose is divided and the initial portion of the dose is not above 30 milligrams; and
  - The subsequent portion is administered to the patient separately after the observation period prescribed by the medical director or program physician.
- The total dose of methadone for the first day must not exceed 40 milligrams unless the medical director or program physician determines that 40 milligrams is not sufficient to suppress the client's opiate abstinence symptoms, and documents in the patient's record the basis for his/her determination.
- A daily dose above 100 milligrams of Methadone shall be justified by the medical director or program physician in the client's record.
- Client's on a daily dose of methadone above 100 milligrams are required to attend the program at least six days per week for observed ingestion (unless the program has received prior written approval from the Department)

9 CCR § 10355
9 CCR § 10370(c)
42 CFR § 8.12(h)(3)(ii)

Medication Dosage Levels 2

- After a patient has missed three (3) or more consecutive doses of replacement narcotic therapy, the medical director or program physician shall provide a new medication order before continuation of treatment.

9 CCR § 10355(f)
42 CFR § 8.12(h)(3)(ii)

Alameda County SUD Providers'

OTP Intake and Assessment Process

Components of ACBH Informing Materials

- Consent for Services
- Freedom of Choice
- Confidentiality & Privacy
- Maintaining a Welcoming & Safe Place (not a State-required informing material)
- “Guide to Medi-Cal Mental Health Services” OR “Guide to Drug Medi-Cal Services”
- Provider Directory for Alameda County Behavioral Health Plan
- Beneficiary Problem Resolution Information
- Advance Directive Information (for age 18+ and when client turns 18)
- Notice of Information 42 CFR PART 2: Information on Drug and Alcohol client Disclosure (for clients receiving Substance Use Treatment services only)

Informing Materials / Admission Criteria: Informing Materials, Incidental Disclosure, ROIs, and Payment Provisions

- All ACBH contracted treatment providers are required to review ACBH Informing Materials (aka Consent to Services and Acknowledgments) packet with the beneficiary (client) prior to signing the signature page. All are available in Alameda County threshold languages.
  - http://www.acbhcs.org/providers/QA/General/informing.htm
- Providers may not remove, modify, or contradict any components of the ACBH form
- OTP providers may have additional privacy notices, sliding scale, informing forms, etc. (see following slides for additional specific information)
- Discussions around informed consent should begin at admission and clients must sign the Informing Materials by the Assessment due date. Providers must retain the signature page in the beneficiary's medical record. This must be completed initially and then reviewed annually.
- Having the Informing Materials' signature page signed does not relieve the provider of their duties to have the Incidental Disclosure Acknowledgement, ROIs, Sliding Scale/Payment Provisions, etc. acknowledged (signed & dated) and in place as required by regulations

ACBH Informing Materials

File the signature page in the chart and give the beneficiary the rest of the handbook for their reference

Give packet to client

Informing Materials -- Your Rights & Responsibilities

Welcome to Alameda County Behavioral Health Plan

Welcome! As a member (beneficiary) of the Alameda County Behavioral Health Plan (BHP) who is requesting behavioral health services with this provider, we ask that you review this packet of informing materials which explains your rights and responsibilities. Alameda County's BHP includes both mental health services offered by the County Mental Health Plan and substance use disorder (SUD) treatment services offered by the County SUD Organized Delivery System; you may be receiving only one or both types of services.

PROVIDER NAME:

The person who welcomes you to services will review these materials with you. You will be given this packet to take home to review whenever you want, and **you will be asked to sign the last page of this packet to indicate what was discussed and that you received the materials.** Your provider will keep the original signature page. Providers of services are also required to notify you about the availability of certain information in this packet every year and the last page of this packet has a place for you to indicate when those notifications happen.

This packet contain a lot of information, so take your time and feel free to ask any questions! Knowing and understanding your rights and responsibilities helps you get the care you deserve.

Consent for Services

As a member of this Behavioral Health Plan (BHP), your signature on the last page of this packet gives your consent for voluntary behavioral health services with this provider. If you are the legal representative of a beneficiary of this BHP, your signature provides that consent.

Your consent for services also means that this provider has a duty to inform you about their recommendations of care, so that your decision to participate is made with knowledge and is meaningful. In addition to having the right to stop services at any time, you also have the right to refuse to use any recommendations, behavioral health interventions or treatment procedures.

This provider may have an additional consent form for you to sign that describes in more detail the kinds of services you might receive. These may include, but are not limited to, assessments, evaluations, individual counseling, group counseling, crisis intervention, psychotherapy, case management, rehabilitation services, medication services, medication assisted treatment, referrals to other behavioral health professionals, and consultations with other professionals on your behalf.

Professional service providers may include, but are not limited to, physicians, registered nurse practitioners, physician assistants, marriage and family therapists, clinical social workers (LCSW),

Must review all of these items with the client and check these boxes

Retain sig. page in chart

Alameda County Behavioral Health Care Services

Beneficiary Name:		Program Name:
Birthdate:	Admit date:	
INSYST #:		RU #, if applies:

Informing Materials -- Your Rights & Responsibilities
Acknowledgement of Receipt

Consent for Services
As described on page one of this packet, your signature below gives your consent to receive voluntary behavioral health care services from this provider. If you are a beneficiary's legal representative, your signature gives that consent.

Informing Materials
Your signature also means that the materials marked below were discussed with you in a language or way that you could understand, that you were given the Informing Materials packet for your records, and that you agree with the method of delivery for the Guide and Provider Directory as checked. You may request an explanation and/or copies of the materials again, at any time.

Initial Notification: Please mark the boxes below to show which materials were discussed with you at admission or any other time.

- ☐ Consent for Services
- ☐ Freedom of Choice
- ☐ Confidentiality & Privacy
- ☐ Maintaining a Welcoming & Safe Place (*not a State-required informing material*)
- ☐ "Guide to Medi-Cal Mental Health Services" OR "Guide to Drug Medi-Cal Services"
  Delivery via: ☐ Web access ☐ E-mail electronic copy ☐ Paper copy
- ☐ Provider Directory for Alameda County Behavioral Health Plan
  Delivery via: ☐ Web access ☐ E-mail electronic copy ☐ Paper copy
- ☐ Beneficiary Problem Resolution Information
- ☐ Advance Directive Information (*for age 18+ & when client turns 18*)
  Have you ever created an Advance Directive? ☐ *Yes* ☐ *No*
  If yes, may we have a copy for our records? ☐ *Yes* ☐ *No*
  If no, may we support you to create one? ☐ *Yes* ☐ *No*
- ☐ Notice of Privacy Practices – HIPAA & HITECH
- ☐ Notice of Information 42 CFR PART 2: Information on Drug and Alcohol Patient Disclosure (*for clients receiving Substance Use Treatment services only*)

Beneficiary Signature: (or legal representative, if applicable)	Date:
Clinician/Staff Witness Initials:	Date:
E-mail address for delivery of Guide & Provider Directory, if applicable:	

QA: Informing Materials – English 6-25-2018 Page 17 of 18

Beneficiary signs here

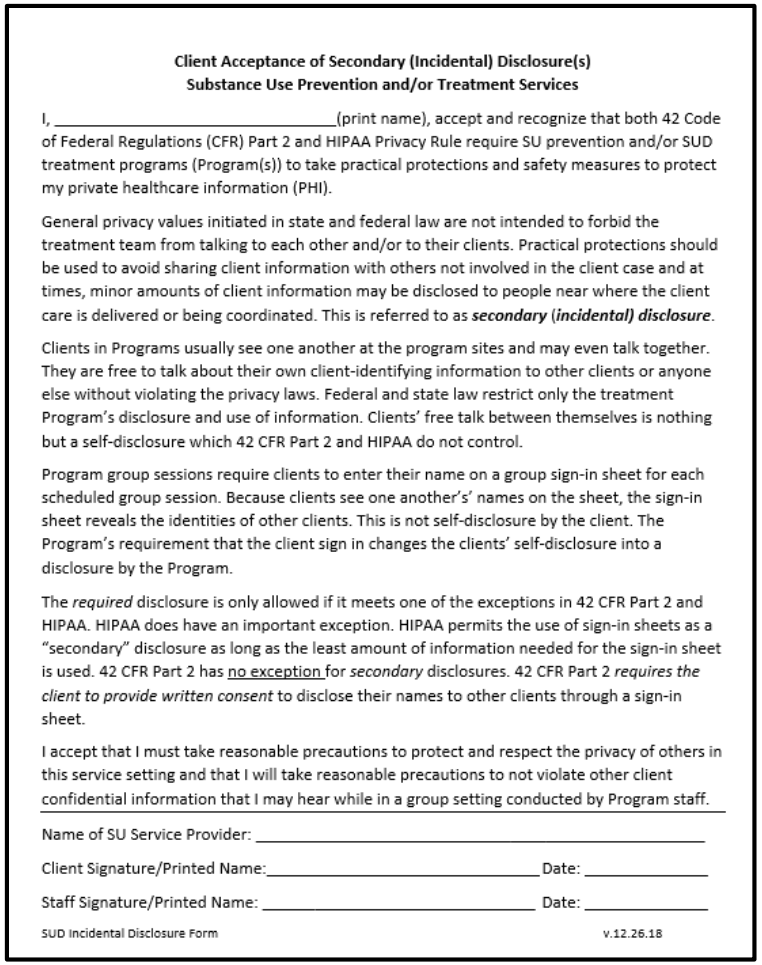
updated 7/30/19

Incidental Disclosures

- 42 CFR, Part 2 does not allow providers to unintentionally disclose PHI (called incidental disclosures) that may occur through conversations with their co-workers in such places as hallways or breakrooms.
- Beneficiaries may unintentionally disclose personal information during casual conversations, “free talk,” with other beneficiaries (clients) outside of the treatment room or provider environment. 42 CFR, Part 2 does not regulate beneficiaries’ conversations. However, the Incidental Disclosure Information form reminds clients about the importance of privacy for others and promotes respect and confidentiality. The Incidental Disclosure form must be reviewed upon admission and be completed for each beneficiary.
- These documents shall be in the beneficiary’s chart and ACBH will be auditing to this standard.

Incidental Disclosures Form

This additional disclosure is required by ACBH and must be maintained in client's chart



Client Acceptance of Secondary (Incidental) Disclosure(s)
Substance Use Prevention and/or Treatment Services

I, _____(print name), accept and recognize that both 42 Code of Federal Regulations (CFR) Part 2 and HIPAA Privacy Rule require SU prevention and/or SUD treatment programs (Program(s)) to take practical protections and safety measures to protect my private healthcare information (PHI).

General privacy values initiated in state and federal law are not intended to forbid the treatment team from talking to each other and/or to their clients. Practical protections should be used to avoid sharing client information with others not involved in the client case and at times, minor amounts of client information may be disclosed to people near where the client care is delivered or being coordinated. This is referred to as ***secondary (incidental) disclosure***.

Clients in Programs usually see one another at the program sites and may even talk together. They are free to talk about their own client-identifying information to other clients or anyone else without violating the privacy laws. Federal and state law restrict only the treatment Program's disclosure and use of information. Clients' free talk between themselves is nothing but a self-disclosure which 42 CFR Part 2 and HIPAA do not control.

Program group sessions require clients to enter their name on a group sign-in sheet for each scheduled group session. Because clients see one another's' names on the sheet, the sign-in sheet reveals the identities of other clients. This is not self-disclosure by the client. The Program's requirement that the client sign in changes the clients' self-disclosure into a disclosure by the Program.

The *required* disclosure is only allowed if it meets one of the exceptions in 42 CFR Part 2 and HIPAA. HIPAA does have an important exception. HIPAA permits the use of sign-in sheets as a "secondary" disclosure as long as the least amount of information needed for the sign-in sheet is used. 42 CFR Part 2 has no exception for *secondary* disclosures. 42 CFR Part 2 *requires the client to provide written consent* to disclose their names to other clients through a sign-in sheet.

I accept that I must take reasonable precautions to protect and respect the privacy of others in this service setting and that I will take reasonable precautions to not violate other client confidential information that I may hear while in a group setting conducted by Program staff.

Name of SU Service Provider: _____

Client Signature/Printed Name:_____ Date: _____

Staff Signature/Printed Name: _____ Date: _____

SUD Incidental Disclosure Form v.12.26.18

Controlled Substance Utilization Review and Evaluation System

CURES 2.0

CURES is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. CURES is intended to reduce prescription drug abuse and diversion without affecting legitimate medical practice or client care.

- Prescribers at OTPs are not required to check CURES prior to starting the first Schedule II, III, IV controlled substance → (c)(1)
- For OTPs, CURES checks are required prior to and every four months when prescribing, ordering, administering, or furnishing Schedule II, III, and IV controlled substances in the following situations:
  1. Prior to starting any subsequent controlled medications → (a)(1)(A)(ii)
  2. Prior to starting take-home medication privileges → (c)(1)
- Due to 42 CFR, Part 2 privacy protections substance use treatment information may not be entered into CURES → (f)

Regardless, ACBH highly recommends all OTPs check CURES for all clients upon admission and whenever indicated

https://oag.ca.gov/cures

Releases of Information (ROIs)

- Health Information is protected by law; Protected Health Information (PHI)
- Must include 42 CFR, Part 2 Final Rule, HIPAA, HITECH requirements
- Best practice is to get a ROI even if contact with an external individual is allowed by law
- ROIs protect both the beneficiary and the agency
- ROIs are valid for dates specified
- Statements such as, “to the end of treatment” are not considered specific dates
- It is highly recommended that specific expiration dates be indicated
- ROIs with non-specific end dates automatically expire after 12 months

updated 7/30/19

Releases of Information (ROIs), Cont.

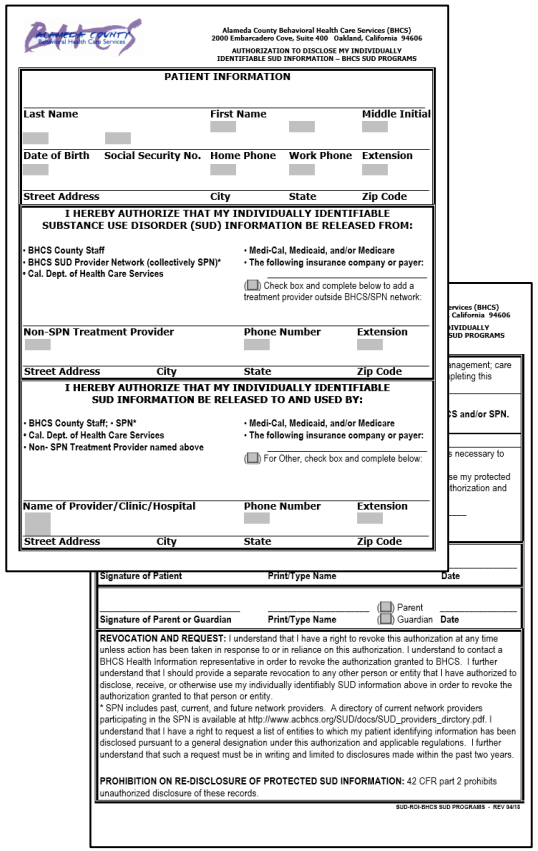
- Required for any contact outside of your agency
- Required ACBH ROIs have been approved by Alameda County Counsel
- ACBH currently has three approved versions of this two page form:
  - SUD Programs ROI
  - Emergency Contact ROI
  - Criminal Justice ROI

ACBH ROI Screenshots

QA highly recommends 2 page ROIs are printed as <u>double sided</u>. There is a high risk that the second page will get separated and/or be unclear as to which ROI it applies

FYI

SUD Programs ROI



Alameda County Behavioral Health Care Services (BHCS)
2000 Embarcadero Cove, Suite 400 Oakland, California 94606

AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Social Security No. | Home Phone | Work Phone | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

- BHCS County Staff
- BHCS SUD Provider Network (collectively SPN)*
- Cal. Dept. of Health Care Services
- Medi-Cal, Medicaid, and/or Medicare
- The following insurance company or payer:

☐ Check box and complete below to add a treatment provider outside BHCS/SPN network:

Non-SPN Treatment Provider | Phone Number | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY:

- BHCS County Staff; - SPN*
- Cal. Dept. of Health Care Services
- Non- SPN Treatment Provider named above
- Medi-Cal, Medicaid, and/or Medicare
- The following insurance company or payer:

☐ For Other, check box and complete below:

Name of Provider/Clinic/Hospital | Phone Number | Extension

Street Address | City | State | Zip Code

Signature of Patient | Print/Type Name | Date

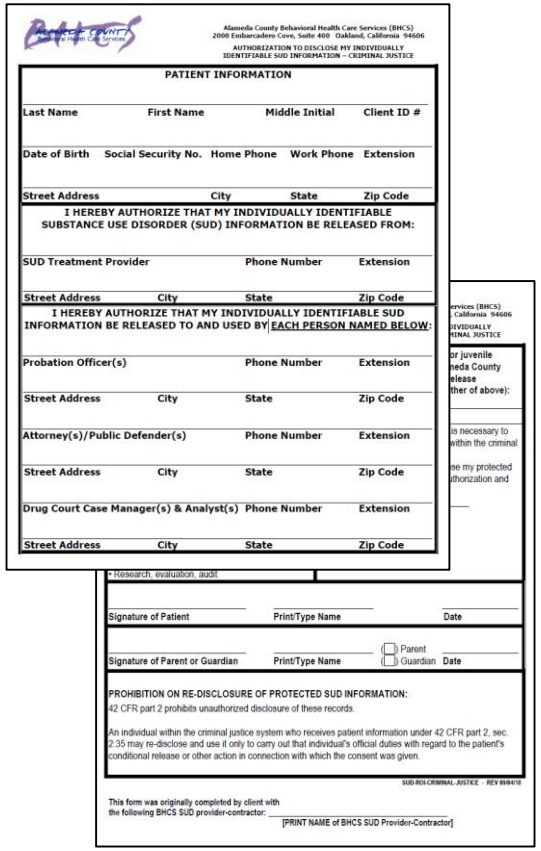
Signature of Parent or Guardian | Print/Type Name | ☐ Parent ☐ Guardian | Date

REVOCATION AND REQUEST: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand to contact a BHCS Health Information representative in order to revoke the authorization granted to BHCS. I further understand that I should provide a separate revocation to any other person or entity that I have authorized to disclose, receive, or otherwise use my individually identifiably SUD information above in order to revoke the authorization granted to that person or entity.
* SPN includes past, current, and future network providers. A directory of current network providers participating in the SPN is available at http://www.acbhcs.org/SUD/docs/SUD_providers_dirctory.pdf. I understand that I have a right to request a list of entities to which my patient identifying information has been disclosed pursuant to a general designation under this authorization and applicable regulations. I further understand that such a request must be in writing and limited to disclosures made within the past two years.

PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR part 2 prohibits unauthorized disclosure of these records.

SUD-ROI-BHCS SUD PROGRAMS - REV 04/18

Criminal Justice ROI



Alameda County Behavioral Health Care Services (BHCS)
2000 Embarcadero Cove, Suite 400 Oakland, California 94606

AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – CRIMINAL JUSTICE

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Client ID #

Date of Birth | Social Security No. | Home Phone | Work Phone | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

SUD Treatment Provider | Phone Number | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY EACH PERSON NAMED BELOW:

Probation Officer(s) | Phone Number | Extension

Street Address | City | State | Zip Code

Attorney(s)/Public Defender(s) | Phone Number | Extension

Street Address | City | State | Zip Code

Drug Court Case Manager(s) & Analyst(s) | Phone Number | Extension

Street Address | City | State | Zip Code

- Research, evaluation, audit

Signature of Patient | Print/Type Name | Date

Signature of Parent or Guardian | Print/Type Name | ☐ Parent ☐ Guardian | Date

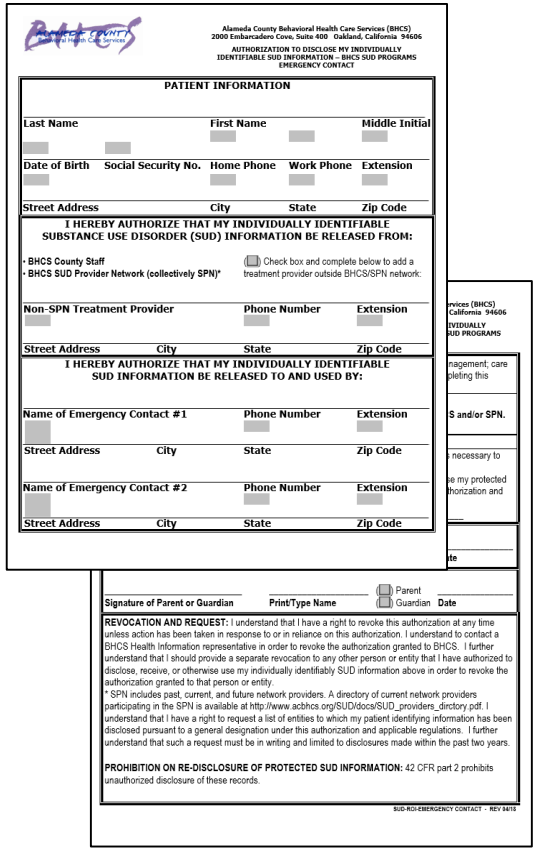
PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION:
42 CFR part 2 prohibits unauthorized disclosure of these records.

An individual within the criminal justice system who receives patient information under 42 CFR part 2, sec. 2.35 may re-disclose and use it only to carry out that individual's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

SUD-ROI-CRIMINAL JUSTICE - REV 09/04/18

This form was originally completed by client with the following BHCS SUD provider-contractor: _____
[PRINT NAME of BHCS SUD Provider-Contractor]

Emergency Contact ROI



Alameda County Behavioral Health Care Services (BHCS)
2000 Embarcadero Cove, Suite 400 Oakland, California 94606

AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS EMERGENCY CONTACT

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Social Security No. | Home Phone | Work Phone | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

- BHCS County Staff
- BHCS SUD Provider Network (collectively SPN)*

☐ Check box and complete below to add a treatment provider outside BHCS/SPN network:

Non-SPN Treatment Provider | Phone Number | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY:

Name of Emergency Contact #1 | Phone Number | Extension

Street Address | City | State | Zip Code

Name of Emergency Contact #2 | Phone Number | Extension

Street Address | City | State | Zip Code

Signature of Parent or Guardian | Print/Type Name | ☐ Parent ☐ Guardian | Date

REVOCATION AND REQUEST: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand to contact a BHCS Health Information representative in order to revoke the authorization granted to BHCS. I further understand that I should provide a separate revocation to any other person or entity that I have authorized to disclose, receive, or otherwise use my individually identifiably SUD information above in order to revoke the authorization granted to that person or entity.
* SPN includes past, current, and future network providers. A directory of current network providers participating in the SPN is available at http://www.acbhcs.org/SUD/docs/SUD_providers_dirctory.pdf. I understand that I have a right to request a list of entities to which my patient identifying information has been disclosed pursuant to a general designation under this authorization and applicable regulations. I further understand that such a request must be in writing and limited to disclosures made within the past two years.

PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR part 2 prohibits unauthorized disclosure of these records.

SUD-ROI-EMERGENCY CONTACT - REV 04/18

ROI Tracker Log Requirements

- With some exceptions, an individual has a right to receive an accounting of disclosures of protected health information made by a covered entity in the six years prior to the date on which the accounting is requested.
- Required components:
  - The date of the disclosure
  - The name of the entity or person who received the protected health information and, if known, the address of such entity or person
  - A brief description of the protected health information disclosed
  - A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure
  - For multiple disclosures to the same entity, the frequency, periodicity, or number of the disclosures made during the accounting period and the date of the last such disclosure during the accounting period are required

ACBH ROI Tracker Log

Meets HIPAA Disclosure Tracking Requirements

Release of Information (ROI) Tracker Log

Beneficiary/Patient Name:			ID Number:				
DATE Request Received	WHO (Requestor) Name of Organization Who Made the Request	WHO (disclosed to whom) Name & Organziation Who Requested the Information (Requestor)	WHO Verified that the ROI (form) Information is Correct & Signed by the Beneficiary	DATE ROI SENT ROI must be sent within 15 days of request	EMPLOYEE COMPLETING THE REQUEST Employee Name & Job Title	METHOD of Transmission: 1) Mail 2) Fax 3) Secure Email 4) Other	BRIEF DESCRIPTION OF DISCLOSED INFORMATION

1. Upon Intake, each client must sign required Releases of Information (ROIs).
2. Maintain the log in the client's medical record.
3. All signed ROIs are maintained in the client file.

Page _____ of _____

Providers may use their own tracking system and/or log as long as the required information can be provided when requested (by the client or other individual).

Tracker log will be requested for audits

Physical Health and SUD Treatment

Physical Health Considerations

- Clients who request DMC-ODS services may have significant physical health issues
- Coordination with physical health providers is required to meet the physical health needs of our clients
- For OTPs the physical exam conducted at admission is one component of the client's health assessment
- When identified physical health issues must be included in plan goals/action steps whenever possible

Health Screening / Questionnaire
Highly recommended for OTPs

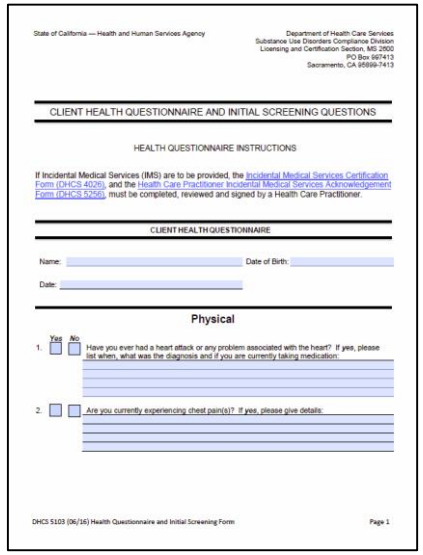
- AOD Certified/Licensed programs may use DHCS Form 5103 for the health questionnaire or may develop their own health questionnaire provided it contains, at a minimum, the information in DHCS Form 5103
- The health questionnaire is a client's self-assessment of their current health status. The health questionnaire is completed and signed prior to the client's admission and retained in the file. Program staff must review each completed health questionnaire. When appropriate, the client must be referred to licensed medical professionals for physical, psychiatric, and laboratory examinations
  - Unless the client needs assistance, this is a questionnaire for them to complete independently
- Health Questionnaire requirement is intended to be a client self-report document that provides information for the treatment staff conducting the intake assessment. It is not a medical history screening or assessment.
- Client's self-report is used to determine if client has immediate medical needs that would impact their ability to safely participate in SUD Treatment. Non-AOD certified/licensed providers are recommended to have the client self-report their medical history using DHCS 5103 in addition to gathering required medical history

DHCS Form 5103
Health Screening Questionnaire

FYI

Meets requirements AOD Alcohol And Drug Certification Standards Section 12020

- DHCS Form 5103, Version (06/16) this is a 10 page form:
- http://www.dhcs.ca.gov/provgovpart/Documents/DHCS_5103.pdf


State of California — Health and Human Services Agency

Department of Health Care Services
Substance Use Disorders Compliance Division
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

CLIENT HEALTH QUESTIONNAIRE AND INITIAL SCREENING QUESTIONS

HEALTH QUESTIONNAIRE INSTRUCTIONS

If Incidental Medical Services (IMS) are to be provided, the Incidental Medical Services Certification Form (DHCS 4026), and the Health Care Practitioner Incidental Medical Services Acknowledgement Form (DHCS 5756), must be completed, reviewed and signed by a Health Care Practitioner.

CLIENT HEALTH QUESTIONNAIRE

Name: Date of Birth:

Date:

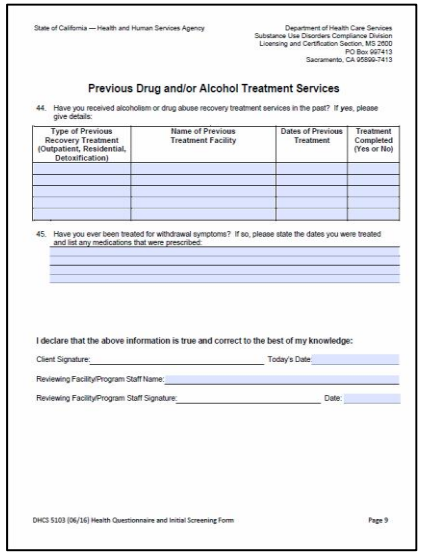
Physical

Yes No

1. Have you ever had a heart attack or any problem associated with the heart? If yes, please list when, what was the diagnosis and if you are currently taking medication:

2. Are you currently experiencing chest pain(s)? If yes, please give details:

DHCS 5103 (06/16) Health Questionnaire and Initial Screening Form Page 1


State of California — Health and Human Services Agency

Department of Health Care Services
Substance Use Disorders Compliance Division
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

Previous Drug and/or Alcohol Treatment Services

44. Have you received alcoholism or drug abuse recovery treatment services in the past? If yes, please give details:

Type of Previous Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Previous Treatment Facility	Dates of Previous Treatment	Treatment Completed (Yes or No)

45. Have you ever been treated for withdrawal symptoms? If so, please state the dates you were treated and list any medications that were prescribed:

I declare that the above information is true and correct to the best of my knowledge:

Client Signature: Today's Date:

Reviewing Facility/Program Staff Name:

Reviewing Facility/Program Staff Signature: Date:

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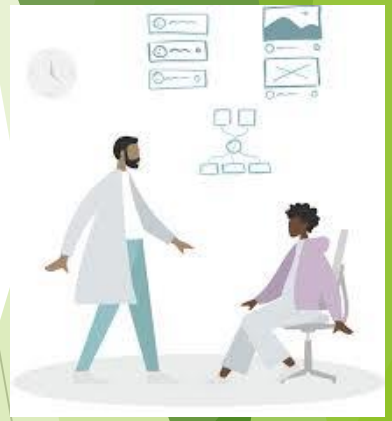
Available in handout section!

OTP Assessment Requirements

Part of the Golden Thread

Assessments: The Foundation of Treatment

- The assessment process is the a key element in the development of a trusting, helping relationship with the beneficiary
- As the assessment process unfolds, important areas will need to be explored in-depth. Document specific information in the assessment document
- It is expected that the assessment process can take several sessions to complete
- The problems or challenges identified during the assessment process are used to inform the client's plan
  - This will be explored more extensively in the client plan section of this training
- Detailed comments are required for each assessed component
- If comment sections and/or checkboxes are left blank, it cannot be determined if that section was assessed and no credit will be given. When it is not clinically appropriate to assess a particular component, indicate the reason why. As treatment progresses, update the assessment information as necessary.



OTP Maintenance Treatment Assessment
Required Assessment Components 1

Within 28 days of admission and prior to the treatment plan being completed, all clients receiving maintenance treatment must receive a comprehensive needs assessment. The following elements must be included in the assessment:

These items will likely be part of the day 1 admission assessment requirements, but should be expanded upon if necessary

- Health care as recorded within the overall impression portion of the physical examination
- Drug/Alcohol use history / Prior addiction history
- Previous SUD treatment history / Prior treatment failure
- Medical history
- Family history
- Psychiatric/psychological history
- Social/recreational history
- Financial status/Economic history
- Educational/Vocational/Rehabilitation
- Employment history
- Criminal history, legal status

IA.III.PP.8.a
9 CCR § 10305.d
9 CCR § 10165

OTP Maintenance Treatment Assessment
Required Assessment Components 2

- The needs assessment must include a narrative evaluation or analysis of the client and their functioning, including a summary of the client's psychological and sociological background.
- Areas identified as significant to the client must be comprehensively explored and documented in the assessment.
- The needs assessment must be completed by a treatment staff (SUD Counselor, LPHA) working within their training and scope of practice. This is an assessment document and not a questionnaire the client completes.

IA.IV.45
9 CCR § 10305.d.1

Additional Perinatal Assessment Items
Required for all LOCs

Perinatal services must address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.

- Mother/child habilitative and rehabilitative service needs (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792)
- Service access needs (i.e., provision of or arrangement for transportation to and from medically necessary treatment)
- Need for education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant
- Needs related to coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).
- If any of these items are endorsed by the client, then it must be indicated in the client plan
  - Must provide transportation when needed (i.e. client cannot access transportation). Indicate reason

Intake Assessment Review Due Dates
For Maintenance Treatment

- The needs assessment must be completed within 28 days from admission
  - As indicated by the complete signature of the LPHA or Counselor who conducted the assessment
- The supervising counselor and medical director must review and co-sign the Needs Assessment document within 14 days from the document's author's signature date
- If during their review, the medical director or supervising counselor determines that the assessment is incomplete or needs additional information then the assessment must be revised. The completion date on the assessment will be the date when all required signatures are present.
  - Revisions do not change the assessment due date

OTP Detoxification Treatment Assessment
Required Assessment Components

- For Detoxification services, Title 9 regulations do not specify additional assessment requirements beyond what is required prior to admission
- When medically necessary and indicated, a needs assessment should be completed

IA.III.PP.8.a
9 CCR § 10305.b

Claiming for Completing the Assessment

- If an assessment is completed in one session, both the gathering of assessment information and completion of the assessment form, one progress note may document the claim. In the progress note, make reference to the assessment form ("see assessment form dated xx/xx/xx"). It is not necessary to repeat all gathered information in both the note and form. The progress note documentation time includes both the time writing the Assessment form and completing the progress note.
- If an assessment is completed over multiple sessions, each progress note must clearly indicate what information was gathered in each session. The Information gathered in each session must be indicated in the progress note, or the progress note must link to specific sections of the assessment. Time spent completing the assessment form may be spread out over each session, or at the last assessment session.
  - An auditor or other individual reviewing the note/claim must be able to determine precisely what information was gathered for each claimed service
- All activities (face-to-face, PN documentation, completing the form, etc.), require dates, start, and end times.
- Documentation time may not be claimed separate from a direct service (exceptions given for OTPs with EHR limitations)

Additional Medical Necessity Requirements

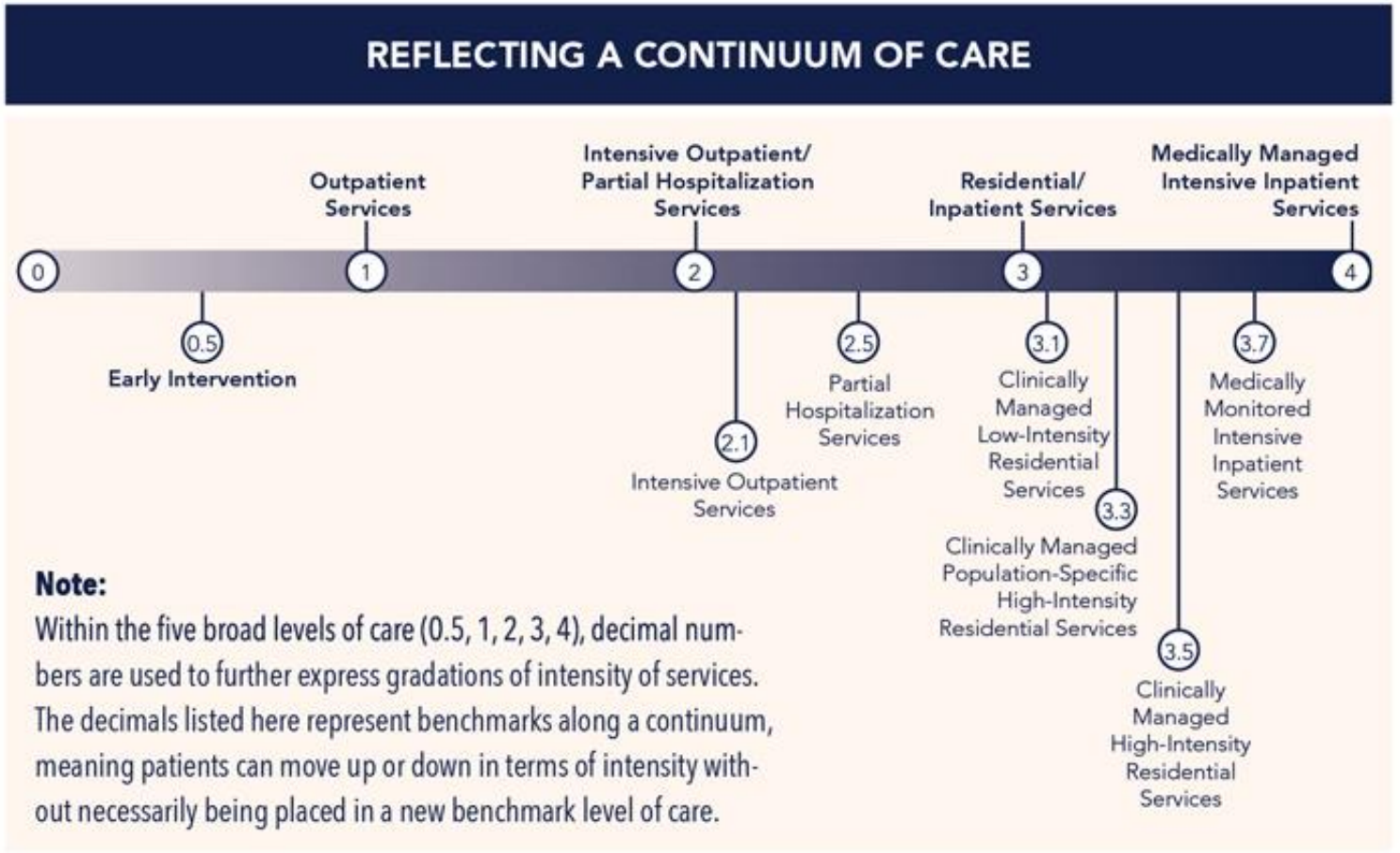
Additional MN requirements for OTPs as indicated in the IA

Overview of IA Medical Necessity Requirements In addition to Title 9 MN Requirements

1. ASAM Level of Care Determination (ALOC)
2. An included DSM-5 SUD diagnosis, that includes an individualized written basis of the client's specific signs and symptoms and impairment to functioning
3. Ensure that services are, "…are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury are covered by the Medi-Cal program, subject to utilization controls…"

IA.III.B.2
IA.III.PP.10.i.a
22 CCR § 51303
22 CCR § 51340.1

ASAM American Society of Addiction Medicine



ASAM LOC Assessments (ALOCs) 1

- Under the IA, the ALOC assessment is a core component of establishment of medical necessity in the SUD system
- It is vital that providers complete the ALOC accurately and correctly. Issues with the level of care assessment can cause full chart disallowances as medical necessity would not be supported.
- ALOCs must be consistent with the client's functioning and presentation and include all LOCs the client meets criteria for
- Providers must complete the ASAM Level of Care (ALOC) accurately to the client's needs, We are finding that often the ALOC confirms the level of care of the provider (e.g. IOS providers determine client needs ASAM 2.1) and is not consistent with the individual's documented presentation and assessment. ACBH will be monitoring ALOCs closely for accuracy.

ASAM LOC Assessments (ALOCs) 2

If the beneficiary is referred to SUD services through one of the portals, a brief ALOC screening will have been completed

- Often the portals' screening will have incomplete information
- May have been a phone screening
- Providers must complete the full ALOC within established medical necessity timelines

ASAM LOC Assessments (ALOCs) 3

- The ASAM Criteria describes treatment as a continuum marked by four broad levels of service and an early intervention level. Within the five broad levels of care, decimal numbers are used to further express gradations of intensity of services.
- The levels of care provide a standard nomenclature for describing the continuum of recovery-oriented addiction services. Using the ASAM assessment clinicians are able to conduct a multidimensional assessment that explores individual risks and needs, as well as strengths, skills and resources.

ASAM LOC Assessments (ALOCs) 4

- Portals – Use *ASAM ALOC Screening Form*
- All other providers use ASAM Level of Care Assessment (ALOC)
  - *ALOC Initial* (first one in any episode)
  - *ALOC Review*
- These forms are identical and have different names for tracking purposes
  - Using identical ALOCs allows for direct comparison across treatment time frames

Alameda County Residential ASAM LOCs

FYI

ASAM LOC	Service Name	Description of Care
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment.
3.2	Withdrawal Management (clinically-managed) residential withdrawal management	24 –hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal.
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for outpatient treatment. (Note: This level is not designated for adolescents). (Currently in development)
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.
3.7 (referral)	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems. 16 hour/day counselor availability. (N/A to this training)
4 (referral)	Medically Managed Intensive Inpatient Services	24-hour nursing care with daily physician care for severe, unstable problems. Counseling available to engage client in treatment. (N/A to this training)

ASAM Dimensions 1

- Each of the six (6) ASAM dimensions require assessment. Make sure to fully document the specific, individualized assessment elements in the comments.
- ALOC risk ratings are based on client presentation and should be similar regardless of the LOC conducting the assessment
- For OTPs, for clients on a stable dose of medication without other functional concerns *Dimension 1* may be scored as *No Risk/Stable* (OTPs must provide a detailed comment) and *Dimension 5* must have at least a risk rating of *Mild*, but should be assessed at the appropriate risk rating.
- Except for *Dimension 1* above, detailed comments are not required for dimensions with risk ratings of *No Risk/Stable*. However, some *No Risk/Stable* ratings may necessitate comments.
- Depending on how the intake is completed, information from the Assessment is used to inform the ASAM and vice versa
- Regardless there must be a congruence between the intake assessment documents, medical necessity, and ASAM
- Train your staff to write detailed comments for each relevant dimension, regardless of the risk rating

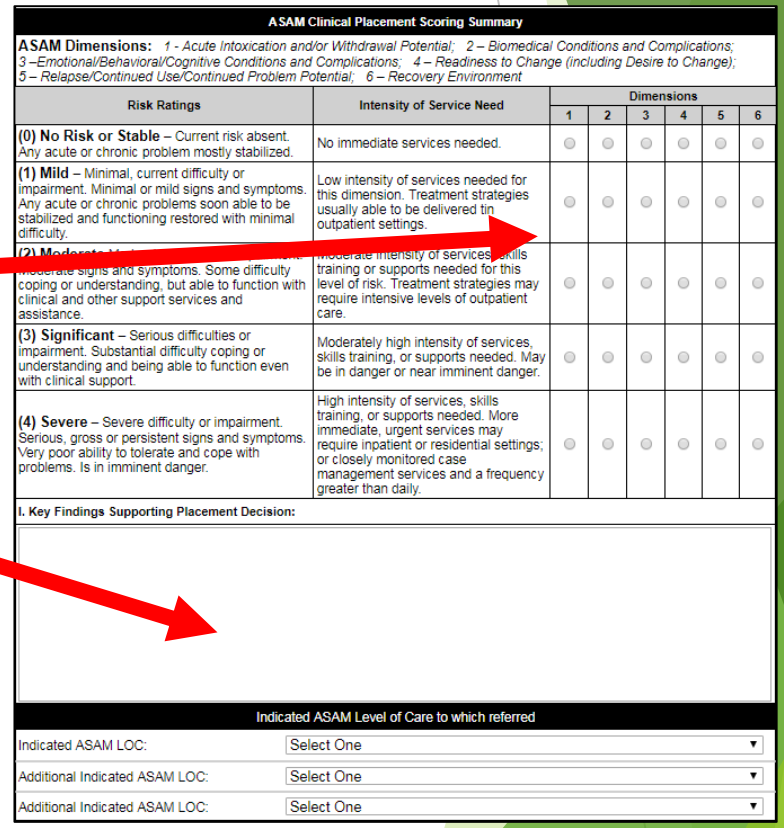
IA.V.B.ii.b.i.2

ASAM Criteria, 3rd Ed. p.86 & 175

ASAM Dimensions 2

ASAM Clinical Placement Scoring Summary

- Be mindful that only one Risk Rating is required for each dimension (score one row per column)
- A detailed narrative written description is required to explain the Key Findings Supporting the Placement Decision
- Refer to ASAM training materials and guidance to assist in determining the Level of Care accurately and consistently



ASAM Clinical Placement Scoring Summary

ASAM Dimensions: *1 - Acute Intoxication and/or Withdrawal Potential; 2 – Biomedical Conditions and Complications; 3 –Emotional/Behavioral/Cognitive Conditions and Complications; 4 – Readiness to Change (including Desire to Change); 5 – Relapse/Continued Use/Continued Problem Potential; 6 – Recovery Environment*

Risk Ratings	Intensity of Service Need	Dimensions					
		1	2	3	4	5	6
(0) No Risk or Stable – Current risk absent. Any acute or chronic problem mostly stabilized.	No immediate services needed.	○	○	○	○	○	○
(1) Mild – Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.	Low intensity of services needed for this dimension. Treatment strategies usually able to be delivered tin outpatient settings.	○	○	○	○	○	○
(2) Moderate – Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance.	Moderate intensity of services, skills training or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.	○	○	○	○	○	○
(3) Significant – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support.	Moderately high intensity of services, skills training, or supports needed. May be in danger or near imminent danger.	○	○	○	○	○	○
(4) Severe – Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger.	High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services and a frequency greater than daily.	○	○	○	○	○	○

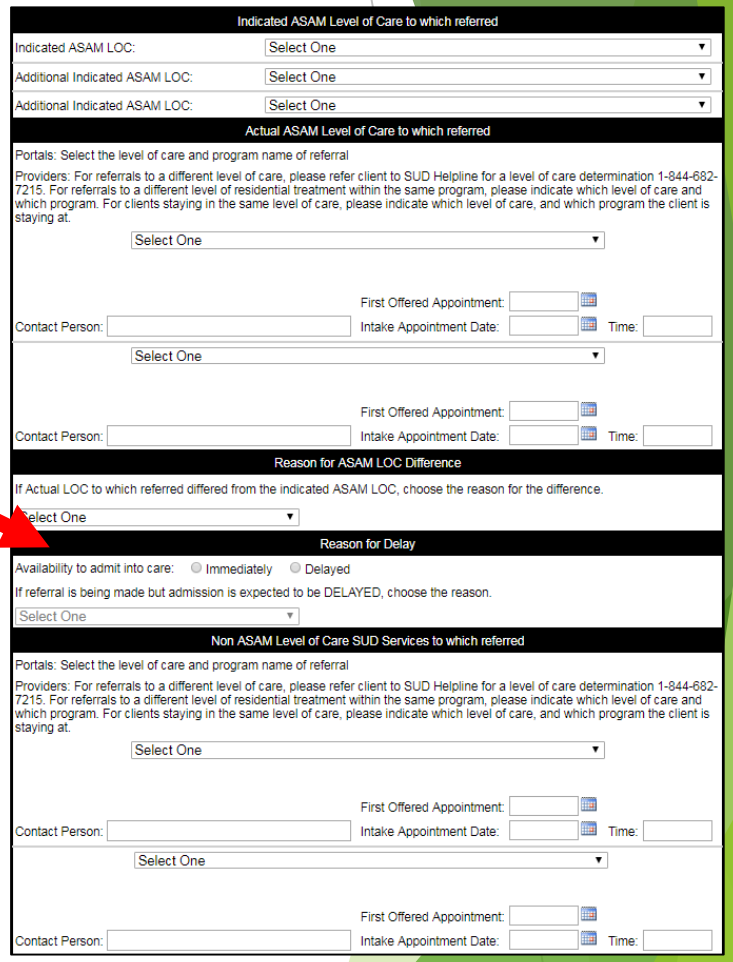
I. Key Findings Supporting Placement Decision:

Indicated ASAM Level of Care to which referred

Indicated ASAM LOC:	Select One
Additional Indicated ASAM LOC:	Select One
Additional Indicated ASAM LOC:	Select One

Indicated / Referred LOC

- The Indicated ASAM LOC is the beneficiary's presentation at the time of assessment
- When the Indicated ASAM LOC differs from the Actual ASAM Level of Care to which referred, choose a reason from the dropdown menu. A more detailed explanation is required in the comment field.
- Beneficiaries may have up to 3 possible ASAM LOCs
- For example:
  - Indicated: OTP
  - Additional Indicated: OS/IOS
  - Additional Indicated: Recovery Residence



ALOC Due Dates

- For OTPs ALOCs are due within 28 days from date of admission and then every 90 days from date of previous ALOC
- ALOCs are due prior to every plan or plan update and whenever clinically indicated
  - ALOCs completed within 45 days of plan date may be used to meet this requirement, if there are clinical changes then the ALOC must be redone.

Who may complete an intake assessment, ALOC, and participate in ACBH CQRT?

- Clinical staff must work within their scope of practice, training, and experience
- Staff who conduct ASAM assessments must have completed the required ASAM trainings prior to conducting the ALOC (see next slide)
- Due to the complexity of assessment, medical necessity, and other related activities, ACBH highly recommends that these documents are completed by LPHAs and Certified SUD Counselors ONLY
- When an agency has no other option, Registered SUD Counselors may complete these activities with the following minimum training and experience:
  - Registered SUD Counselors who have one year full time equivalent SUD treatment experience; OR
  - Registered SUD Counselors who have completed the following hours towards their certified credential (essentially the equivalent of half of CCAPP CADC-I requirement):
    - 158 hours of approved education
    - 127 practicum hours (internship experience)
    - 1500 hours of supervised work experience (includes practicum hours)
    - AND Supervisor must provide an attestation of experience and knowledge to conduct Intake Assessments, ALOC ← Maintain in employee's personnel file. This will be requested during an audit.

ASAM Training Modules

Required

Preview More Info

ASAM Module 1 – Multidimensional Assessment eLearning

Preview More Info

ASAM Module 2 – From Assessment to Service Planning and Level of Care

Recommended

Preview More Info

ASAM Module 3 – Introduction to *The ASAM Criteria*

Trainings available on: https://www.changecompanies.net/etraining/

CG ALOC Data Entry Instructions 1

- OTPs are allowed to have data entry staff input data from completed ALOCs into Clinician's Gateway
- The Counselor/LPHA completes the ALOC, then data entry staff enter the information into CG exactly as written on the completed ALOC form. The ALOC in CG must be identical to the completed ALOC.
- When creating the ALOC in CG the data entry staff must change the ownership of the ALOC to the treatment staff who completed/signed the ALOC. → For instructions, see next slide
- The assessment staff who completed the form, must then go into CG, review the form and confirm it's accuracy, then sign the ALOC. The ALOC form in CG must be signed/finalized by a staff with the training and credentials to do so.
- If your agency uses this option, it is highly recommended that your confirm your data entry process with QA. To explore this option, contact ACBH SUD TA for guidance on developing the required validation checks.

CG ALOC Data Entry Instructions 2

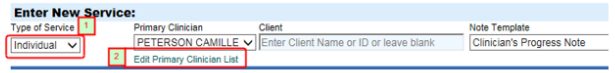
See handouts – This is the same process for ALOCs

Clinician's Gateway Staff Corral – Starting Notes for Another Staff

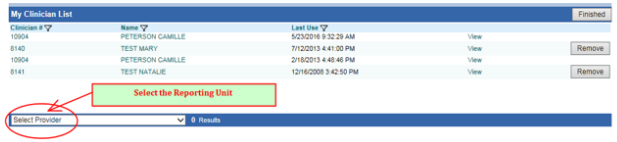
Using the Staff Corral, one staff person can start a note for another Primary Clinician. The person who is listed as the clinician on a note must Finalize the note to sign it with their electronic signature.

Build your Staff Corral

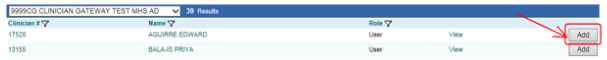
1. Choose "Individual" as the type of note, to launch the note writing line.
2. Below the Primary Clinician field click on "Edit Primary Clinician List"



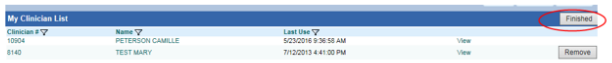
3. Select the Reporting Unit from the drop down menu where the clinician works.



4. Choose the clinician by clicking the Add button.

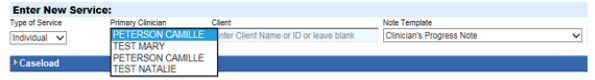


5. Click Finished when you are done adding clinicians for whom you will start notes.



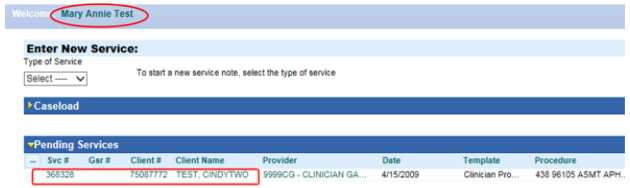
Write a Note for a different primary clinician

1. Start writing an Individual Note
2. Choose the Primary Clinician from the drop down list that you created by building your Staff Corral.



3. Enter all the appropriate information into the body of the note
4. Click "Save the note to the Primary Clinician's Queue".

5. The note now appears on the Primary Clinician's Pending Services List.



6. The Primary Clinician must "Finalize" the note in order to approve it and sign it with their signature.

Referrals to other Levels of Care
OTP ←→ Other SUD LOCs

- Some SUD LOCs may be provided simultaneously, such as OTP and OS, or OTP and RES, or OTP and RR and IOS
- When an ALOC indicates an additional or different level of care than is currently being provided, the provider conducting the ALOC should refer and assist the client to connect to the identified LOC
- Case Management services are provided to assist these referrals
- All referrals to residential services must go through one of the ACBH SUD Access Points

Diagnosis requirements for OTPs
In addition to Title 9 Requirements

- Under DMC-ODS, OTPs are required to document the signs and symptoms for at least one included diagnosis that will be the primary focus of treatment
- OTPs, beneficiaries must be diagnosed with at least one included Opioid Use Disorder diagnosis
- At this time, the individualized written bases for diagnoses are due by the treatment plan completion date
- The written basis for the diagnoses that are the focus of treatment must be documented separately from the treatment plan
- Diagnoses can only be completed by LPHAs within their training, experience and scope of practice. When the diagnosis is established by a registered/waivered LPHA, a Licensed LPHA co-signature required within the due date

ACBH Initial Medical Necessity Form

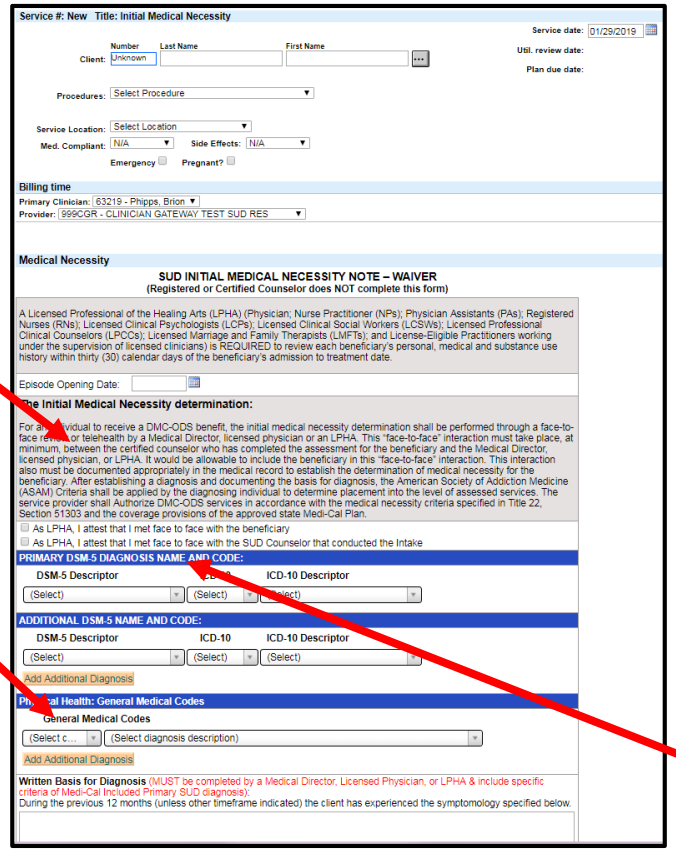
- The IMN form includes the additional med. nec. components required by the IA (except ALOC)
- This form documents the basis for SUD diagnosis in the client's individual medical record
- Recommended for OTPs, or at a minimum include all of the elements of the form in the medical record
- An included diagnosis must be established by the initial plan due date (28 days) and by a LPHA. If the LPHA who establishes the diagnosis is registered with their respective licensing board, a licensed LPHA co-signature is required.

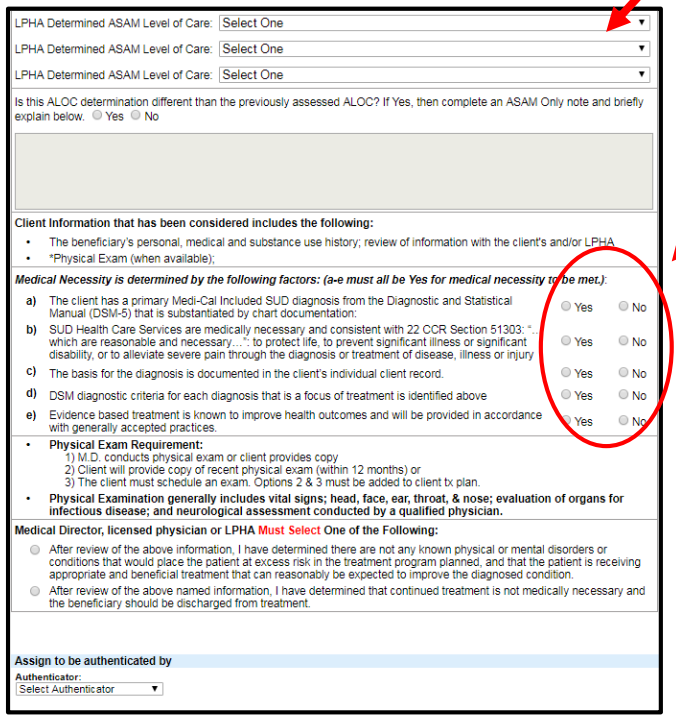
Initial Medical Necessity Form

Covers the additional SUD Med. Nec. requirements

The LPHA indicates here if they met face-to-face with the beneficiary or the SUD Counselor who conducted the assessment

LPHA must include the written basis for each treated diagnosis. DSM-5 criteria must be individualized and include specific signs and symptoms for each SUD diagnosis.





In CG up to 9 diagnoses may be added to the beneficiary's medical record

LPHA enters all ASAM levels of care here (up to 3)

All must be determined as 'Yes' in order for medical necessity to be established.

IMN may only be completed by an LPHA. If LPHA is registered or waivered, then a licensed LPHA must review and co-sign the form

If not, medical necessity will not have been established and claims will be disallowed

Levels of Care on IMN

- As part of establishing medical necessity the LPHA must review the ASAM
- The LPHA may require that the ALOC be redone if they feel it is not accurate or is missing elements
- The LOC information from the ALOC is included in the IMN and indicates the LPHA concurs with the ALOC findings
- By signing the IMN, the LPHA is attesting that medical necessity is met and they have reviewed the required components of the intake to inform their decision

A few review questions are coming up, we know the answers are in your handout, they're right there on the next page. Please don't look so we can all figure them out together.

Medical Necessity & Assessment Review Questions

What are the requirements to establish Medical Necessity for SUD services?

- Pre-Admission OTP requirements
- A DHCS included SUD diagnosis which is the Primary Focus of Treatment
- Appropriate ASAM LOC (ALOC)

Who may establish a diagnosis?

- LPHA (with co-signatures if registered/waivered LPHA). At OTPs diagnoses will probably be established prior to admission by a physician

Who may complete the ASAM?

- LPHA, certified SUD Counselor. Registered SUD Counselor if they meet knowledge, experience, and ASAM training requirements

Who MAY NOT formulate a diagnosis?

- Certified/Registered SUD Counselor

Medical Necessity & Assessment Review Cont.

All are reasons for full chart non-compliance from the date of non-compliance until completed

Does a checkbox list or simply restating the DSM-5 criteria for a SUD diagnosis suffice as a written basis for the diagnosis?

- No. The written basis for the diagnosis completed by an LPHA must be individualized with timeframes indicated for all criteria.

What is the timeline for establishing medical necessity and on-going treatment for ACBH SUD programs?

- For OTPs medical necessity must be established prior to admission/initial dose and then annually thereafter.

Why would a medical necessity form need a co-signature?

- If the LPHA completing the form was registered or waivered with their respective board

Client Plans

Part of the Golden Thread

Client Plans & Documentation

Client Plans & Documentation

SUD Client Plans 1

- Each person admitted to treatment services must have an individually prepared client plan
  - The development of the client plan should be, as much as possible, a collaborative process between the primary SUD Counselor/LPHA and the beneficiary
  - The LPHA or SUD Counselor must attempt to engage the beneficiary to meaningfully participate in the preparation of the initial client plan and updated client plans.
  - Plans should be specific and written in language the beneficiary understands (not overly clinical or with acronyms)

SUD Client Plans 2
Required components (except Detoxification OTP)

- A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation
- Goals to be reached which address each problem
- Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals
- Target dates for the accomplishment of action steps and goals
- A description of the services, including the type of counseling, to be provided and the frequency thereof
- The assignment of a primary therapist or counselor
- The beneficiary's DSM-5 diagnosis as documented by the Medical Director or LPHA
- If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination
- If documentation of a beneficiary's physical examination, which was performed during the prior twelve months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness

SUD Client Plans 3
Additional OTP Maintenance Requirements

- Goals to be achieved by the client based on the needs identified during the assessment process and with estimated target dates for attainment in accordance with the following:
  - Short-term goals are those which are estimated to require ninety (90) days or less for the client to achieve
  - Long-term goals are those which are estimated to require a specified time exceeding ninety (90) days for the client to achieve.

SUD Client Plans 4
OTP Detoxification Services Plan Requirements

- Provisions to assist the client to understand illicit drug addictions and how to deal with them
- Provisions for furnishing services to the client as needed when the period of detoxification treatment is completed
- The treatment services required and a description of the role they play in achieving the stated goals
- The type and frequency of scheduled counseling services

SUD Client Plans 5

On the client plan, providers should attempt to link identified needs to the corresponding ASAM Dimension:

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

SUD Client Plans 6
Client Plan Goals

- Goals must be established collaboratively with the client that addresses each active problem (not deferred)
- Goals may focus on the client's personal vision of recovery, wellness, and the life they envision for themselves
- ACBH recommends providers use S.M.A.R.T. (Specific, Measurable, Attainable, Realistic, and Time Bound) style goals

Measurable and attainable goals create opportunity for success

SUD Client Plans 7
Deferring Client Plan Goals

- If a challenge is not going to be addressed during the plan period it may be deferred
- Must indicate reason for each deferral on the plan

Name a few reasons why a goal would be deferred

SUD Client Plans 8
Action Steps 1

- Steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
- During the plan development process providers assist the client in developing the short-term action steps related his/her identified goal(s)
- Instead of indicating that the client will participate in groups or treatment, indicate what will be the expected benefit to client.

SUD Client Plans 9
Action Steps 2

- Provider Action Steps must focus on helping the client achieve their treatment goals
- Interventions for Collateral should include listing significant others by their names and roles (professional relationships do not qualify for Collateral services) for whom contact is planned and indicating “others as needed”
- Only approved ACBH abbreviations (acronyms) may be used in the Medical Record—see website for list

SUD Client Plans 10
Action Steps 3

Use This:

Client will be able to identify 5 personal relapse prevention skills.

Client will develop a safety plan and learn the three states of the domestic violence cycle of abuse.

Not This:

Client will attend Relapse Prevention Group

Client will participate in individual counseling every week.

SUD Client Plans 11
Frequency of Services

- Use specific expected frequency of services (e.g. 1x/week and as needed)
- The frequency of services indicated in the plan must match the frequency of services provided
- The Client Plan should be updated if the planned frequency doesn't correspond with the beneficiary's actual use of services
- ACBH will be checking this in upcoming audits

SUD Client Plans 12
Description of Services OTPs

- The following services types need to be identified in OTP plans:
  - Individual Counsel
  - Collateral
  - Medical PsychoTX
  - Patient Education
  - Group Counsel
  - Case Management
    - Service Coordination
    - Care Coordination
  - Medication Services
  - Methadone Dispensing
  - Buprenorphine Dispensing
  - Disulfiram Dispensing
  - Bupr-Nalox Administering
- Best practice is to include a brief description of the type of services
- Intake, treatment planning, physician consultation, crisis, and discharge planning do not need to be in the plan.

SUD Client Plan 13
Tentative Discharge Plan

- The purpose of the tentative discharge is to map out a path for treatment and what the client's life situation or presentation may be when they no longer require services
- Starting this process early on in treatment maps out a path to work towards
- Like all parts of the plan, the tentative discharge plan must be written in a way that is helpful to the client and uses language the client will readily understand

SUD Client Plan 14
Additional Requirements

- Plan must indicate the **primary** SUD Counselor/LPHA. If this changes, indicate the change in a progress note and update on the next plan.
- If a beneficiary has a significant medical illness, the plan must contain a goal to obtain appropriate treatment for the illness
- DSM-5 SUD Diagnosis (both code and name with specifiers are required)
  - The diagnosis must be completed/established prior to the plan being completed

Updating SUD Client Plans
Additional OTP Maintenance Plan Requirements

- Updates occur whenever medically necessary or at least once every three (3) months from the date of admission
- A summary of the client's progress or lack of progress toward each goal identified on the previous treatment plan.
- New goals and behavioral tasks for any newly identified needs, and related changes in the type and frequency of counseling services

Signature Requirements Reminder

- All treatment staff signatures in SUD must include the printed name, credentials, legible signature, and date signed
- When beneficiaries are required to sign documents, ask that they print their name, sign legibly, and include that day's date. If they have difficulty with this, note this on the progress note documenting the service.
- One of the most common causes of non-compliance is due to incomplete signatures that did not contain all components – Will cause claims disallowances.

IA.III.PP.12
9 CCR § 10305
ACBH Requirement

Client Plan Completion Requirements 1
Signatures for Initial Plan

- The Initial Plan must be signed and completed within 28 days of admission
  - The completion date is the date the SUD Counselor or LPHA who completes the plan signs it. This is the plan date.
- The client must sign also sign the plan within 28 days of admission
  - See related slides for specific requirements
- For clients in OTP Maintenance, both the supervising counselor and Medical Director/Physician must review and co-sign the plan within 14 days from the plan's effective date

Client Plan Completion Requirements 2
Signatures for Plan Updates

- The SUD Counselor or LPHA who authored the plan update must complete it and sign it by the due date
  - This date is the plan's effective date
- For clients in OTP Maintenance, both the supervising counselor and Medical Director/Physician must review and co-sign the plan update within 14 days from the plan's effective date
- The client's signature on the plan update is due 30 days from the date the SUD Counselor/LPHA signed the plan
- Plans may need to be updated more frequently based on beneficiary status/functioning

What if the beneficiary is unwilling or unable to sign the plan or plan update?

- The beneficiary's signature is required on the plan and plan update. It is the formal attestation that the beneficiary has participated in the plan development and their agreement to the specifics of treatment.
- If the beneficiary refuses to sign the plan, the provider must document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment – if not may cause multiple claims disallowances
- A beneficiary not being available to sign the plan or the provider forgetting to have the beneficiary sign are not valid reasons for non-signature on the plan or plan update

Services required to be listed in the Plan

What are unplanned services?

- These are services that do not need to be included in the client plan in order to be provided
- The only unplanned services are: Intake/Assessment, Treatment Planning, Crisis, Discharge, and Physician Consultation
- Dosing before completion of the Assessment and Plan 28 day due date

What are planned services?

- Services that are required to be identified in the plan in order to be provided
- Planned Services may be provided prior to the initial plan due date, if the initial plan has not yet been completed.
- Once an initial plan is completed, regardless of the plan due date, only services identified in the plan may be provided. Adding other planned services requires a plan revision before they may be claimed.

Potential Client Plan Issues
Non-Compliance

Services may be disallowed when:

- Plan signatures are missing or incomplete
- The additional Perinatal Assessment items were not addressed on the plan. (See Perinatal Slides)
- Plan is not individualized

What are some common reasons for client plan non-compliance?

- Primary SUD Counselor/LPHA not identified in the plan
- Target Dates of Goals/Action Steps not indicated or expired
- Frequency and Type of Services (modalities) not specified
- Goals, Objectives and Measurable Action Steps are missing or vague
- Plan was not completed on time
- DSM-5 diagnosis is not on the plan

Perinatal Client Plans

Additional requirements for perinatal beneficiaries:

- Prenatal exposure to substances harms developing fetuses. If this is identified as a need in the assessment there must be a goal to provide education to the mother, action steps, and target date must be included in the plan to address this problem.
- Does the mother need assistance in accessing ancillary services (dental, social, community, educational/vocational, and other services that are medically necessary to prevent risk to the fetus)?
  - If yes, the plan must include a goal, action steps, and target date to accomplish this goal

Perinatal Client Plans, cont.

- **Was a need for mother/child habilitative services identified in the assessment?**
  - If yes, the plan must include a goal, action steps, and target date to accomplish this goal
- **Were sexual or physical abuse issues identified in the assessment?**
  - If yes, the plan must include a goal, action steps, and target date to accomplish this goal
- **Are there service access needs (i.e. transportation, financial, other barriers) identified in the assessment?**
  - If yes, the plan must include a goal, action steps, and target date to accomplish this goal

How to claim for writing the Client Plan 1

- If the plan is completed in one session (both face-to-face collaboration with the client) and writing the plan, it may be documented as one treatment planning session. Start and stop times for each component must be clearly documented.

Example:

- Interventions: Counselor and client met to discuss plan goals and action steps (60 minutes). Following the session, counselor used information gathered in the session to develop and write client plan (50 minutes). See plan dated 11/10/18. Counselor and client sign the plan at the next face-to-face meeting.

How to claim for writing the Client Plan 2

- If the development of the plan took place over several sessions, document each session separately.
  - For the treatment planning sessions, indicate the sections of plan template that were completed in the progress note or write data in the note.
  - After the last session, on the same day that the note is written for that service, also write the plan. Include the time (including date, start and end times) spent doing each activity: Session time, PN documentation, plan writing, travel time, etc.

A few review questions are coming up, we know the answers are in your handout, they're right there on the next page. Please don't look so we can all figure them out together.

Client Plan Review Questions

If a service type or modality is not listed in the plan can those services be claimed?

- Unplanned services (intake/assessment, treatment planning, crisis, physician consultation, discharge) may be provided at anytime, and do not need to be listed in the plan
- Planned services (group, individual, case management, medication, collateral, patient education, dosing after 28 days etc) may only be provided when included in the plan and after the initial plan due date. Planned services may be provided prior to the plan due date

When is a plan update due for a person receiving OTP Detoxification services?

- For short-term detoxification services, it is unlikely a client would need a plan update
- For long-term detoxification services, a plan update may be required

What part of the diagnosis needs to be listed on the plan?

- The ICD-10 code and DSM-5 name (and any specifiers)

Client Plan Review Questions

- **When does the plan need to be updated?**
  - OTP Maintenance treatment requires plan updates once every 3 months from EOD (in the 3 month window). Depending on the length of services, detoxification services may require a plan update.
- **Can the time I spent writing the plan be claimed?**
  - For outpatient services, yes the time spent documenting is claimed along with the treatment plan services.

Service Types

Including InSyst Procedure Codes

Intake/Assessment
465 OTP-NTP Intake/Assessment

- Intake/Assessment services consist of the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services.
- Intake/Assessment procedure codes at OTPs should be used for services related to completing the Intake Needs Assessment and other related assessment services
- Intake/Assessment does not need to be in the plan in order to be provided
- May be provided by SUD Counselors and LPHAs
- Documentation time may be claimed for completing the needs assessment document as long as it is claimed along with a direct service session
- Intake/Assessment may be claimed on the same day as the initial dosing claim if it is for the purposes of completing the intake needs assessment

STC.X.135
IA.III.PP.8
9 CCR § 10305

Treatment Planning
496 OTP-NTP Treatment Planning

- For each beneficiary the provider must prepare an individualized written client plan, based upon information obtained in the intake and assessment process. OTP plan are required to be completed within the first 28 days of intake, and then within every 3 months thereafter or whenever there is a change in treatment modality or significant event that would then require a new plan.
- This code is used to claim for services related to developing, updating, or otherwise related to the client plan.
- May be provided by SUD Counselors and LPHAs with required co-signatures.

9 CCR § 10305
IA.III.PP.12

Counseling Services Available at OTPs

- The primary counselor must arrange for between 50 and 200 minutes of counseling services each calendar month the client is receiving maintenance treatment services. By medical order, the medical director may adjust the minimum and maximum number of counseling services a specific client receives.
- The three types of counseling services available at OTPs and meet the counseling requirement are:
  - Individual Counseling
  - Group Counseling
  - Medical Psychotherapy
- Staff who provide counseling services must operate within their scope of practice, training, and have valid credentials at the time the service is provided
- All counseling services are planned services and need to be identified in the client plan in order to be provided past the initial plan due/completion date

IA.IV.44
9 CCR § 10345
MHSUDS IN 15-028

Counseling Services

The following does not qualify as a counseling session

- Interactions conducted with program staff in conjunction with dosage administration.
- Self-help meetings, including the 12-step programs of Narcotics Anonymous, Methadone Anonymous, Cocaine Anonymous, and Alcoholics Anonymous.
- Educational sessions, including client orientation sessions
- Administrative intervention regarding payment of fees.

Individual Counseling

- Services are conducted in a confidential setting so that individuals not participating in the counseling session cannot hear the comments of the beneficiary, SUD counselor or LPHA.
- Individual counseling focuses on reducing or stopping substance use, skill building, adherence to a recovery plan, and social, family, and professional/educational outcomes.

Individual Counseling
455 OTP-NTP Individual Counsel

- Session between a beneficiary and a LPHA or SUD counselor
- Individual Counseling must be indicated in Client Plan with frequency (e.g. 1x/week)
- Is an individual session, with face-to-face discussion with the patient, on a one-on-one basis, on issues identified in the client's treatment plan
- May be provided by SUD Counselors and LPHAs

Group Counseling
506 OTP NTP Group Counsel

- Group counseling services provided by 1-2 treatment staff, with a minimum of four clients and no more than ten clients and having a clear goal and/or purpose that is a common issue identified in the treatment plans of all participating clients
- Groups must have between 4 and 10 clients
- Group Counseling must be indicated in Client Plan with frequency (e.g. 3x/week)
- A beneficiary that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.
- May be provided by SUD Counselors and LPHAs

OTP Medical Psychotherapy
479 OTP-NTP MedicalPsychoTX

- Medical psychotherapy session, with face-to-face discussion conducted by the medical director (or delegated physician) on a one-on-one basis with the client, on issues identified in the client's treatment plan.
- May only be provided by a psychiatrist
- Must be indicated in Client Plan with frequency (e.g. 2x/month)

Counseling Services

- All program staff who provide counseling services must be licensed, certified or registered to obtain certification or licensure from their respective California licensing board (e.g. Board of Behavioral Sciences, Board of Psychology, California Board of Registered Nursing, Board of Vocational Nursing and Psychiatric Technicians) when providing the service.
- Staff who may provide counseling services are nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with an opiate addiction.

Collateral
474 OTP NTP Collateral

- Sessions with LPHAs or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals.
- Significant persons are individuals that have a personal relationship (family member, non-paid advocate, sponsor, etc.), AND not an official or professional relationship (CWW, Probation Office, Teacher, etc.) with the beneficiary.
  - Teachers, outside therapists, probation workers, CWWs, etc. are considered professional relationships and cannot be claimed as collateral. Case Management may apply.
- Releases of Information are required for collateral contacts
- Collateral must be indicated in Client Plan with frequency (e.g. 2x/month)
- May be provided by SUD Counselors and LPHAs

Crisis Intervention
491 OTP-NTP Crisis Intervention

- “Crisis intervention” is a face-to-face contact between a beneficiary who is at risk for imminent threat of relapse and a LPHA or counselor
- “Crisis” for SUD means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.
- Services must focus on alleviating crisis problems
- Not required to be in the plan as crises by definition are unplanned events
- As crises can happen anytime, and by definition are unexpected, it’s good practice to have signed ROIs in place in case of emergency
- May be provided by SUD Counselors and LPHAs

Patient Education
483 OTP-NTP Patient Education

- Means providing research based education on addiction, treatment, recovery and associated health risks
- May be provided as an individual or group service (group client ed. code coming soon)
- When documenting a Patient Education group (a non-clinical service), at a minimum, the service note for group patient education must always relate back to the individualized client plan.
- Patient Education must be indicated in Client Plan with frequency (e.g. 2x/month)
- Patient Education groups may only have 2-12 participants per group
- May be provided by SUD Counselors and LPHAs

Physician Consultation
Code TBD

- Are services to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
- Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice when developing treatment plans for DMC-ODS beneficiaries with complex cases.
- Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-to-drug interactions, or level of care considerations.
- ACBH is working to contract with one or more physicians or pharmacists in order to provide consultation services. Until then this service may not be claimed.

Medication Services and Medication Assisted Treatment (MAT)

- Methadone treatment is only allowed at OTPs
- OTP/NTPs are required to provide access to Buprenorphine, Naloxone, and Disulfiram
- Additional MAT may be provided at OTPs if the client meets OTP admission requirements
- OS/IOS/RES prescribers may claim for medication services if within their scope of practice and training. The prescribed medication needs to be picked up by the client at a local pharmacy
  - Prescribed medication may not be methadone, buprenorphine, naloxone, and disulfiram for opioid treatment
  - RES also requires IMS Certification to provide medication services
- Beneficiaries may also be referred to their primary care physician for medication services
- MAT is not available through Recovery Support Services programs, the client may receive MAT elsewhere

Medication Services
Allowed for all LOCs when specified in contract

- Definition: The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication
- May only be conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice, licensure, training, and experience
- OS/IOS/RES providers may prescribe if within their scope of practice and training. The prescribed medication needs to be picked up by the client at a local pharmacy
  - Prescribed medication currently may not be any medication for opioid treatment
  - RES requires IMS Certification
- Prescription and administration of medications may occur at the following locations:
  - OTPs (only certain medications)
  - Fee-for-service primary care physicians
- Medication Services must be indicated in Client Plan with frequency (e.g. 2x/month)

OTP Medication Services
InSyst Procedure Codes

- 519 OTP-NTP Methadone Dosing
- 520 OTP-NTP MAT Buprenorphine
- 521 OTP-NTP MAT Buprenorphine Brand
- 522 OTP-NTP MAT Disulfiram Generic
- 523 OTP-NTP MAT Disulfiram Brand

524 OTP-NTP MAT Naloxone Generic
525 OTP-NTP MAT Naloxone Brand
526 OTP-NTP MAT Bupr-Nalox Gen
527 OTP-NTP MAT Bupr-Nalox Brand

Dispensing or Dosing are planned services and must be indicated in the plan, with frequency (e.g. daily)

Case Management Services
Available at all LOCs

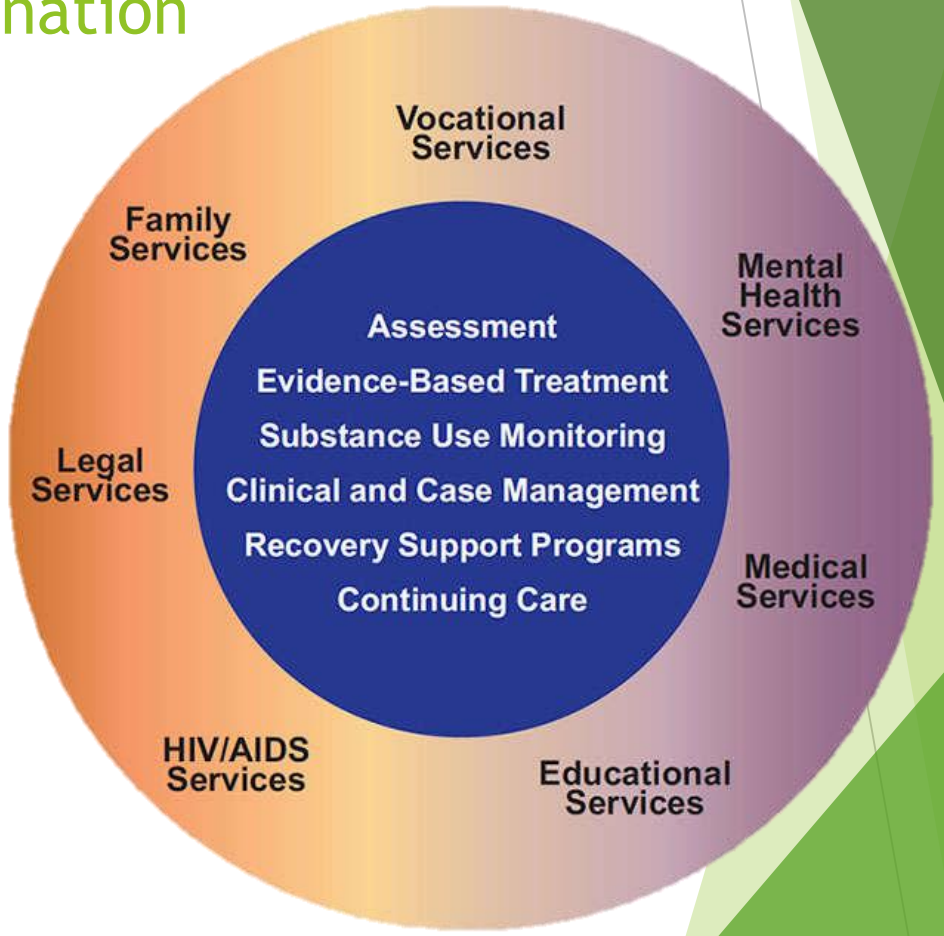
- To assist a beneficiary in being able to access medical, educational, social, prevocational, vocational, rehabilitative, and community services.
- Focus on coordination of SUD care and integration centered around primary care especially with beneficiaries with chronic SUD issues
  - Interaction with the criminal justice system allowed, if needed
- Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.
- Case management services may be provided by a LPHA or Registered/Certified SUD Counselor
- Case management services must be provided when transitioning beneficiaries between levels of care.

OTP Case Management Services

511 Case Management: Care coordination

512 Case Management: Service coordination

- Case Management Services do not count towards the counseling services requirement
- CM services are planned services and need to be identified in the client plan in order to be provided past the initial plan due/completion date (with frequency – e.g. 1x/week and as needed)



Discharge Planning
501 OTP-NTP Discharge Planning

- Process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services
- Discharge Services are not required to be in the plan in order to be claimed

Tracking Codes
Exist for each program type

- On the procedure code table there are several “Tracking Codes”
- These are not codes for billing and have no claim associations
- Tracking codes are required by CG on forms only, they should automatically populate in the corresponding form

SUD InSyst Procedure Code Table

Alameda County Behavioral Health Care Services
Substance Use Disorder - InSyst Procedure Codes effective 7-1-18

Insyst Proc Code	InSyst SUD Proc Code	Short name	SFC	HCPC Code	PHY	PSY	PSY TECH	NP	PA	RN	Pharm	PhD	PhD Waivered	LCSW	LPCC	LPCC FAMILY	MFT	Intern/ Lic-elig pract	Rehab Coun/ SUD Counselor (Cert/Reg)	Unlicensed/ Non-Prof Staff
254	IOS Case Mgmt-Care Coord	IOS CMCARE	GC	H0006	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
255	IOS Case Mgmt-Serv Coord	IOS CMSERV	GC	H0006	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
270	IOS Physician Consultation	IOSPHYCSLT	DC	G9008	X	X														
278	IOS Rec Srv - Individual Coun	IOS RSINDV	EC	[illegible]	[illegible]	[illegible]		X	X	X	X	X	X	X	X	X	X	X	X	
281	IOS Rec Srv - Group Coun		FC	H0005	X	X		X	X			X	X	X	X	X	X	X	X	
284	IOS Rec Srv Case MgmtCareCoo[illegible]	IOSRSCMCAR	GD	H0006	X	X		X	X	X	X	X	[illegible]	[illegible]	X	X	X	X	X	
285	IOS Rec Srv Case M[illegible]oord	IOSRSCMSRV	GD	H0006	X	X		X	X	X	X	X	X	X	[illegible]	X	X	X	X	
289	IOS Rec S[illegible]nitoring SAA	IOS RS MON	CB	T1012	X	X		X	X	X	X	X	X	X	X		X	X	X	X
	Opiod Treatment Program (OTP)/ Narcotic Treatment Program (NTP)																			
197	SUD CG Informational Note	SUD CGNOTE	OO	no Mcal bill																
880	SUD Tracking-Assessment	SUDTRKASST	OO	no Mcal bill																
881	SUD TRACKING MED NECESS/JUSTIF	SUDTRKMNEC	OO	no Mcal bill																
882	SUD TRACKING ALOC	SUDTRKALOC	OO	no Mcal bill																
883	SUD TRACKING DISCHARGE	SUDTRKDISC	OO	no Mcal bill																
455	OTP-NTP-NTP Individual Counsel	NTP INDIV	ED	H0004	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
465	OTP-NTP-NTP Intake/Assessment	NTP INTAKE	ED	H0004	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
474	OTP-NTP-NTP Collateral	NTP COLLAT	ED	H0004	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
479	OTP-NTP-NTP Medical PsychoTX	NTP MEDPTX	ED	H0004	X	X		X	X											
483	OTP-NTP Patient Education	NTP PT ED	ED	H0004	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
486	OTP-NTP Medication Services	NTP MEDS	ED	H0004	X	X	X	X	X	X										
491	OTP-NTP Crisis Intervention	NTPCRISINT	ED	H0004	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
496	OTP-NTP Treatment Planning	NTP TXPLNG	ED	H0004	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
501	OTP-NTP Discharge Plng	NTP DISCH	ED	H0004	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
506	OTP-NTP Group Counsel	NTP GROUP	FD	H0005	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
519	OTP-NTP Methadone Dosing	NTPMETHDOS	MA	H0020	X	X	X	X	X	X										
520	OTP-NTP MAT Buprenorphine Gen	NMAT BUP G	AC	S5000	X	X														
521	OTP-NTP MAT Buprenorphine Bran	NMAT BUP B	BC	S5001	X	X														
522	OTP-NTP MAT Disulfiram Generic	NMAT DIS G	AC	S5000	X	X														
523	OTP-NTP MAT Disulfiram Brand	NMAT DIS B	BC	S5001	X	X														
524	OTP-NTP MAT Naloxone Generic	NMAT NAL G	AC	S5000	X	X														
525	OTP-NTP MAT Naloxone Brand	NMAT MAL B	BC	S5001	X	X														
526	OTP-NTP MAT Bupr-Nalox Gen	NMATBUNALG	AC	S5000	X	X														
527	OTP-NTP MAT Bupr-Nalox Brand	NMATBUNALB	BC	S5001	X	X														
	[illegible]ally Managed 3.1 Low-Intensity Reside[illegible] Services																			
197	SUD CG Informa[illegible]	SUD CGNOTE	OO	no Mcal bill																
880	SUD Tracking-Assessment	SUDTRKASST	OO	no Mcal bill																
881	SUD TRACKING MED NECESS/JUSTIF	[illegible]TRKMNEC	OO	no Mcal bill																
882	SUD TRACKING ALOC	SUDTRKALOC	[illegible]	[illegible]																
101	3.1 RES Residential Day	3.1 RES DY	LA	H0019	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
106	3.1 RES Non-DMC Assessment NMN	3.1NMNASMT	OO	no Mcal bill	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
109	3.1 RES NonDMC Residential NMN	3.1 NMNRDY	OO	no Mcal bill	X	X		X	X	X	X	X	X	X	X	X	X	X	X	
112	3.1 RES Case Mgmt-Care Coord	3.1 RCMCAR	GG	H0006	X	X		X	X	X	X	X	X	X	X	X	X	X	X	

Progress Notes

Part of the Golden Thread

Claiming using Progress Notes

- Progress notes are the backbone of claiming and ongoing documentation in the clinical record
- In order to claim for all services except dispensing, a progress note is required
- Forms such as the Client Plan are not for claiming
  - For example, if a OTP SUD Counselor and a beneficiary meet to develop the client plan, the SUD Counselor might meet with the beneficiary to discuss plan goals, then later that day or the next day the SUD Counselor sits down to write the plan. The SUD Counselor would document that this way:
    - Possible to write one note
      - Document the face-to-face session with dates and times of service
      - Include documentation date/time for writing the progress note and writing the plan

OTP Counseling Progress Notes 1

- Required for each claim for each unique service made for SUD services
- For example, two groups on the same day require separate group notes – two (2) notes on that day
- Must be completed by the staff that provided the service within 7 calendar days of the service (the date of service is day 1)
- Providers must enter the actual time and minutes on the service note, InSyst will calculate correct claiming

OTP Counseling Progress Notes 2

Progress notes are individual narrative summaries and must include all of the following:

- The topic of the session or purpose of the service
- Type of counseling format (i.e., individual, group, or medical psychotherapy) – Must either be the exact code Name or code.
  - Recommend that providers use the Procedure Code and Name on notes
- Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service

OTP Counseling Progress Notes 3

A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals, including:

- Response to a drug-screening specimen which is positive for illicit drugs or is negative for the replacement narcotic therapy medication dispensed by the program
- New issue or problem that affects the client's treatment
- Nature of prenatal support provided by the program or other appropriate health care provider
- Goal and/or purpose of the group session, the subjects discussed, and a brief summary of the client's participation

OTP Group Claiming
Using ACBH Template As An Example

- How are OTPs currently claiming for group services?

Reimbursement of Documentation Time 1

- The Medical Director, LPHA, or counselor who provided the service may claim for time spent documenting that service
- Documentation time related to dosing activities is not claimable
- Reimbursable documentation activities include:
  - Time spent completing progress notes, client plans, continuing services justification, and discharge documentation is reimbursable
- Typical time spent documenting a 50 minute service is 10 minutes, but the content of the note must substantiate the time claimed for documentation
- Writing of the Assessment, IMN/CSJ, Client Plans, etc. may take longer than 20% of total face-to-face and doc time.
- Documentation alone is not reimbursable, there must be a claimed contact service
- Must include date and start/end times for all claimed time, including documentation times, an auditor must be able to reconstruct all of the claimed time by reading the note

Reimbursement of Documentation Time 2

- For OTPs who have technological/EHR limitations that do not allow for non-continuous claiming, a second note that claims for service documentation time may claimed and included in the medical record.
- In these situations, two notes are required. One to claim for the service, the other to claim for the documentation time.
- The progress note for the service (e.g. Ind. Counseling) must include the documentation time in the body of the note, but this time is not included in the claimed time.
- The documentation time note may be brief but must clearly indicate what note the documentation time refers to.
  - For example, “Claiming 10 minutes to document 5/14/19 Individual Counseling service, see 5/14/19 progress note.”

Documenting Case Management and Physician Consultation

- FOR ALL SUD PROVIDERS: Case Management and Physician Consultation are separate services and need to be claimed and documented separately
- The time spent providing Case Management and Physician Consultation services do not count towards minimum or maximum service requirements as they are separate services.
  - For example, at OTPs, time spent providing Case Management services does not count towards the 50 minute minimum monthly counseling service requirement
- Providers must use a single service progress note to separately document these services
- Additionally, Case Management services may not be combined with other service types when claiming and must be claimed/documented separately

Requirements for Physician Consultation Notes

Physician Consultation notes must include all of the following:

- Beneficiary's name
- The purpose of the service
- Date, start and end times of each service
- Identify if services were provided face-to-face, by telephone or by telehealth
- ACBH Consultants name and discipline. e.g. Charles, Smith, PharmD

- The physician completing the note must sign their name and include their printed name, credentials, and date signed
- Progress notes must be completed within seven (7) calendar days of the service

Case Management Services, Cont.

- Care Coordination
  - Bringing together various providers and information systems to coordinate health services, client needs, and information to help better achieve the goals of treatment and care. Use this code for the medically necessary coordination of services (linking/monitoring) within the Alameda County SUD Provider Network (SPN).
- Service Coordination
  - A service to assist clients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, and/or other community services. Its is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost effective outcomes. In order to link client with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate service needed for the client to optimize care through effective, relevant networks of support. Use this code for the medically necessary coordination of services (linking/monitoring) outside of the Alameda County SUD Provider Network (SPN).

Requirements for Case Management Notes

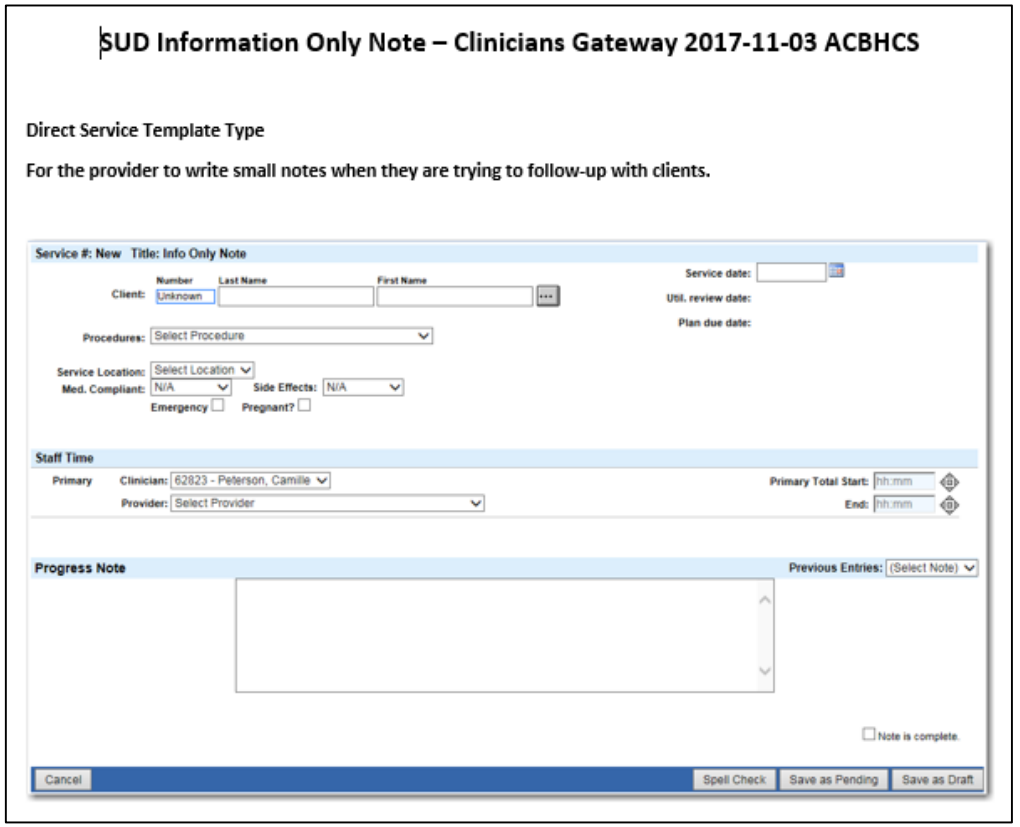
Case Management progress notes must include all of the following:

- Beneficiary's name
- The purpose of the service
- A description of how the service relates to the beneficiary's client plan problems, goals, action steps, objectives, and/or referrals
- Date, start and end times of each service
- Identify if services were provided in-person, by telephone, or by telehealth
- If services were provided in the community, identify the location and how the provider ensured confidentiality.
- The SUD Counselor or LPHA completing the note must sign their name and include their printed name, credentials, and date signed

CM notes must be completed within seven (7) calendar days of the service

Information Only Note
CG screenshot example

Use this note for recording information that is not billable but needs to be documented in the client's medical record.



Transportation vs. Travel Time

- Transportation is when a staff transports a beneficiary to an off-site location. It may be to an appointment, a community resource, to pick up their medications, or any number of other off-site activities. Time transporting clients is not reimbursable, except at SUD RES programs (where it counts towards the required 20 hours of structured therapeutic activities per week).
- A staff providing counseling or other treatment interventions while going 1:1 off-site with a beneficiary may claim only the actual time providing the treatment service. This must be documented clearly and be a medically necessary service.
- Travel Time is the time a treatment staff spends traveling (one-way or round trip) to meet the beneficiary at their home and in the community. The beneficiary is not with the staff during time claimed as Travel Time.

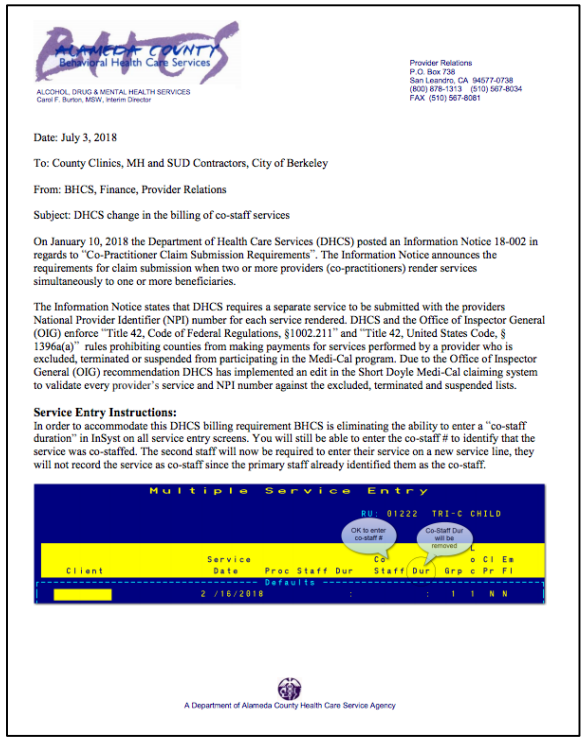
SUD Group Treatment Requirements

OTP Counseling Groups

- OTP counseling may only be between 4 and 10 participants regardless of staffing — reason for non-compliance
  - OTP Counseling Groups larger than 10 participants must be divided into separate groups with different group facilitators (counselors/LPHAs)
  - Groups with more than 10 participants may not be claimed for any of the participants. Instead, a non-billable note would be completed for each group participant.
- A client that is 17 years of age or younger may not participate in group counseling with any participants who are 18 years of age or older — reason for non-compliance for all group members.
- However, a client who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's Medi-Cal certified school site.

IA.III.PP.13
IA.IV.42
9 CCR § 10345.b.3.B

Claiming in InSyst for Co-Staffing



ALAMEDA COUNTY
Behavioral Health Care Services

ALCOHOL, DRUG & MENTAL HEALTH SERVICES
Carol F. Burton, MSW, Interim Director

Provider Relations
P.O. Box 738
San Leandro, CA 94577-0738
(800) 878-1313 (510) 567-8034
FAX (510) 567-8081

Date: July 3, 2018

To: County Clinics, MH and SUD Contractors, City of Berkeley

From: BHCS, Finance, Provider Relations

Subject: DHCS change in the billing of co-staff services

On January 10, 2018 the Department of Health Care Services (DHCS) posted an Information Notice 18-002 in regards to "Co-Practitioner Claim Submission Requirements". The Information Notice announces the requirements for claim submission when two or more providers (co-practitioners) render services simultaneously to one or more beneficiaries.

The Information Notice states that DHCS requires a separate service to be submitted with the providers National Provider Identifier (NPI) number for each service rendered. DHCS and the Office of Inspector General (OIG) enforce "Title 42, Code of Federal Regulations, §1002.211" and "Title 42, United States Code, § 1396a(a)" rules prohibiting counties from making payments for services performed by a provider who is excluded, terminated or suspended from participating in the Medi-Cal program. Due to the Office of Inspector General (OIG) recommendation DHCS has implemented an edit in the Short Doyle Medi-Cal claiming system to validate every provider's service and NPI number against the excluded, terminated and suspended lists.

Service Entry Instructions:
In order to accommodate this DHCS billing requirement BHCS is eliminating the ability to enter a "co-staff duration" in InSyst on all service entry screens. You will still be able to enter the co-staff # to identify that the service was co-staffed. The second staff will now be required to enter their service on a new service line, they will not record the service as co-staff since the primary staff already identified them as the co-staff.

Multiple Service Entry

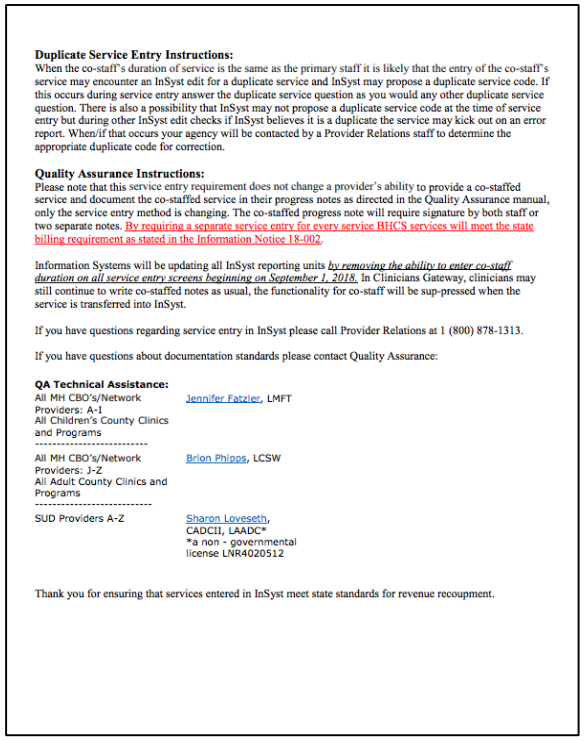
BU: 01222 TRI-C CHILD

OK to enter co-staff #

Co-Staff Dur will be removed

Client	Service Date	Proc	Staff	Dur	Co Staff	Dur	Grp	c	Pr	Cl	Fl
Defaults											
	2/16/2018						1		1	N	N

A Department of Alameda County Health Care Service Agency



Duplicate Service Entry Instructions:
When the co-staff's duration of service is the same as the primary staff it is likely that the entry of the co-staff's service may encounter an InSyst edit for a duplicate service and InSyst may propose a duplicate service code. If this occurs during service entry answer the duplicate service question as you would any other duplicate service question. There is also a possibility that InSyst may not propose a duplicate service code at the time of service entry but during other InSyst edit checks if InSyst believes it is a duplicate the service may kick out on an error report. When/if that occurs your agency will be contacted by a Provider Relations staff to determine the appropriate duplicate code for correction.

Quality Assurance Instructions:
Please note that this service entry requirement does not change a provider's ability to provide a co-staffed service and document the co-staffed service in their progress notes as directed in the Quality Assurance manual, only the service entry method is changing. The co-staffed progress note will require signature by both staff or two separate notes. By requiring a separate service entry for every service BHCS services will meet the state billing requirement as stated in the Information Notice 18-002.

Information Systems will be updating all InSyst reporting units *by removing the ability to enter co-staff duration on all service entry screens beginning on September 1, 2018.* In Clinicians Gateway, clinicians may still continue to write co-staffed notes as usual, the functionality for co-staff will be sup-pressed when the service is transferred into InSyst.

If you have questions regarding service entry in InSyst please call Provider Relations at 1 (800) 878-1313.

If you have questions about documentation standards please contact Quality Assurance:

QA Technical Assistance:

All MH CBO's/Network Providers: A-I All Children's County Clinics and Programs	Jennifer Fatzler, LMFT
All MH CBO's/Network Providers: J-Z All Adult County Clinics and Programs	Brion Phipps, LCSW
SUD Providers A-Z	Sharon Loveseth, CADCII, LAADC* *a non - governmental license LNR4020512

Thank you for ensuring that services entered in InSyst meet state standards for revenue recoupment.

Each staff claiming for group services must have separate claim lines in InSyst in order to comply with DHCS and OIG enforcement of 42 CFR Regulations.

Group Sign-In Sheets

Improper handling of group sign-in sheets was a frequent cause of non-compliance during prior SUD audits

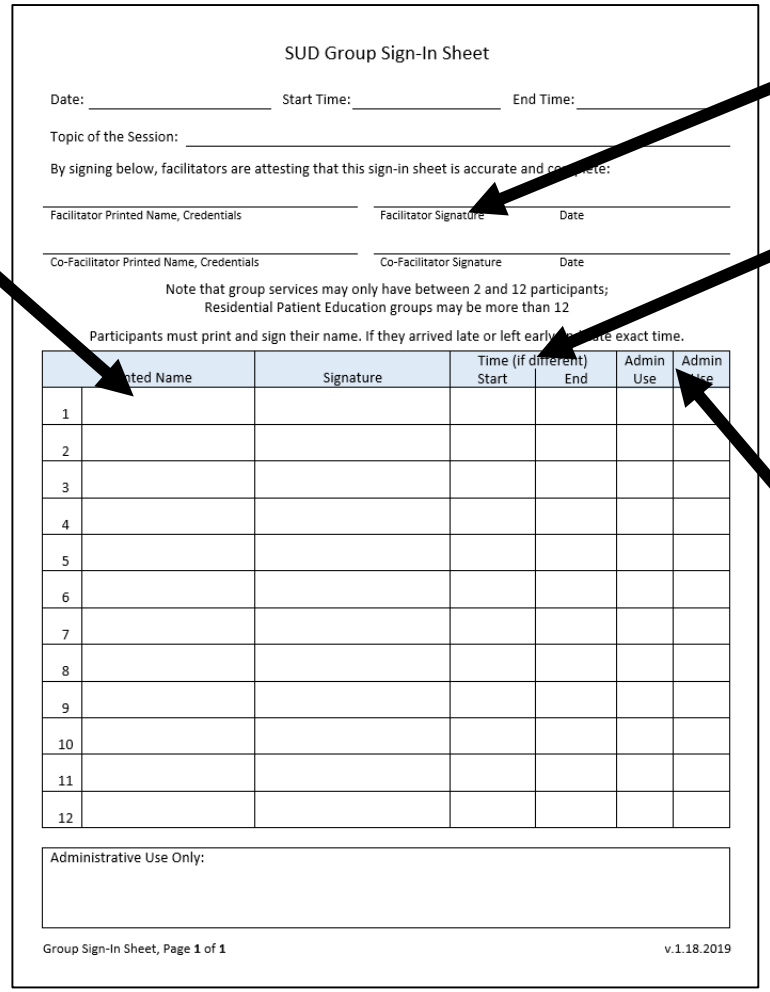
- For each group counseling session a sign-in sheet must be completed with these items:
  - Date of the group session
  - Topic of the group
  - Start and End time for the group
  - If an individual's start and end time is different, note that as well
  - A typed or legibly printed list of participants' names attending the group (pre-typed ok)
  - Signature of each participant who attended the session (must be clear that it matches the name — if not legible due to client's writing inability, counselor must indicate)
  - Legibly printed name and signature of LPHA(s)/counselor(s)
    - Certifies it is accurate and complete
- Group Sign-in sheets must be kept separate from the chart as it contains multiple clients' PHI and provided to ACBH whenever a chart is audited

Group Sign-In Sheets

Make sure members print their names legibly (pre-typed lists ok).

Keep sign-in sheets separately from the chart in order to maintain confidentiality

When charts are requested for audit, remember to provide all corresponding sign-in sheets, otherwise the auditor is unable to confirm group compliance.



SUD Group Sign-In Sheet

Date: _____ Start Time: _____ End Time: _____

Topic of the Session: _____

By signing below, facilitators are attesting that this sign-in sheet is accurate and complete:

Facilitator Printed Name, Credentials | Facilitator Signature | Date

Co-Facilitator Printed Name, Credentials | Co-Facilitator Signature | Date

Note that group services may only have between 2 and 12 participants;
Residential Patient Education groups may be more than 12

Participants must print and sign their name. If they arrived late or left early, indicate exact time.

	Printed Name	Signature	Time (if different) Start	Time (if different) End	Admin Use	Admin Use
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

Administrative Use Only:

Group Sign-In Sheet, Page 1 of 1 v.1.18.2019

All facilitators must sign, attesting that the information on the sign-in sheet is accurate

For each group member attending, they must sign their name, indicating they attended the group. If the time they attended is different than above, this must noted in the two right columns.

For Residential providers who use non-treatment staff to input data for daily notes, there are ADMIN columns to document their inputting of this data into the daily note and that the treatment staff who sign the note also confirms this information. Sees slide on transcribing requirements for additional information

Dispensing Requirements

For controlled narcotic medications

Administering Narcotic Controlled Substances

- Every person or entity that handles controlled substances must be registered with DEA or be exempt by regulation from registration
- Controlled narcotic substances used for treatment at OTPs may ONLY be administered by the following individuals (licenses pursuant to B&PC):
  - Physicians/Surgeons
  - Registered Nurses acting under the instruction of a physician/surgeon
  - Physician Assistants acting under the client-specific authority of a physician/surgeon supervisor
- When acting under the direction of a physician/surgeon, the following individuals may also administer narcotic controlled substances orally (licenses pursuant to B&PC):
  - Psychiatric Technicians
  - Vocational Nurses
  - Pharmacists

9 CCR § 10260
HSC § 11215
DEA Practitioners Manual
21 CFR § 1301.22.a
21 CFR § 1301.12

Dosing/Dispensing Log Requirements

- Each program must maintain accurate records of medications used in replacement narcotic therapy traceable to specific clients, records must include:
  - Name of substance
  - Batch code marks
  - Strength of substance
  - Dosage form
  - Date dispensed
  - Adequate identification of patient (consumer)
  - Amount consumed
  - Amount and dosage form taken home by patient
  - Dispenser's initials
- These records must be maintained by a physician, pharmacist, or health professional authorized to compound, administer or dispense medications used in replacement narcotic therapy
  - The staff who administers the dose must initial the corresponding entry
- These records must be retained for a period of three years and be available at the time of an audit

9 CCR § 10255
21 CFR § 1304.24

Claiming for Dosing/Dispensing

- Providers must use the corresponding procedure code for the medication being administered
- Claim may be made either by the staff who administered the dose or the prescriber of the medication
- These codes are only used when dispensing or administering and when the OTP provides the medication for allowable take home services:
  - 519 OTP-NTP Methadone Dosing
  - 520 OTP-NTP MAT Buprenorphine
  - 521 OTP-NTP MAT Buprenorphine Brand
  - 522 OTP-NTP MAT Disulfiram Generic
  - 523 OTP-NTP MAT Disulfiram Brand
  - 524 OTP-NTP MAT Naloxone Generic
  - 525 OTP-NTP MAT Naloxone Brand
  - 526 OTP-NTP MAT Bupr-Nalox Gen
  - 527 OTP-NTP MAT Bupr-Nalox Brand

Take Home Medications

Rules, Requirements, and Exceptions

Take Home Medication Procedures 1

- For all dispensed medications except Methadone, the provider must follow the Take-Home Step Schedules identified in their approved Program Protocol
- Take-Home requirements for Methadone must follow Step requirements noted in ADP 12-10
- Any patient in comprehensive maintenance treatment may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and State and Federal holidays.

9 CCR § 10365
42 CFR § 8.12 (i)(1)

Take Home Medication Procedures 2

- The medical director or physician will determine the quantity of take-home medications
- The program must instruct the client of their obligation to safeguard the medications
- The program must label each take-home dosage container per 9 CCR § 10365.d requirements
- Clients on a daily dose of methadone above 100 milligrams are required to attend the program at least six days per week for observed ingestion unless the program has received prior written approval from the Department.

Take Home Medication Procedures 3

Self-administered take-home medication can only be provided to a client if the medical director or program physician has determined, in their clinical judgment, that the client is responsible in handling narcotic medications, and has documented his or her rationale in the client's record. The rationale must be based on consideration of the following criteria:

- Absence of use of illicit drugs and abuse of other substances, including alcohol
- Regularity of program attendance for replacement narcotic therapy and counseling services
- Absence of serious behavioral problems while at the program
- Absence of known criminal activity, including the selling or distributing of illicit drugs
- Stability of the client's home environment and social relationships
- Length of time in maintenance treatment
- Assurance that take-home medication can be safely stored within the client's home
- Whether the rehabilitative benefit to the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion

Take Home Medication Procedures 4
Criteria for Take-Home Medications

The medical director or program physician may place a client on one of the six take-home medication schedules, only when at least the additional following criteria have been met:

- Documentation in the client's record that the client is participating in gainful vocational, educational, or responsible homemaking (i.e., primary care giver, retiree with household responsibilities, or volunteer helping others) activity and the client's daily attendance at the program would be incompatible with such activity;
- Documentation in the client's record that the current monthly body specimen collected from the client is both negative for illicit drugs and positive for the narcotic medication administered or dispensed by the program; and
- No other evidence in the client's record that he or she has used illicit drugs, abused alcohol, or engaged in criminal activity within the last 30 days (for Steps I-V) and the last year for Step VI

Take Home Medication Procedures 5
Take-Home Step Levels

- Step I Level – Administer a single take home medication for State approved holidays.
- Step II Level – After 90 days of continuous maintenance treatment → 2* day take home supply + 5 days of clinic observed ingestion.
- Step III Level – After 180 days of continuous maintenance treatment → 3* day take home supply + 4 days of clinic observed ingestion.
- Step IV Level – After 270 days of continuous maintenance treatment → 6* day take home supply + 1 day of clinic observed ingestion.
- Step V Level – After 1 year of continuous treatment → 2* week supply of medication + 2 times a month of clinic observed ingestion.
- Step VI Level – After 2 years of continuous treatment → 1 month take-home supply + 1 clinic observed ingestion a month.

* Plus 1 day for state holiday

Take Home Medication Procedures 6
Exceptions to Take-Home Privileges

The medical director or program physician may grant an exception to take-home medication criteria and dosage schedules for any of the following reasons:

- The client has a physical disability or chronic, acute, or terminal illness that makes daily attendance at the program a hardship. The program must verify the client's physical disability or illness, and include medical documentation of the disability or illness in the client's record. The client shall not be given at any one time, more than a two-week take-home supply of medication.
- The client has an exceptional circumstance, such as a personal or family crisis, that makes daily attendance at the program a hardship. When the client must travel out of the program area, the program shall attempt to arrange for the client to receive his or her medication at a program in the client's travel area. The program shall document such attempts in the client's record. The client shall not be given at any one time, more than a one-week take-home supply of medication.
- The client would benefit, as determined by the medical director or program physician, from receiving his or her medication in two split doses, with one portion dispensed as a take-home dose, when the medical director or program physician has determined that split doses would be more effective in blocking opiate abstinence symptoms that an increased dosage level.

The medical director or program physician must document in the client's record the granting of any exception and the facts justifying the exception.

DHCS may grant temporary exceptions allowing at most up to a month supply for clients with over two years of continuous treatment. Clients are required to attend the program at least once each month.

9 CCR § 10385
42 CFR 8.12

Take Home Medication Procedures 7
Restricting Take-Home Privileges

The medical director or program physician must restrict a client's take-home medication privileges by moving the client back at least one step level on the take-home medication schedule for any of the following reasons:

- Clients on step level schedules I through V who have submitted at least two consecutive monthly body specimens which have tested positive for illicit drugs and/or negative for the narcotic medication administered or dispensed by the program, unless the program physician invalidates the accuracy of the test results
- Clients on step level schedule VI who have submitted at least two monthly body specimens within the last four consecutive months which have tested positive for illicit drugs and/or negative for the narcotic medication administered or dispensed by the program, unless the program physician invalidates the accuracy of the test results
- Clients, after receiving a supply of take-home medication, are inexcusably absent from or miss a scheduled appointment with the program without authorization from the program staff
- The client is no longer a suitable candidate for take-home medication privileges as presently scheduled, based on take home requirements

Regardless, a medical director or physician may revoke take-home privileges for any reason, including:

- The client is sharing, giving away, selling, or trading the medication administered or dispensed by the program
- The client attempts to register in another narcotic treatment program
- The client alters or attempts to alter a test or analysis for illicit drug use

The medical director or program physician shall order the restriction or revocation within fifteen (15) days from the date the program has obtained evidence for any of the reasons identified

Take Home Medication Procedures 8
Restoring Take-Home Medication Privileges

- The medical director or program physician, when restoring each step of a client's restricted take-home medication privileges, must:
  - Determine that the client is responsible for handling narcotic medications per take-home medication requirements
  - Ensure that the client has completed at least a 30-day restriction, and the most recent monthly body specimen collected from the client is both negative for illicit drugs and positive for the narcotic medication administered or dispensed by the program when restoring the following:
    - Step level schedules I through V which were restricted due to drug-screening test or analysis results
  - Ensure that at least the previous three (3) consecutive monthly body specimens collected from the client are both negative for illicit drugs and positive for the narcotic medication administered or dispensed by the program when restoring the following:
    - Step level schedule VI which was restricted due to drug-screening test or analysis results
    - Any step which was restricted due to an unexcused absence after receiving a supply of take-home medication
- Restoring take home medication privileges may not circumvent take-home requirements
- Clients cannot advance to a step level they have not previously satisfied the requirements for that level

Continuing SUD Services

Beyond 6 months from date of admission

Continuing SUD Services
No changes from Title 9 Requirements

In order to continue treatment, Title 9, Ch. 4 requires the medical director or physician to document the following in the chart:

- At least annually, the medical director or physician must complete a periodic review or evaluation
- Then annually, after two continuous years of treatment, the medical director or physician, must document an evaluation that includes:
  - Evaluation of the client's progress, or lack of progress in achieving their treatment goals
  - Determination, in their clinical judgment that the client's status indicates that such treatment should be continued for a longer period of time because discontinuance from treatment would lead to a return to opiate addiction.

9 CCR § 10165
9 CCR § 10410

Discharges from OTP Services

Treatment Termination Procedures

- A client may voluntarily terminate participation in a program even though termination may be against the advice of the medical director or program physician
- If the medical director or program director determines that the client's continued participation in the program creates a physically threatening situation for staff or other clients, the client's participation may be terminated immediately
- A client's participation in a program may be involuntarily terminated by the medical director or program physician for cause
- When discharge occurs on an involuntary basis, the provider must notify the beneficiary according to ACBH NOABD Policy

Treatment Termination Procedures

- If a program utilizes disciplinary proceedings which include involuntary termination for cause, the program must include in its protocol reasons and procedures for involuntarily terminating a client's participation in the program. The procedures shall provide for:
  - Explanation to the client of when participation may be terminated for cause
  - Client notification of termination
  - Client's right to hearing
  - Client's right to representation
- If the program elects not to terminate for cause, the protocol must state that clients shall not be involuntarily terminated for cause except for safety reasons

Treatment Termination Procedures

Except for safety reasons, either voluntary or involuntary termination must be individualized, under the direction of the medical director or program physician, and take place over a period of time not less than 15 days, unless:

- The medical director or program physician deems it clinically necessary to terminate participation sooner and documents why in the client's record
- The client requests in writing a shorter termination period
- The client is currently within a 21-day detoxification treatment episode

Discharge Summary or Discharge Plan?

- Depending on the circumstances of the discharge, either a *Discharge Plan* or *Discharge Summary* must be completed
- A discharge summary is a summary of treatment services, progress, and prognosis — it is only used when contact with the client is lost, all other discharges require a discharge plan
  - Must be completed within 30 days of last face-to-face service
- A discharge plan is a plan to support client's discharge from the program
  - A plan is developed in conjunction with the client and is intended to transition client from treatment services
  - Can be claimed when completed face-to-face with client
  - In order to be claimed, discharge plans must be prepared (discussed and signed with client) within 30 days prior to the last face-to-face treatment

Discharge Plan

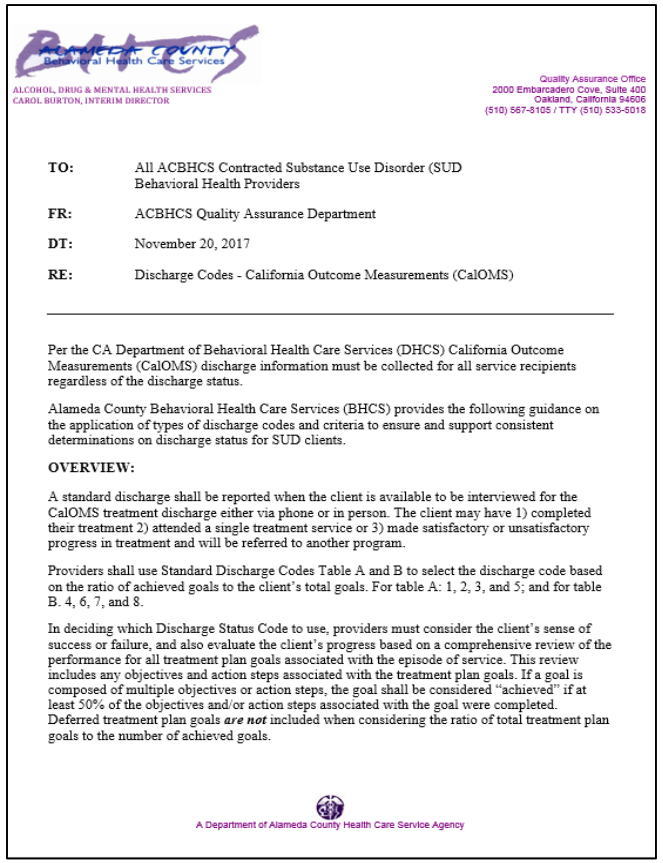
- Discharge Plans MUST include:
  - The date of discharge
  - The reason for the discharge
  - A summary of the client's progress during treatment
  - Description of each client's triggers and a plan to assist the client to avoid relapse when confronted with triggers
  - A support plan
  - Complete signature of LPHA or counselor
  - Client's legibly printed name, date, and signature
- Must document that client was provided (or offered and reason for refusal) a copy of their discharge plan at the last face-to-face.

"Client discharged from the program" is not a discharge plan!

Discharge Summary
Required when client contact is lost

- The discharge summary must be completed within 30 calendar days of the last face-to-face contact with the beneficiary
- Discharge Summary MUST include:
  - The client's name
  - Date of discharge
  - Duration of treatment (admission date to date of last service)
  - Reason for discharge and if discharge was involuntary or successful completion of SUD services
  - A narrative summary of the treatment episode
  - The client's prognosis
- A Discharge Summary is required (whenever contact is lost with a beneficiary) but it is not a claimable activity.

Discharge Codes
California Outcome Measurements (CalOMS)



ALCOHOL, DRUG & MENTAL HEALTH SERVICES
CAROL BURTON, INTERIM DIRECTOR

Quality Assurance Office
2000 Embarcadero Cove, Suite 400
Oakland, California 94606
(510) 567-8105 / TTY (510) 533-5018

TO: All ACBHCS Contracted Substance Use Disorder (SUD Behavioral Health Providers

FR: ACBHCS Quality Assurance Department

DT: November 20, 2017

RE: Discharge Codes - California Outcome Measurements (CalOMS)

Per the CA Department of Behavioral Health Care Services (DHCS) California Outcome Measurements (CalOMS) discharge information must be collected for all service recipients regardless of the discharge status.

Alameda County Behavioral Health Care Services (BHCS) provides the following guidance on the application of types of discharge codes and criteria to ensure and support consistent determinations on discharge status for SUD clients.

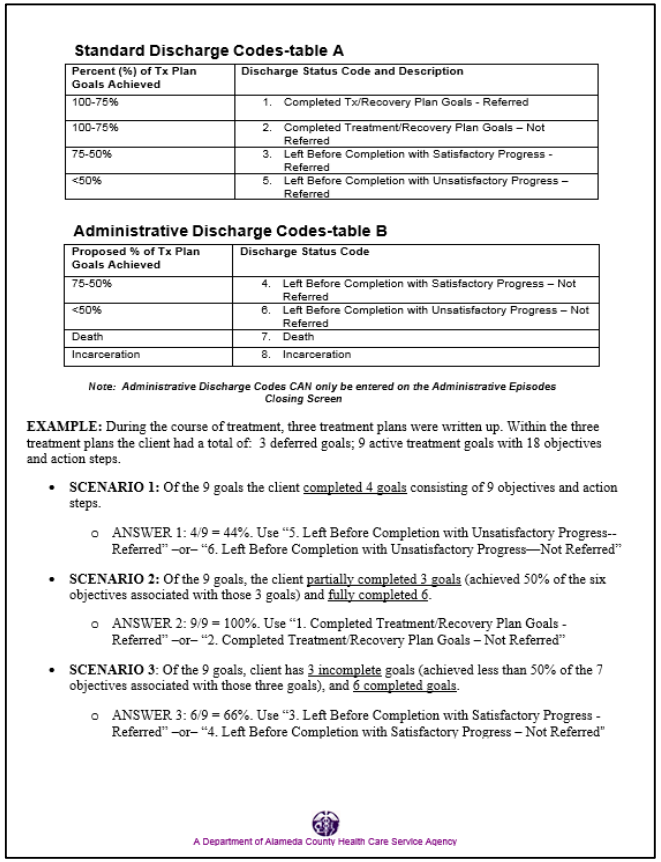
OVERVIEW:

A standard discharge shall be reported when the client is available to be interviewed for the CalOMS treatment discharge either via phone or in person. The client may have 1) completed their treatment 2) attended a single treatment service or 3) made satisfactory or unsatisfactory progress in treatment and will be referred to another program.

Providers shall use Standard Discharge Codes Table A and B to select the discharge code based on the ratio of achieved goals to the client's total goals. For table A: 1, 2, 3, and 5; and for table B. 4, 6, 7, and 8.

In deciding which Discharge Status Code to use, providers must consider the client's sense of success or failure, and also evaluate the client's progress based on a comprehensive review of the performance for all treatment plan goals associated with the episode of service. This review includes any objectives and action steps associated with the treatment plan goals. If a goal is composed of multiple objectives or action steps, the goal shall be considered "achieved" if at least 50% of the objectives and/or action steps associated with the goal were completed. Deferred treatment plan goals ***are not*** included when considering the ratio of total treatment plan goals to the number of achieved goals.

A Department of Alameda County Health Care Service Agency



Standard Discharge Codes-table A

Percent (%) of Tx Plan Goals Achieved	Discharge Status Code and Description
100-75%	1. Completed Tx/Recovery Plan Goals - Referred
100-75%	2. Completed Treatment/Recovery Plan Goals – Not Referred
75-50%	3. Left Before Completion with Satisfactory Progress - Referred
<50%	5. Left Before Completion with Unsatisfactory Progress – Referred

Administrative Discharge Codes-table B

Proposed % of Tx Plan Goals Achieved	Discharge Status Code
75-50%	4. Left Before Completion with Satisfactory Progress – Not Referred
<50%	6. Left Before Completion with Unsatisfactory Progress – Not Referred
Death	7. Death
Incarceration	8. Incarceration

Note: Administrative Discharge Codes CAN only be entered on the Administrative Episodes Closing Screen

EXAMPLE: During the course of treatment, three treatment plans were written up. Within the three treatment plans the client had a total of: 3 deferred goals; 9 active treatment goals with 18 objectives and action steps.

- **SCENARIO 1:** Of the 9 goals the client completed 4 goals consisting of 9 objectives and action steps.
  - ANSWER 1: 4/9 = 44%. Use "5. Left Before Completion with Unsatisfactory Progress--Referred" –or– "6. Left Before Completion with Unsatisfactory Progress—Not Referred"
- **SCENARIO 2:** Of the 9 goals, the client partially completed 3 goals (achieved 50% of the six objectives associated with those 3 goals) and fully completed 6.
  - ANSWER 2: 9/9 = 100%. Use "1. Completed Treatment/Recovery Plan Goals - Referred" –or– "2. Completed Treatment/Recovery Plan Goals – Not Referred"
- **SCENARIO 3**: Of the 9 goals, client has 3 incomplete goals (achieved less than 50% of the 7 objectives associated with those three goals), and 6 completed goals.
  - ANSWER 3: 6/9 = 66%. Use "3. Left Before Completion with Satisfactory Progress - Referred" –or– "4. Left Before Completion with Satisfactory Progress – Not Referred"

A Department of Alameda County Health Care Service Agency

Discharge Codes
California Outcome Measurements (CalOMS)

Standard Discharge Codes-table A

Percent (%) of Tx Plan Goals Achieved	Discharge Status Code and Description
100-75%	1. Completed Tx/Recovery Plan Goals - Referred
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Administrative Discharge Codes-table B

Proposed % of Tx Plan Goals Achieved	Discharge Status Code
75-50%	4. Left Before Completion with Satisfactory Progress – Not Referred
<50%	6. Left Before Completion with Unsatisfactory Progress – Not Referred
Death	7. Death
Incarceration	8. Incarceration

Required Drug Tests or Analyses

For OTPs

Drug Screening Requirements 1

- All OTP clients are required to submit body specimens for testing
  - For clients receiving Detoxification treatment, drug tests are required prior to the first dose and any other time deemed necessary by the attending physician
  - For clients receiving Maintenance treatment drug tests or analyses are required prior to the first dose and then at least random monthly tests
- Providers may claim for time spent collecting of urine samples when deemed “medically indicated” and it is part of the intake or individual session
- The provider must establish procedures which protect against falsification and/or contamination of the sample
- Document the results in the file and if part of an individual session, may claim documentation time for this.
- For OTPs lab fees are included in the daily dosing rate and are not separately claimable

Drug Screening Requirements 2
Initial Results: + for methadone or metabolites

- If the initial test is positive for methadone or its metabolites, then the OTP has to attempt to determine where the client acquired the methadone
  - From another provider (Hospital, other OTP, etc.) → Contact the other facility and verify (ROI required)
    - Visiting/Courtesy/Guest dosing OR former patient
  - Client does not report or states methadone is from the street → Provider still must confirm that the client is not receiving services at another OTP
    - Multiple registration checks to all OTPs in a 50 mile radius (ROI required)

If the client refuses to sign these ROIs, then the client cannot be admitted to the program

9 CCR § 10215
9 CCR § 10220
9 CCR § 10310

Drug Screening Requirements 3
Initial Results: + for other drugs

- If a client reports and/or tests positive for other substances, then the treating physician must be made aware of these substances and considered as part of the client's physical fitness to receive methadone treatment
  - Both legal, prescription, and illegal substances must be taken into consideration
- For clients with concerns about addiction to additional substances that the OTP is not or cannot treat, referrals to additional LOCs may be necessary

Drug Screening Requirements 4
Random Results: + for methadone or metabolites

- Random monthly (or more) testing should indicate the client has the expected amount of methadone or its metabolites in the client's system
- Deviations from the expected amounts (either more or less) must be addressed with the client

Drug Screening Requirements 5
Random Results: + for other drugs

- Random monthly (or more) testing may indicate client has started or resumed using additional substances, providers are required (by regulation and good clinical practice) to address these changes in functioning:
  - Inform physician or medical director of drug tests that are positive for additional, unknown (to this client), or otherwise concerning positive drug tests (increased or continued use). It is out of the scope of practice of non-medical staff to make medical decisions regarding medications or other medication related interactions.
  - Consider referrals to additional SUD treatment at other LOCs
  - Consider updating the client's treatment plan

As always, document the program's response in the medical record

Drug Screening Requirements 6

Substance abuse testing for narcotic treatment programs operating in the state can be performed only by a laboratory approved and licensed by the CA Department of Public Health for the performance of those tests

https://www.cdph.ca.gov/Programs/CEH/DFDCS/Pages/MLRP.aspx

CA H&SC 11839.24
CA H&SC 11839.27

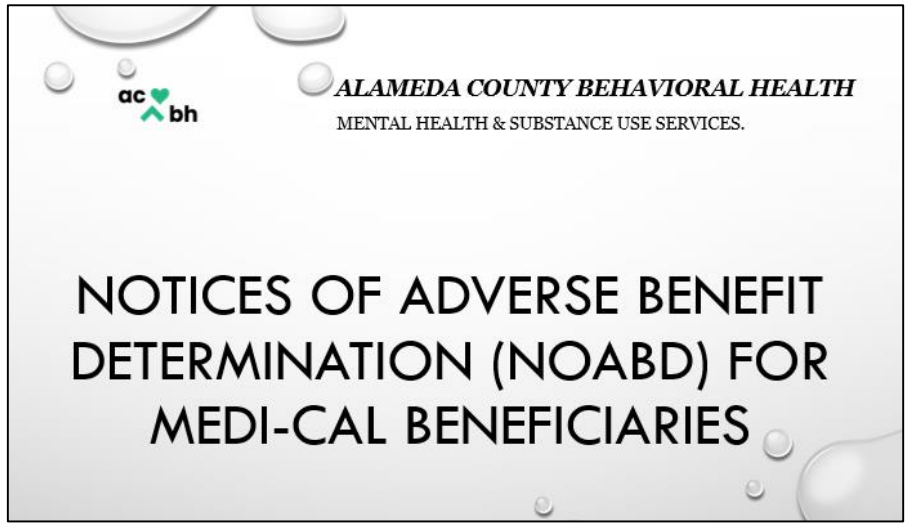
Drug Screening Requirements 7
Client refusal or missed test

- When a client fails to provide a body specimen when required, the program must proceed as though the client's sample disclosed the presence of an illicit drug(s)
- Such failures must be documented in the client's medical record

NOABDs, Grievances, Appeals, Fair Hearings

Notice of Adverse Benefit Determination NOABD

- ACBH has recently updated it's NOABD policy
- Please refer to ACBH NOABD training materials and policy updates from Summer 2019



What is a “grievance”?

- Is an expression of dissatisfaction about any matter other than an adverse benefit determination.
- Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.
- Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Grievances

Grievances may be filed by a consumer or their designated representative to ACBH as follows:

- By phone: (800) 779-0787 Consumer Assistance Line
- Via US mail:
  2000 Embarcadero Cove, Suite 400
  Oakland, CA 94606
- In person:
  - By visiting the provider site to obtain forms and assistance
  - By visiting Consumer Assistance at Mental Health Association, 954-60th Street, Suite 10, Oakland, CA 94608

Grievances, cont.

- Draft ACBH P&P is in the handouts provided or on the providers' website
- ACBH encourages providers to utilize the ACBH grievance process instead of an internal grievance process

Grievance & Appeal Process

alameda county behavioral health

MENTAL HEALTH & SUBSTANCE USE SERVICES

Consumer Assistance
Toll Free: 1 (800) 779-0787
California Relay Service, Dial 711

GRIEVANCE AND APPEALS PROCESS

If you have a concern or problem or are not satisfied with your behavioral health services, the Behavioral Health Plan (BHP) wants to be sure your concerns are resolved simply and quickly. You or your representative may file a Grievance or Appeal with the Consumer Assistance office at 1(800) 779-0787. You may also ask your provider if they have a process for resolving grievances. **Please use the Grievance and Appeal Request Form to file a Grievance or to request an Appeal.** Please note that appeals may only be filed with Consumer Assistance and *not* with your provider. **You will not be subject to discrimination or any other penalty for filing a Grievance or Appeal.**

A **Grievance** is defined as an expression of dissatisfaction about any matter regarding your behavioral health services that are not one of the problems covered by the Appeal and State Fair Hearing processes described below. Examples of grievances might be as follows: the quality of care of services provided, aspects of interpersonal relationships – such as rudeness of an employee, etc. **Steps to file a Grievance:**

- File a Grievance orally or in writing. Oral grievances do not have to be followed up in writing. You may authorize another person to act on your behalf.
- You may file a Grievance at any time.
- You will receive a written acknowledge of receipt of your Grievance postmarked within 5 days of receipt of the Grievance.
- The BHP has 90 calendar days after the receipt of your Grievance to review it and notify you or your representative in writing about the decision. If resolution of your grievance is not reached within 90 calendar days you will be provided prompt oral and/or written notification of your rights and specific information on your grievance.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP feels that there is a need for additional information and that the delay is for your benefit in which case you will receive oral and written notice from the BHP.

Where to File Your Grievance

With Alameda County Behavioral Health (ACBH):

By phone: 1-800-779-0787 Consumer Assistance
For assistance with hearing or speaking, call 711, California Relay Service
Via US Mail: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
In Person: By visiting Consumer Assistance at Mental Health Association, 954-60th Street, Suite 10, Oakland, CA 94608

With your provider: Your provider may resolve your grievance internally or direct you to ACBH above. You may obtain forms and assistance from your provider.

Alameda County Behavioral Health Care Services
A Department of Alameda County Health Care Service Agency

An **Appeal** is a review by the BHP of an Adverse Benefit Determination (ABD). An **Adverse Benefit Determination** is defined to mean any of the following actions taken by the BHP or a BHP-contracted provider regarding Medi-Cal behavioral health care services: 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2)The reduction, suspension, or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner; 5) The failure to act within the required timeframes for standard resolution of grievances and appeals; or 6) The denial of a beneficiary's request to dispute financial liability. The decision made by the BHP about your behavioral health services may be described in a **Notice of Adverse Benefit Determination (NOABD)** letter sent or given personally to you.
Steps to file an Appeal:

- Only Medi-Cal beneficiaries may file a Standard or Expedited Appeal with ACBH regarding a NOABD for a Medi-Cal behavioral health service.
- File an Appeal in person, on the phone or in writing within 60 days of the date of a NOABD. If you file the Appeal orally, you must follow it up with a signed written Appeal. If you did not receive a NOABD, there is no deadline for filing; so you may file at any time. You may authorize another person to act on your behalf.
- Upon request, your benefits will continue while the Appeal is pending IF you file the Appeal within 10 calendar days from the date the NOABD was mailed or given to you.
- You will receive a written acknowledge of receipt of your Appeal postmarked within 5 calendar days of receipt of the Appeal.
- The BHP has 30 days after the receipt of your Appeal to review it and notify you or your representative in writing about the decision.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP feels that there is a need for additional information and that the delay is for your benefit in which case you will receive oral and written notice from the BHP.
- Appeals are not available to beneficiaries that are not happy with the outcome of a grievance.

An **Expedited Appeal** can be requested if you think waiting 30 days could seriously jeopardize your mental health or substance use disorder condition and/or your ability to attain, maintain or regain maximum function. If the BHP agrees that your appeal meets the requirements for an Expedited Appeal, the BHP will resolve it within 72 hours after the Expedited Appeal is received.
Steps to file an Expedited Appeal:

- File an Expedited Appeal in person, on the phone or in writing within 60 days of the date of a Notice of Adverse Benefit Determination (NOABD). Verbal and in person requests for Expedited Appeals do not have to be put in writing. You may authorize another person to act on your behalf.

- Upon request, your benefits will continue while the Expedited Appeal is pending IF you file the Appeal within 10 calendar days from the date the NOABD was mailed or given to you.
- The BHP has 72 hours after the receipt of your Expedited Appeal to review it and notify you or your representative in a written Notice of Appeal Resolution (NAR), and may notify you verbally as well.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP feels that there is a need for additional information and that the delay is for your benefit.
- If the BHP decides that your appeal does not qualify for an Expedited Appeal, they will notify you right away verbally and in writing within 2 calendar days. Your appeal will then follow the Standard Appeal process.

Where to File Your Appeal

With Alameda County ACBH:

By phone: 1-800-779-0787 Consumer Assistance
For assistance with hearing or speaking, call 711, California Relay Service
Via US Mail: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
In Person: By visiting Consumer Assistance at Mental Health Association, 954-60th Street, Suite 10, Oakland, CA 94608

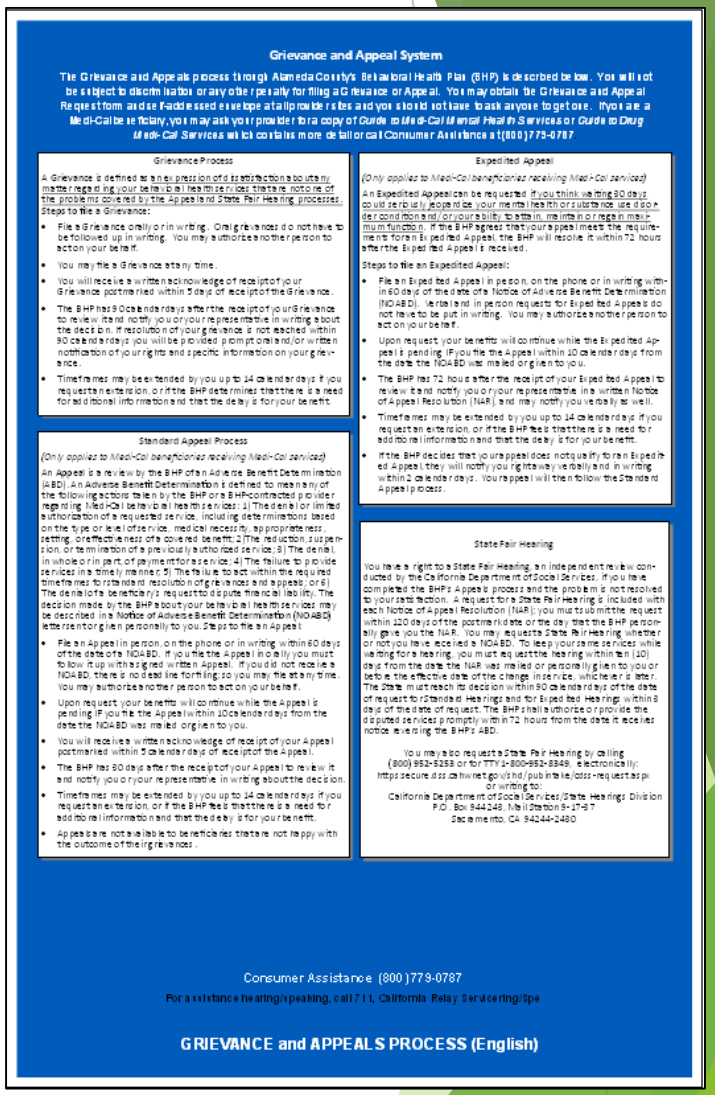
You have a right to a **State Fair Hearing**, an independent review conducted by the California Department of Social Services, if you have exhausted the BHP's Appeals process. A request for a State Fair Hearing is included with each Notice of Appeal Resolution (NAR); you must submit the request within 120 days of the postmark date or the day that the BHP personally gave you the NAR. You may request a State Fair Hearing whether or not you have received a NOABD. To keep your same services while waiting for a hearing, you must request the hearing within ten (10) days from the date the NAR was mailed or personally given to you or before the effective date of the change in service, whichever is later. The State must reach its decision within 90 calendar days of the date of request for Standard Hearings and for Expedited Hearings within 3 days of the date of request. The BHP shall authorize or provide the disputed services promptly within 72 hours from the date it receives notice reversing the BHP's ABD. You may request a State Fair Hearing by calling 1(800) 952-5253, or for TTY 1 (800) 952-8349, online to https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx or writing to: California Department of Social Services/State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, CA 94244-2430.

For more detailed information on the Grievance or Appeals process, please ask your provider for a copy of *Guide to Medi-Cal Mental Health Services* OR *Guide to Drug Medi-Cal Services*. For questions or assistance with filling out forms, you may ask your provider or call:

Consumer Assistance: 1(800) 779-0787

Grievances

- All of the following ACBH Grievance materials must be posted and available in the lobby:
  - Poster
  - Forms
  - Envelopes
- Beneficiaries with Grievances & Complaints of any type must be referred to the ACBH Grievance Line, see poster for more information



Grievance and Appeal System

The Grievance and Appeals process through Alameda County's Behavioral Health Plan (BHP) is described below. You will not be subject to discrimination or any other penalty for filing a Grievance or Appeal. You may obtain the Grievance and Appeal Request form and self-addressed envelope at all provider sites and you should not have to ask anyone to get one. If you are a Medi-Cal beneficiary, you may ask your provider for a copy of *Guide to Medi-Cal Mental Health Services* or *Guide to Drug Medi-Cal Services* which contains more detail or call Consumer Assistance at (800) 779-0787.

Grievance Process

A Grievance is defined as an expression of dissatisfaction about any matter regarding your behavioral health services that are not one of the problems covered by the Appeals and State Fair Hearing processes.

Steps to file a Grievance:

- File a Grievance orally or in writing. Oral grievances do not have to be followed up in writing. You may authorize another person to action your behalf.
- You may file a Grievance at any time.
- You will receive a written acknowledge of receipt of your Grievance postmarked within 5 days of receipt of the Grievance.
- The BHP has 90 Calendar days after the receipt of your Grievance to review it and notify you or your representative in writing about the decision. If resolution of your grievance is not reached within 90 calendar days you will be provided prompt oral and/or written notification of your rights and specific information on your grievance.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP determines that there is a need for additional information and that the delay is for your benefit.

Expedited Appeal

(Only applies to Medi-Cal beneficiaries receiving Medi-Cal services)

An Expedited Appeal can be requested if you think waiting 30 days could seriously jeopardize your mental health or substance use disorder condition and/or your ability to attain, maintain or regain maximum function. If the BHP agrees that your appeal meets the requirements for an Expedited Appeal, the BHP will resolve it within 72 hours after the Expedited Appeal is received.

Steps to file an Expedited Appeal:

- File an Expedited Appeal in person, on the phone or in writing within 60 days of the date of a Notice of Adverse Benefit Determination (NOABD). Verbal and in person requests for Expedited Appeals do not have to be put in writing. You may authorize another person to act on your behalf.
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- Upon request your benefits will continue while the Appeal is pending IF you file the Appeal within 10 calendar days from the date the NOABD was mailed or given to you.
- You will receive a written acknowledge of receipt of your Appeal postmarked within 5 calendar days of receipt of the Appeal.
- The BHP has 30 days after the receipt of your Appeal to review it and notify you or your representative in writing about the decision.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP feels that there is a need for additional information and that the delay is for your benefit.
- Appeals are not available to beneficiaries that are not happy with the outcome of the grievance.

State Fair Hearing

You have a right to a State Fair Hearing, an independent review conducted by the California Department of Social Services. If you have completed the BHP's Appeals process and the problem is not resolved to your satisfaction. A request for a State Fair Hearing is included with each Notice of Appeal Resolution (NAR); you must submit the request within 120 days of the postmark date or the day that the BHP personally gave you the NAR. You may request a State Fair Hearing whether or not you have received a NOABD. To keep your same services while waiting for a hearing, you must request the hearing within ten (10) days from the date the NAR was mailed or personally given to you or before the effective date of the change in service, whichever is later. The State must reach its decision within 90 calendar days of the date of request for Standard Hearings and for Expedited Hearings within 3 days of the date of request. The BHP shall authorize or provide the disputed services promptly within 72 hours from the date it receives notice reversing the BHP's ABD.

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California Department of Social Services/State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Consumer Assistance (800) 779-0787

For assistance hearing/speaking, call 711, California Relay Service/Spe

GRIEVANCE and APPEALS PROCESS (English)

Miscellaneous Items

Visiting or Courtesy Dosing Requirements
All must be documented in the medical record

When a client requests temporary/visiting services, OTPs must complete the follow steps prior to admission:

1. The client signs a ROI allowing the temporary OTP to contact primary OTP
2. The temporary OTP contacts the primary OTP:
    a. Determines that the client has received prior approval to receive services on a temporary basis from another OTP. → Prior approval is required
    b. Confirm that medication will not be provided for the same time period
    c. Documentation of a medication change order from the referring MD/physician permitting the client to receive temporary medications (not to exceed 30 days)
    d. Documentation that the MD/physician has accepted responsibility for this client, concurs with the referring MD's dosing schedule, and will properly supervise medication administration

9 CCR § 10295
9 CCR § 10205
9 CCR § 10210

Visiting or Courtesy Dosing Requirements
Additional Documentation Requirements

Documentation of services for clients receiving temporary services must include:

- The name of the program contacted
- The date and time of the contact
- The name of the program staff member contacted
- The results of the contact

9 CCR § 10295
9 CCR § 10205
9 CCR § 10210

Visiting or Courtesy Dosing Requirements
Billing Challenges

- Billing challenges can occur when a client has their Medi-Cal in another county
- Temporary services for visiting clients may not exceed 30 days of treatment
- Take-home medications are not allowed for visiting clients
- OOC visiting clients may only receive methadone

9 CCR § 10295
9 CCR § 10205
9 CCR § 10210

Minor Consent for SUD Services

- Family Code § 6929 allows for minors aged 12 – 17 to consent for services related to the treatment of a drug or alcohol related disorder
- Medication services and other types of treatment services that pose a higher client risk are typically not allowed without parental/guardian consent
- DHCS has provided guidance that in order for Medi-Cal to be claimed for services where the minor has consented to treatment, the *Medi-Cal Minor Consent Program* must be used.
- Remember children under 12 years old are NOT eligible for Minor Consent related to drug or alcohol abuse, a sexually transmitted disease or for outpatient mental health care.

Cal. Family Code § 6929,
MHSUDS IN 14-002,
MHSUDS IN 18-061,
22 CCR § 50147.1,
22 CCR § 51473.2,

OTP Treatment of Minors

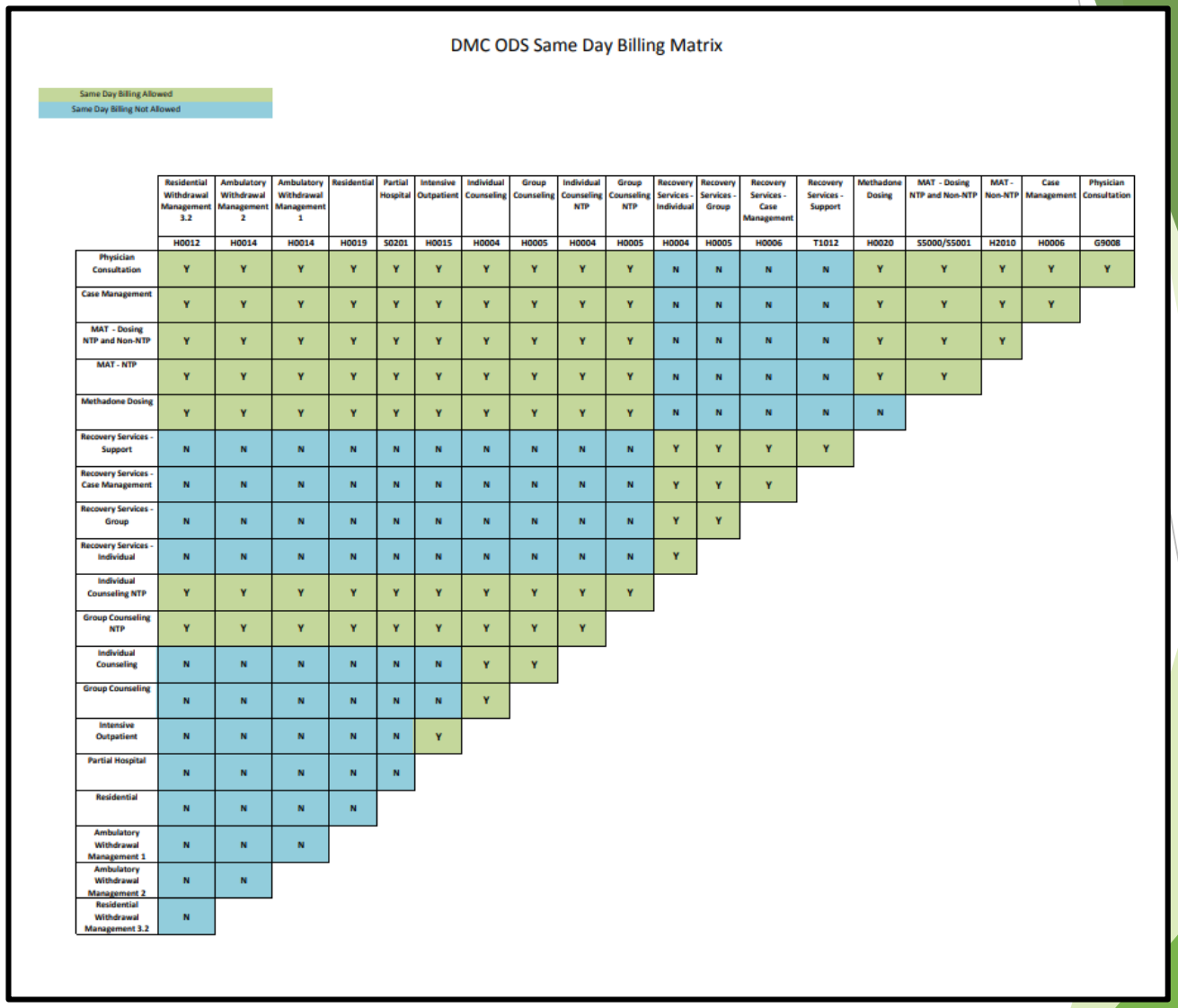
- Detoxification treatment for individuals who are under 18 years of age requires written consent of their parent(s) or guardian prior to the administration of the first medication dose
- State regulations do not allow maintenance treatment for individuals who are under 18 years of age. DHCS will review temporary exceptions to this rule with or without written consent of their parent(s) or guardian.
- OTPs may seek exceptions to these requirement on an individual client basis by submitting a temporary exception request to DHCS.
- Licensed OTPs may submit exception requests using Form SMA-168: Exception Request and Record of Justification. This form must be submitted to DHCS and the Substance Abuse and Mental Health Services Administration (SAMHSA) via the SAMHSA OTP Extranet website. In order to access Form SMA-168, OTPs must be logged into the Extranet website.

9 CCR § 10270
MHSUDS IN 18-061

SUD Lockouts

- Beneficiaries with Medi-Cal and Medicare (Medi-Medi) are not eligible to receive SUD services. Refer the individual to their Medicare or primary care provider.
- If a Medi-Cal beneficiary is incarcerated, claiming is not allowed on the days of incarceration
  - Services are allowed for adjudicated adolescents
- Claiming is locked out after 60 days from EOD if out-of-county Medi-Cal has not transferred to Alameda County
- SUD services additionally may not be allowed, due to duplication of service and same day billing considerations
- SUD services are not locked out if the beneficiary is receiving mental health services, as long as there is not a duplication of services and the services provided remain medically necessary

DMC-OS Same Day Billing Matrix (updated 5/25/2017)



DMC ODS Same Day Billing Matrix

Same Day Billing Allowed
Same Day Billing Not Allowed

	Residential Withdrawal Management 3.2	Ambulatory Withdrawal Management 2	Ambulatory Withdrawal Management 1	Residential	Partial Hospital	Intensive Outpatient	Individual Counseling	Group Counseling	Individual Counseling NTP	Group Counseling NTP	Recovery Services - Individual	Recovery Services - Group	Recovery Services - Case Management	Recovery Services - Support	Methadone Dosing	MAT - Dosing NTP and Non-NTP	MAT - Non-NTP	Case Management	Physician Consultation
	H0012	H0014	H0014	H0019	S0201	H0015	H0004	H0005	H0004	H0005	H0004	H0005	H0006	T1012	H0020	S5000/S5001	H2010	H0006	G9008
Physician Consultation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y
Case Management	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	
MAT - Dosing NTP and Non-NTP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y		
MAT - NTP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y			
Methadone Dosing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N				
Recovery Services - Support	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y					
Recovery Services - Case Management	N	N	N	N	N	N	N	N	N	N	Y	Y	Y						
Recovery Services - Group	N	N	N	N	N	N	N	N	N	N	Y	Y							
Recovery Services - Individual	N	N	N	N	N	N	N	N	N	N	Y								
Individual Counseling NTP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y									
Group Counseling NTP	Y	Y	Y	Y	Y	Y	Y	Y	Y										
Individual Counseling	N	N	N	N	N	N	Y	Y											
Group Counseling	N	N	N	N	N	N	Y												
Intensive Outpatient	N	N	N	N	N	Y													
Partial Hospital	N	N	N	N	N														
Residential	N	N	N	N															
Ambulatory Withdrawal Management 1	N	N	N																
Ambulatory Withdrawal Management 2	N	N																	
Residential Withdrawal Management 3.2	N																		

Drug Medi-Cal Eligibility

- Check Medi-Cal Eligibility at intake and the first week of each month (if any services are being claimed to Medi-Cal)
  - If client loses Medi-Cal eligibility, the provider should assist the beneficiary in regaining Medi-Cal.
- If a beneficiary has out-of-county Medi-Cal but has moved to Alameda County, providers may begin SUD treatment but must immediately begin to work with the beneficiary to have their Medi-Cal switched to Alameda County.
  - The ACBH Network office can assist with this process → Contact ASAP after determination
- No services can be claimed over 60 days for out-of-county Medi-Cal and all such services may not exceed the dollar amount indicated in the provider contract

Other Insurance or Private Pay

- If a beneficiary has another insurance, private pay, or funding source not directly or indirectly paid by Alameda County funds then those services are not subject to Alameda County SUD requirements.
- These services may have other requirements and providers will need to check with the funding source for those specific requirements.
- For questions, or to determine funding sources in complicated cases, contact ACBH (e.g. Kaiser Medi-Cal)

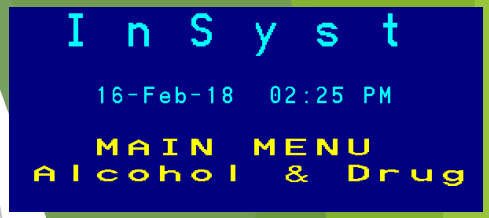
InSyst

- All staff who will be claiming to DMC need to be enrolled in InSyst
- Registered and Certified counselors must have their InSyst Staff Mask indicate “Rehab Counselor” not “Unlicensed Staff”

- Please refer to IS page on the ACBH provider website for more information about upcoming InSyst trainings and resources

http://www.ACBH.org/providers/Insyst/Insyst.htm

Backing out Claims in CG/InSyst



- The process to back out claims depends on when the claim in question occurred
- When a service has already been claimed, follow the Claims Correction instructions from ACBH Finance. Typically progress notes in CG must remain in the EHR as part of the evidentiary trail. → http://www.acbhcs.org/providers/Forms/Forms.htm#CCF
- For backed out notes add an addendum to the note explaining the situation and the solution (i.e. service was replaced, or disallowed, etc.).
- Always follow instructions from the IS, Network Office, or Finance regarding CG/InSyst. QA may not always have the most current information about InSyst/CG procedures.
- When in doubt contact IS, Network Office, or Finance

Tobacco Guidelines for SUD Providers

ACBH released a memo on 1/12/18 outlining treatment options for SUD beneficiaries who use, or whose lives are impacted by, tobacco products

ALCOHOL, DRUG & MENTAL HEALTH SERVICES
CAROL BURTON, INTERIM DIRECTOR

Quality Assurance Office
2000 Embarcadero Cove, Suite 400
Oakland, California 94606
(510) 567-8105 / TTY (510) 533-5018

TO: All ACBHCS County and Contracted Substance Use Disorder (SUD) Providers

FR: ACBHCS Quality Management Department

DT: January12, 2018

RE: Tobacco Guidelines for SUD Providers

Purpose:
This memo is intended to clarify claiming to SUD Drug Medi-Cal with
ACBHCS Provider Tobacco Policies and Consumer Treatment Proto

BHCS Quality Assurance Guidance:
Tobacco Use Disorder (F17.200) is not a DHCS included diagnosis i
substance use disorder (SUD) beneficiaries and cannot be claimed t
Cal.

SUD contracted providers offer and provide counseling sessions whe
plan problem and associated action steps support recovery from SUD
prevention. Beneficiaries whose recovery outcome may benefit by inc
use as a problem in their treatment plan may receive tobacco related
DMC SUD contracted provider.

Group services may be provided if a client's SUD symptoms and rec
impacted by Tobacco/Nicotine use. The documentation requirements
memo are necessary in order to claim SUD treatment services and ir
to Tobacco/Nicotine use.

Assessment: Current assessment standards require substance use/
assessed, including Tobacco/Nicotine products.

A comprehensive assessment of Tobacco/Nicotine use may inclu
- Current/historical use of tobacco and nicotine related produ
- Exposure to tobacco and nicotine related products
- Familial history of tobacco and nicotine use
- Risk for use/relapse

A Department of Alameda County Health Care Service Agency

- The impact the client's use of or exposure to tobacco/nicotine on their recovery from SUD.
- Experiences of quitting/attempting to quit

For some clients, tobacco use or exposure can significantly impact their ability to maintain recovery and may be part of the etiology of developing or exacerbating SUD symptoms. Compounding the issue, their SUD symptoms/impairments may be preventing them from accessing area/community resources to assist with tobacco cessation.

In order to claim group counseling services, the assessment shall demonstrate all of the following:

- The client's use/exposure to tobacco/nicotine products are exacerbating the SUD symptoms that are being treated and/or are a trigger for relapse.
- The client's SUD impairments to functioning are preventing them from accessing needed community supports/resources (Adults only); for adolescents, this is not a requirement as it is not expected that adolescents have the ability to seek out community resources on their own.

Treatment Planning: It is important to reiterate, that 1) in order to claim for services the treatment plan must contain an identified tobacco use objective/goal/problem and associated action steps and 2) direct treatment of Tobacco Use Disorder is not claimable through SUD/DMC. All treatment plan *Goals (problems)*, *Objectives*, *Action Steps,* and *Interventions* must follow existing SUD clinical documentation standards and be related to treatment of a Drug Medi-Cal Included substance use disorder.

- **Objectives/Goals to Address the Identified Problem** must only be related to treating the client's included substance use diagnosis, recovery from SUD, and relapse prevention.
- **Group counseling** must be identified as a modality in the treatment plan in order to be claimed. Group counseling focused on tobacco cessation may be appropriate only if it is related to the treatment plan goals of the individual and provided by a "counselor or therapist" as defined in Title 22.
- **Service interventions** must be related to reducing the symptoms of the included diagnosis or focus on the client's recovery from SUD and/or relapse prevention. The modality, frequency and timeframe for group services should be clearly identified in the treatment plan.

Progress Notes: When documenting services in progress notes, if the assessment and plan adequately document the need for services, the provider shall document client's progress towards meeting their treatment plan goals, objectives and/or actions steps and if the service is having the intended impact on their recovery from SUD and/or relapse prevention.

For additional documentation questions, please contact your assigned Quality Assurance Technical Assistance staff. Contact information found here (see QA Technical Assistance"): http://www.acbhcs.org/providers/QA/QA.htm

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Sources / Resources

DHCS INs:
http://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/Enclosure%204_15_30.pdf

42 CFR §: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

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

CMS STC: http://www.dhcs.ca.gov/provgovpart/Documents/CAMedi-Cal2020STCsAmended04052018.pdf

Want to learn more about the DMC-ODS Waiver?

- http://www.dhcs.ca.gov/provgovpart/Documents/11.10.15_Revised_DMC_ODS_FACT_SHEET.pdf
- http://www.ACBH.org/providers/SUD/medi-cal.htm

42 CFR, Part 2 Final Rule Sources

42 CFR Part 2, Final Rule is effective as of February 2, 2018. Some resources are provided below:

- https://www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-client-records
- https://lac.org/wp-content/uploads/2018/01/Jan-2018-Final-Rule-Synopsis.pdf
- https://lac.org/samhsa-revises-42-cfr-part-2-new-final-rule-confidentiality-substance-use-disorder-treatment-information/
- https://www.psychiatry.org/psychiatrists/practice/practice-management/hipaa/42-cfr-part-2
- https://www.asam.org/advocacy/issues/confidentiality-(42-cfr-part-2)

Printing in CG

If you see this warning on printed CG notes, the note was not printed correctly and is not a valid clinical document

- When printing documents in Clinician's Gateway for CQRT or audit purposes, you must print using the proper print method.
- There is a PRINT button at the bottom of the screen
- Or you can search and tag
- Both of these methods essentially download the requested documents as PDF and then they can be printed as official documents.
- If printed using CTRL-P or the browser's print dialogue a notification will be printed in red on the top of documents printed this way indicating they are not valid.


1/30/2019 Clinician's Gateway version 3.6.0 (View Service)

Clinicians Gateway SUD

View Finalized Service

Welcome: Brion Phipps

WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATON SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Individual Service (15588), Primary Clinician: Peterson, Camille, Admin/Supp (62823) Type: Service Note Daily RES

Client: TEST, ADAM R. (10067802)
Provider: 999CGR - CLINICIAN GATEWAY TEST SUD RES
Procedure: 101 3.1 RES Residential Day
Service Location: Residential Treatment
Emergency: No
Service Date: 12/17/2018
Med. Compliant: N/A Side Effects: N/A

Role	Staff #	Staff Name	NPI	Time	Approved
Primary Clinician	62823	Peterson, Camille, Admin/Supp		24:00	

Secondary Procedure (Child's Bed Day): 303 Child's Bed Day Number Of Children: 1

Instructions & Pre-Existing Diagnoses

When writing progress notes, respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress. Reminder: Providers are required to establish and maintain a sign-in sheet for every group counseling session, independent from CG. Sign-in sheet shall contain: 1) legibly printed Counselor/LPHA name & signature who conducts the session; 2) start & end time of group session; 3) date of group session 4) topic of session; and, 5) client legibly printed name and signature.

Episode Diagnosis Information

Primary Secondary Tertiary SU GMC

Primary FF Time: 02:00 Hours:Minutes

Services were provided in:English by ☐ interpreter or ☐ clinician

ICD-10: Z03.89
DSM 5:

Primary ICD-10 and DSM 5 do not match - you must update Insyst or CG

Summary of Daily Services

Instructions: It is highly recommended that this note be completed by an SUD Counselor/LPHA who provided a reimbursable service on the day this note is documenting. Additional SUD Counselors/LPHAs may add addendums as needed.

☐ See Weekly Summary for additional information (Required if no Optional Daily Narrative below)

Daily Service 1

Counseling Session Type: Intake/Assessment
Session Topic: Assessment - gather information with client

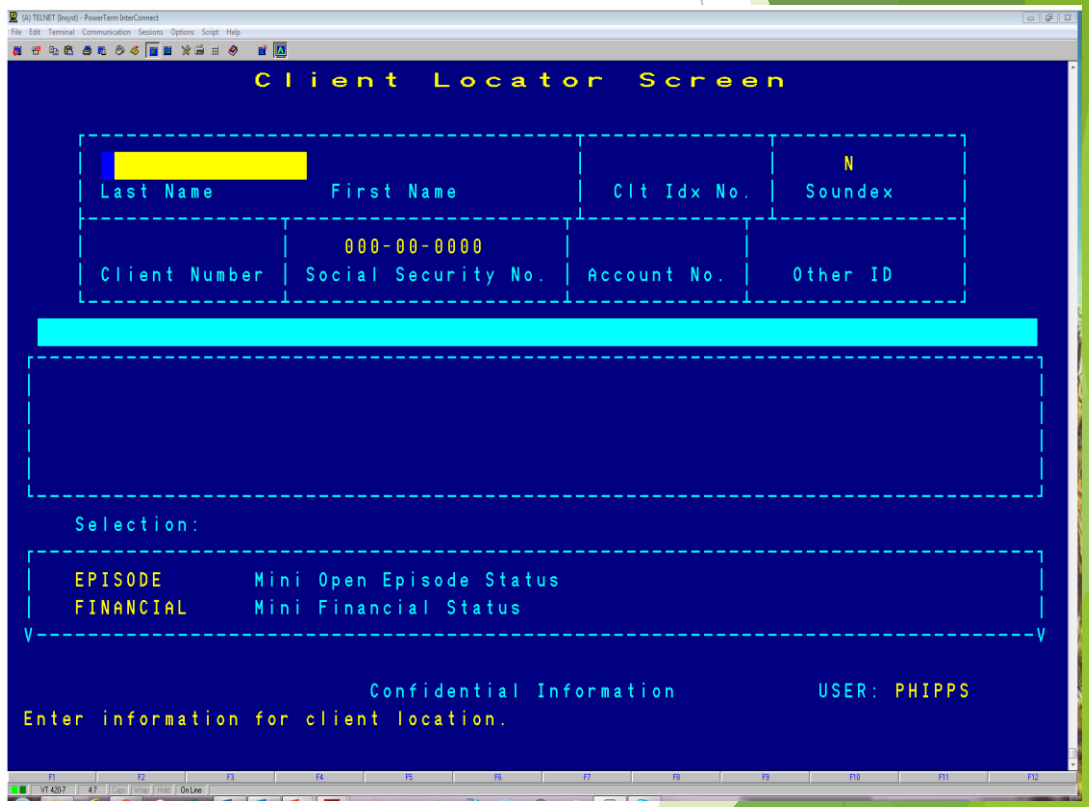
Individual Start Time: 9:00 AM End Time: 10:00 AM Duration: 1 hr 0 min
Primary staff: CHU, WILLIE, Adjunct Co-staff: Location: Residential Treatment

Was this service provided in the field/community? ○ Yes ● No ☐ Add Travel Time
If Yes, describe how confidentiality in the community was ensured:
Comments (Optional):

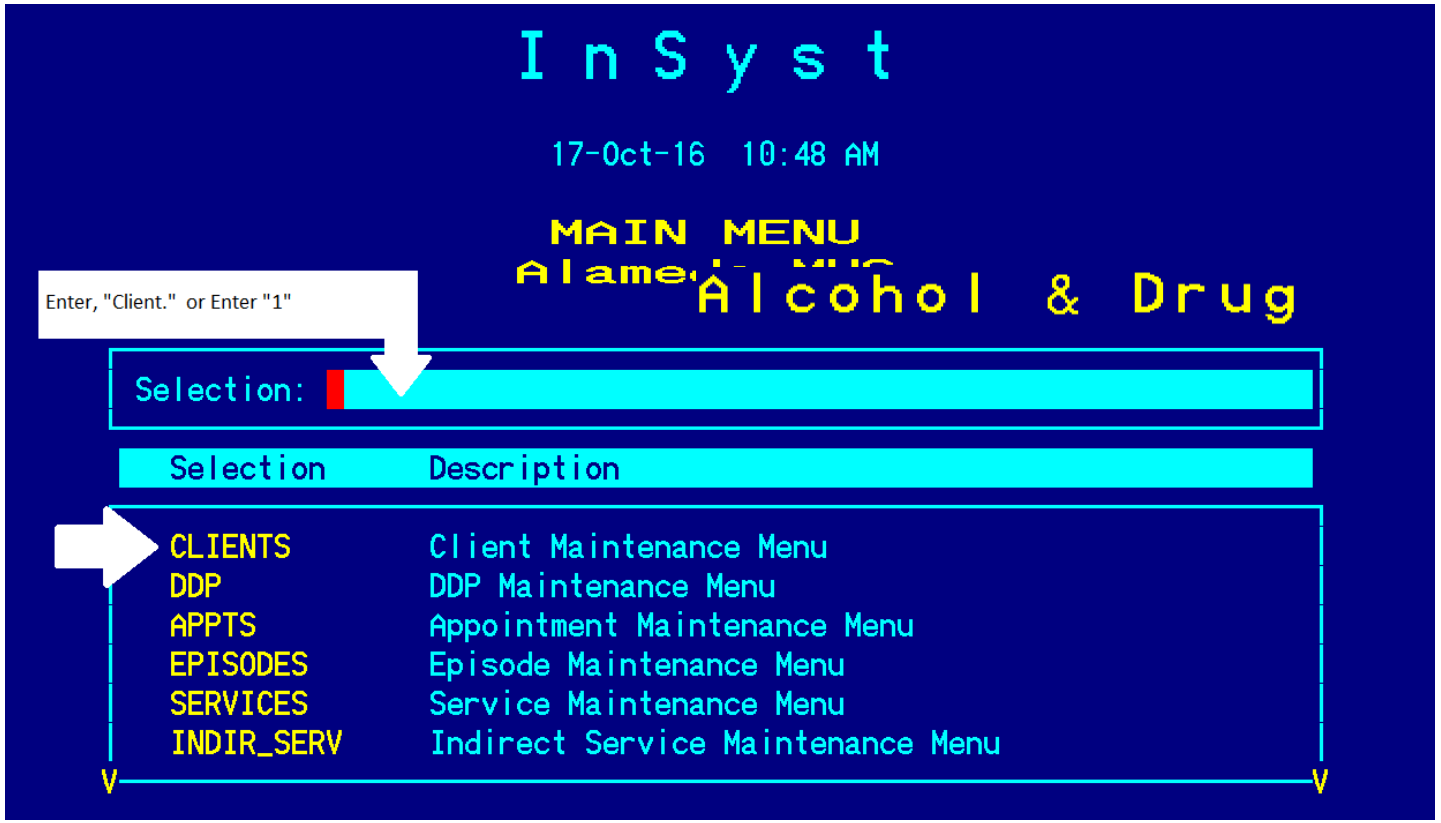
http://cgate.bhcs.internal/CGSUD/serviceentry/ViewService.aspx?INDV_SRV_NUMBER=15588 1/2

How to Print InSyst Face Sheet

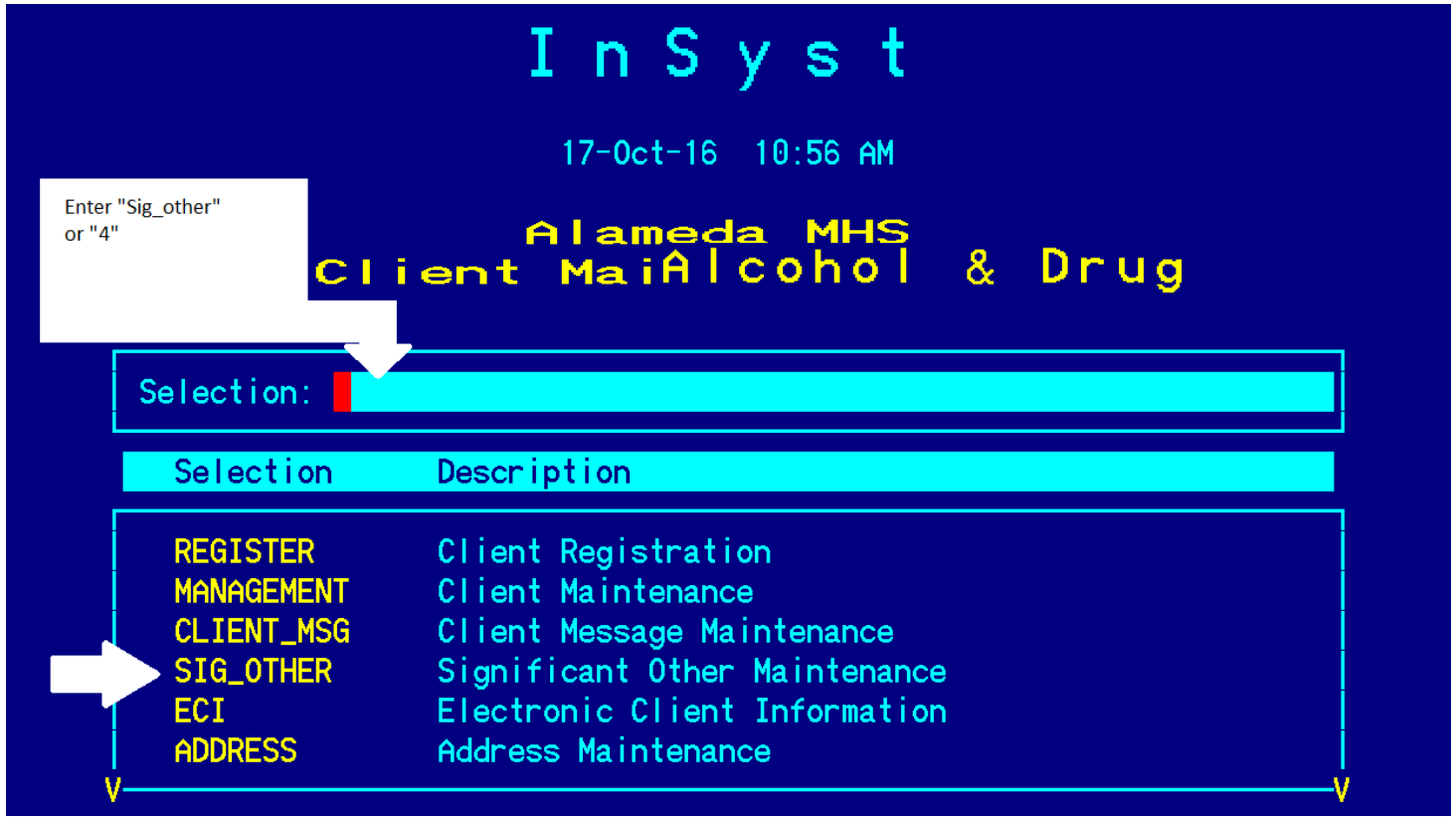
- Navigate to the *InSyst Client Locator Screen* (1,7 from main menu)
- With the client's information on the *InSyst Client* Locator Screen press Num-Lock + F, then press F6
- This will print the client's *InSyst Face Sheet* to the designated printer
- These instructions are also in the InSyst Mini-Manual



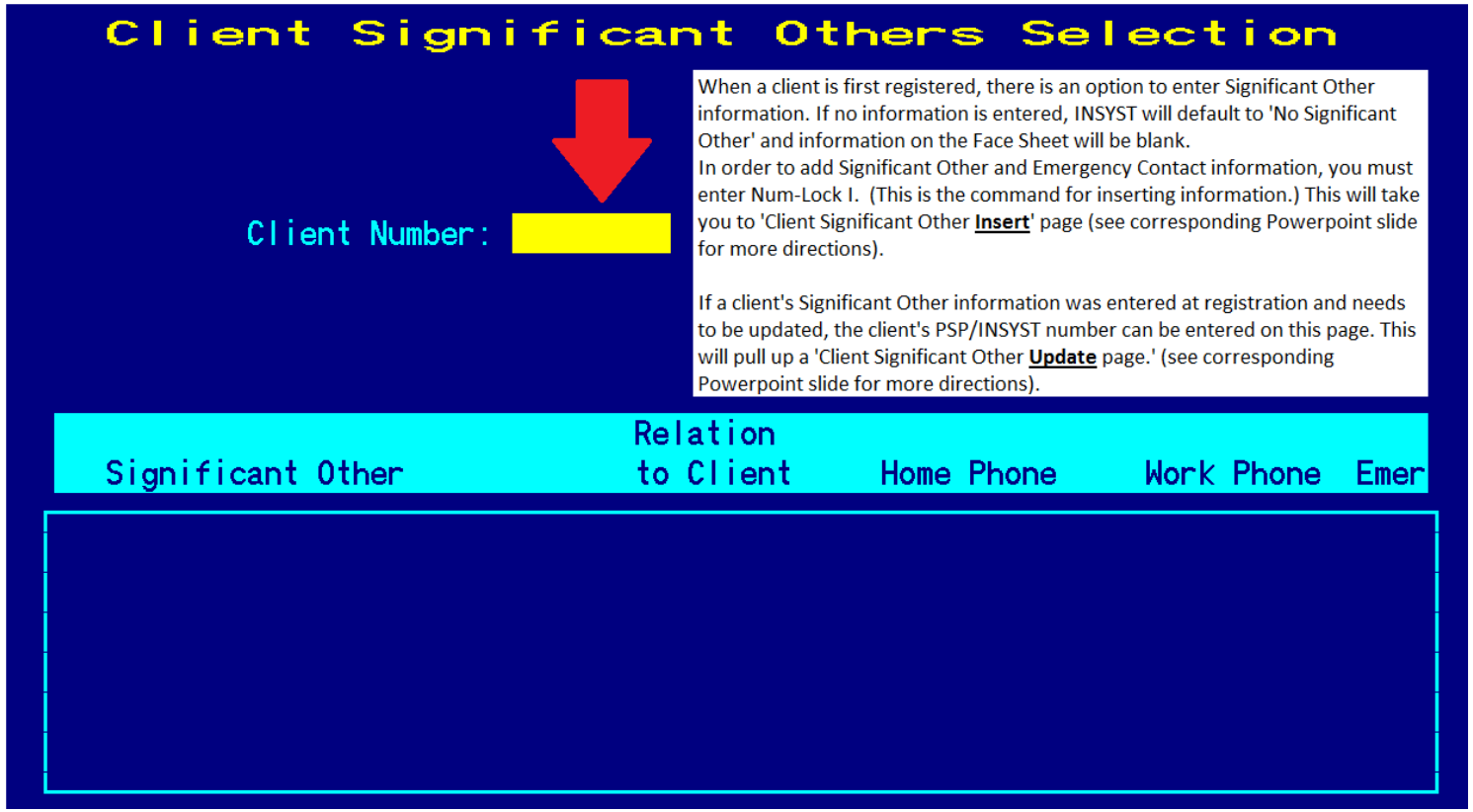
How to Update Emergency Contact Information



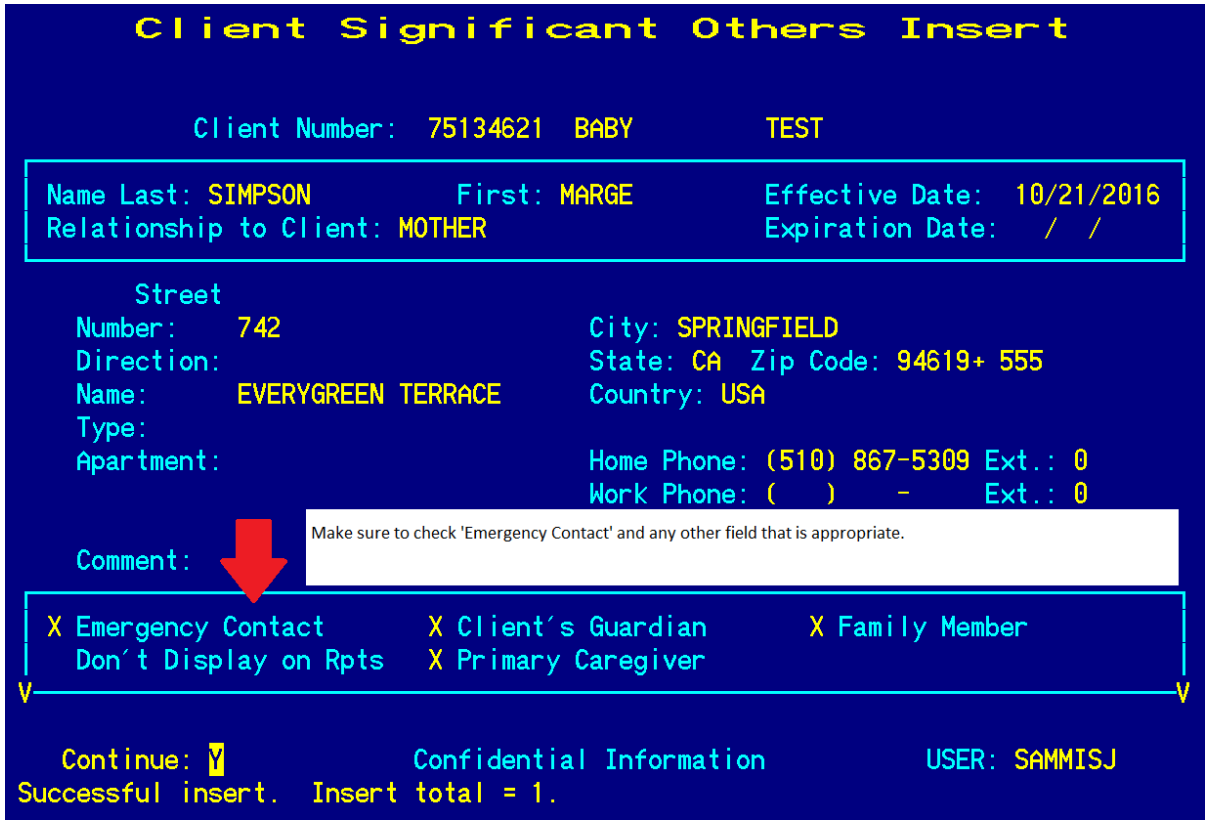
How to Update Emergency Contact Information



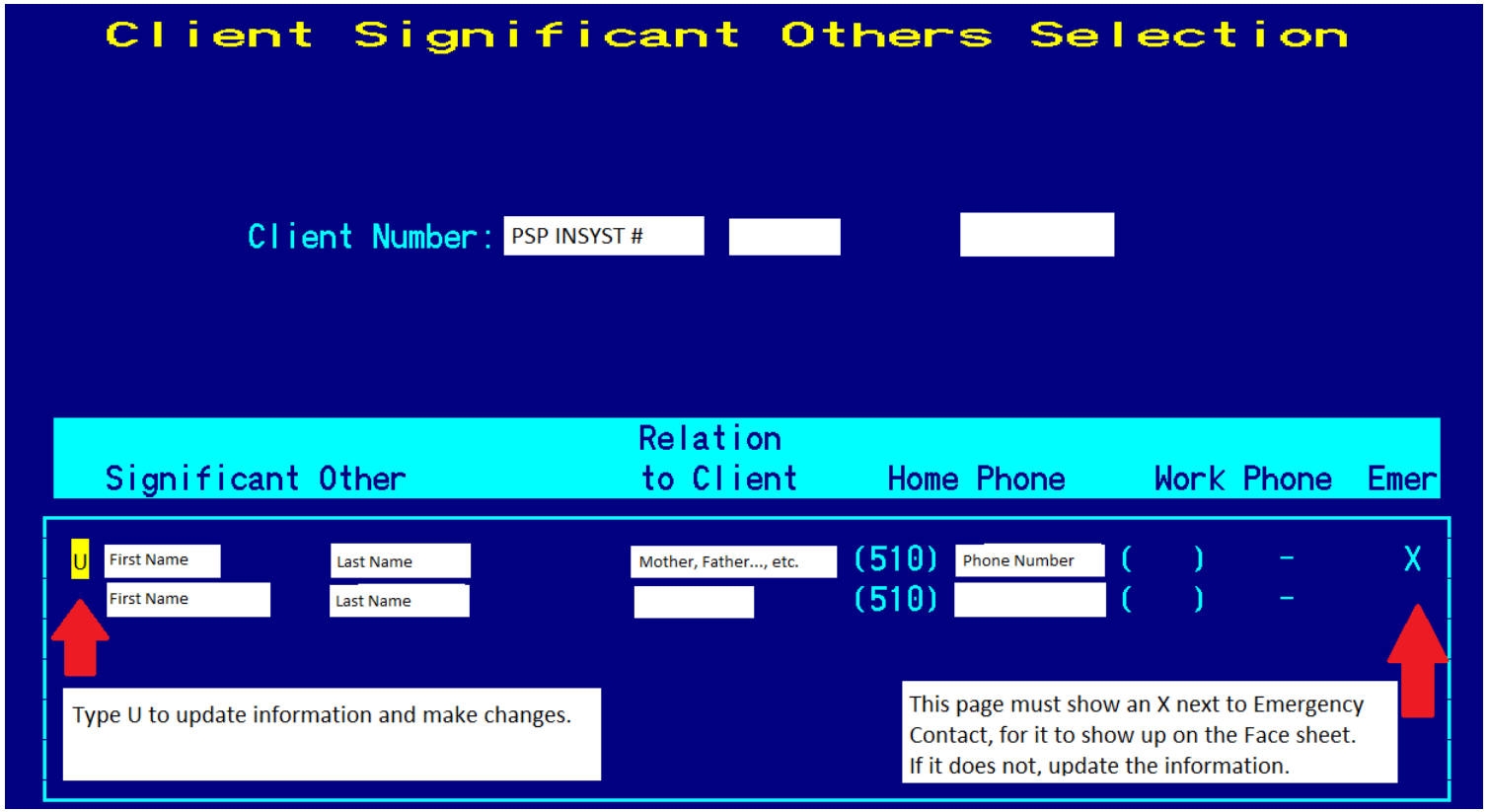
How to Update Emergency Contact Information



Inserting Significant Other Info if None was Entered at Episode Opening



Updating Significant Other Information that has already been entered



How to Update Emergency Contact Information