



***DMC-ODS PRACTICE
GUIDELINES &
CLINICAL PROCESS
STANDARDS***



Table of Contents

DMC-ODS PRACTICE GUIDELINES & CLINICAL PROCESS STANDARDS	1
<i>Continuity of Care & Care Coordination-Case Management</i>	4
<i>Monitoring Services</i>	11
<i>Utilization Management Program</i>	12
Utilization Management Components	12
<i>Quality Assurance – Regulatory Framework</i>	19
<i>Documentation Standards</i>	24
Intake/Beneficiary Admission.....	26
Establishing Medical Necessity.....	29
Assessment.....	33
Treatment Plans	35
Progress Notes.....	39
Group Sign-In Sheets.....	46
Continuing Services Justification	46
Discharges and Transfers.....	47
Minimum/Maximum Service Requirements.....	48
SUD Lockouts	53
Same Day Billing (DHCS IN 17-039).....	54
Due Dates and Signatures	55
Opioid Treatment Services (formerly Narcotic Treatment Programs).....	59
Practice Standards	90
Evidence Based Practice.....	90
Older Adult Substance Use Disorder (SUD) Standards of Practices and Workforce Development	92
Drug Testing.....	94
<i>Clinical Quality Review Team (CQRT)</i>	99
ACBH Quality Assurance (QA) Office Operated CQRT Participation	100
Episode Opening Date (EOD) Drug Medi-Cal:.....	101
Chart Documentation & Preparing for the CQRT	102
The CQRT Process.....	104



Complaints/Grievances and Appeals Processes..... 106
 Complaint/Grievance Process 106
Workforce 116



Continuity of Care & Care Coordination-Case Management

Alameda County Behavioral Health (ACBH) and its contracted providers offer care coordination and ensure continuity of care in collaboration with partner organizations and agencies. Continuity of care extends to beneficiaries who receive SUD treatment in the DMC-ODS, as well as those who require care coordination between levels of care within the DMC-ODS, and/or with mental health service providers, hospitals, health care clinics and others.

Under the DMC-ODS Plan, beneficiaries will be assessed and have access to a full continuum of SUD services with an emphasis on engaging the beneficiary in the right care, at the right time, with the right provider, utilizing the principles of the American Society of Addiction Medicine (ASAM) Placement Criteria. Beneficiaries will be linked to all levels of care within the DMC-ODS through the SUD Access & Referral Helpline. Additional DMC-ODS access points have been developed for special populations, and include: Center Point's Criminal Justice Case Management Program (AB109), Drug Court, and Cherry Hill Detox. Referrals to the SUD Access & Referral Helpline may come through a variety of community sources including, specialty mental health treatment providers, managed care plans, Emergency Rooms, Integrated Behavioral Health Coordinators at FQHCs, providers of homeless assistance/outreach, housing resource centers, Child Welfare, and Alameda County Care Connect care managers.

Beneficiary's treatment services shall be coordinated across Levels of Care (LOC); from the initial point of contact, first call or in-person visit, first offered appointment, referral, intake/assessment and determination of medical necessity, treatment planning, transition planning, discharge, and recovery support services. Prior to any changes in the LOC, the SUD service provider shall conduct an A-LOC re-assessment. When a change in the LOC is confirmed (and authorized for Residential Treatment and Recovery Residence), the treatment plan must be updated to reflect the change in SUD treatment and frequency of services.

Care Coordination Procedures

1. Beneficiaries shall have an ongoing source of care appropriate to their needs with an SUD provider case manager designated as primarily responsible for coordinating services. Beneficiaries will be informed as to whom to contact, and how to contact, their designated case manager upon initial intake into an SUD treatment program. For Narcotic Treatment Programs, the individual counselors will provide this function.
2. Coordination of services will be furnished to beneficiaries:
 - a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
 - b. With the services the beneficiary receives from any other managed care organizations or provider of health services, including primary care, specialty



- mental health services, and care management / health home services.
 - c. With the services the beneficiary receives in fee for service Medicaid
 - d. With the services the beneficiary receives from the community and social support providers.
3. Beneficiaries will access care through the following access points:
 - a. 24-hour toll free SUD Access and Referral Helpline 844-682-7215
 - b. Walk-ins or referrals directly to Outpatient, Intensive Outpatient, Recovery Support Services, or Opioid Treatment Programs.
 - c. Referrals to an in-person ASAM screening conducted by Center Point's Criminal Justice Case Management program, or Drug Court case management services
 - d. In-person ASAM screenings and treatment referrals conducted at Cherry Hill Detox for beneficiaries receiving withdrawal management services
 4. Initial screenings of each beneficiary's needs shall be conducted upon intake.
 - a. At every access point in Alameda County, beneficiaries will be triaged for risk and for other needs for assistance to address potential barriers to successful engagement and retention in SUD services and will be advised of the benefits to which they are entitled under the DMC-ODS waiver. Initial screenings will be completed using a universal screening tool based on the ASAM dimensions (ACBH approved brief ASAM tool) by trained screening staff.
 - b. Upon screening, the beneficiary will be referred/linked to the appropriate ASAM level of care (LOC) to ensure there are not disruptions in services. Placement considerations include results from the ASAM screening, geographic accessibility, threshold language needs, and the beneficiary's preferences. The beneficiary will be referred to ACBH SUD network providers for an intake appointment for the following services:
 - i. ASAM 1.0 and 2.1 Outpatient, Intensive Outpatient, and Recovery Support Services
 - ii. ASAM 1.0 and 2.1 Perinatal Outpatient, Intensive Outpatient, and Recovery Support Services
 - iii. ASAM OTP 1.0 Opioid Treatment Programs
 - iv. ASAM 3.2 Residential Withdrawal Management
 - v. ASAM 3.1, 3.3 or 3.5 - Residential services
 - vi. ASAM 3.1, 3.3 or 3.5 - Perinatal Residential
 - vii. Recovery Residence (adjunct to outpatient, intensive outpatient or recovery support)
 - viii. Medication Assisted Treatment Services
 5. ACBH and its subcontracted providers may share with DHCS or other managed care organizations or providers of care management serving the beneficiary the results of any identification and assessment of the beneficiary's needs to facilitate effective care coordination, and to prevent duplication of case management activities or other services, with appropriate client Release of Information in place.



6. Each provider furnishing services to beneficiaries will maintain and share, as appropriate, a beneficiary's health record in accordance with lawful and professional standards.
7. In the process of coordinating care, each beneficiary's privacy will be protected in accordance with privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.
8. For beneficiaries identified through the assessment process as having special health care needs, including co-occurring disorders:
 - a. At intake, and ongoing throughout SUD treatment, treatment provider will assess to identify any ongoing conditions that may require treatment for co-occurring disorders or additional needs requiring services delivered by other care providers. The assessment will indicate such conditions in the treatment plan and will ensure linkage to the appropriate service providers, including complementary programs specialized in treating the other type of condition.
 - b. SUD Providers will produce a treatment plan meeting the criteria below for beneficiaries with co-occurring mental health, physical health, or other needs requiring supportive services (e.g. housing, child welfare, probation) determined to need a course of treatment or regular care monitoring. The treatment plan shall be:
 - i. Developed with beneficiary participation, and in consultation with any providers of care or care management for the beneficiary;
 - ii. Developed by a person trained in person-centered planning using a person-centered process and a plan as defined in 42 CFR §441.301(c)(1);
 - iii. Approved/authorized services for Residential treatment by the County Utilization Management team in a timely manner and Outpatient treatment authorized by Quality Assurance (QA)
 - iv. Reviewed and revised upon reassessment of functional need, at least every 90 days, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3);
 - c. SUD Providers will ensure that beneficiaries who need treatment for co-occurring mental health or physical health needs, &/or who require services to address potential barriers to successful engagement with SUD treatment, have access to services from other qualified providers as appropriate for the beneficiary's condition(s). This access will be facilitated through the SUD Provider's referral to managed care plan, primary care provider, Federally Qualified Health Center, provider of Care Management / Health Home Services, homeless assistance, supportive housing, the ACBH ACCESS line for specialty mental health services, or other agencies. SUD treatment providers will be responsible for coordinating SUD treatment with the other agencies and services to which the beneficiary is referred during the



beneficiary's episode of SUD treatment.

9. Intake, Assessment, and Authorization

- a. Beneficiaries referred to a residential program will be connected to a contracted Care Navigator provided by the Substance Use Referral & Access Line, Drug Court, or the Criminal Justice Case Management Program.
 - i. The Care Navigator will maintain at least monthly contact with the beneficiary through the time that he/she is engaged in residential treatment. The primary job of the Care Navigator will be to ensure that the beneficiary successfully connects with and engages in residential treatment; in addition the Care Navigator will ensure that the beneficiary successfully connects with subsequent treatment services recommended post-residential. For a beneficiary who is experiencing homelessness at the time of entry into residential treatment, the Care Navigator will ensure that the beneficiary is assessed for potential housing assistance that may be accessed through a Housing Resource Center (Alameda County's coordinated entry system for homeless assistance).
 - ii. In the event that a beneficiary is placed on a residential waitlist, the Care Navigator will ensure that interim services are provided during the period of time that the beneficiary is waiting for SUD treatment.
- b. The residential treatment provider will conduct a comprehensive face to face ASAM assessment within five (5) days of intake appointment at the residential program; the provider will submit a prior authorization request to Utilization Management (UM) on the date of intake, and submit the Initial Medical Necessity Criteria form and final ASAM determination within 5 business days. UM will render an authorization decision within one business day of receipt of this request.
- c. Alameda County DMC-ODS outpatient, intensive outpatient and recovery services providers will aim to admit eligible beneficiaries within five (5) business days, but will admit all appropriate beneficiaries no later than ten (10) business days from the date the initial screening was completed. For Opioid Treatment Programs, the DMC-ODS will provide an appointment within three (3) business days from request to appointment.
- d. The final LOC determination for placement will be based on the comprehensive assessment, and may override the determination from the initial screening process. In the event that a full comprehensive assessment yields a different LOC, the provider shall be responsible for transitioning the beneficiary to the appropriate level of care, which may include transitioning (and providing or arranging transportation) to another provider facility. For residential cases, the provider may work with the beneficiary's Care Navigator to successfully transition to a new provider.

10. Re-Assessments



- a. Re-assessments provide an opportunity for treatment staff to review and document a beneficiary’s progress by comparing the most recent functioning and severity levels to those at intake. All six (6) ASAM dimensions will be reviewed to determine the beneficiary’s current level of functioning and severity. The purpose of the re-assessment will be to determine whether the beneficiary continues to require the current LOC, or whether an alternative LOC may be more appropriate.
 - i. Treatment staff will conduct re-assessments at the following intervals:

Level of Care (LOC)	Re-Assessment Maximum Timeframe
Residential Withdrawal Management, Level 3.2	5 days
Residential Treatment, Level 3.1, 3.3, 3.5	30 days
Intensive Outpatient, Level 2.1	60 days
Outpatient Treatment, Level 1.0	90 days
Opioid Treatment Programs	1 year
Medication Assisted Treatment	1 year

- ii. Re-assessments may also occur at times of significant change or could warrant a transfer to a higher or lower level of care. Changes that could warrant such re-assessments may include, but are not limited to:
 1. Achieving Treatment Plan goals
 2. Inability to achieve treatment plan goals despite amendments to the treatment plan
 3. Reoccurrence of severe symptoms or new issues that cannot be addressed adequately in the current LOC
 4. Beneficiary request

11. Transitioning between Levels of Care and the Role of Care Coordination, including specialized Care Navigators for beneficiaries receiving Residential Services

- a. Alameda County contracts with the following agencies to provide care navigation for beneficiaries served in Residential: CenterPoint (Substance Use Access & Referral Line, AB109 Criminal Justice Case Management), and Drug Court case management. Care Navigators from these organizations will provide a specialized form of case management to beneficiaries from the point at which they initiate an ASAM screening that yields a Residential



recommendation. The Care Navigator will focus on helping clients effectively engage in Residential treatment. To do this, the Care Navigator will maintain at least monthly contact (sometimes weekly) with the beneficiary during his/her course of residential treatment; this contact will include communication with the treatment provider. In addition, the Care Navigator will ensure that the beneficiary successfully connects with any recommended subsequent treatment services following the course of treatment in residential.

- b. For beneficiaries served in residential treatment, the treatment provider will be responsible for providing service coordination for beneficiaries who have an assigned Care Navigator (from Substance Use Referral & Access Line, Drug Court, or the Criminal Justice Case Management Program). Service coordination is defined as case management services that assist the beneficiary to access needed medical, educational, social, prevocational, vocational, and rehabilitative or other community services. In addition, the residential treatment providers will be responsible for making referrals to other levels of care within the DMC-ODS, and will collaborate with the assigned Care Navigator to ensure that the beneficiary has a smooth transition to the next level of care.
- c. Prior to a change in the level of care, all SUD service providers must conduct an A-LOC re-assessment. When a change in level of care is confirmed, the treatment plan must be updated to reflect the change in SUD treatment and frequency of services.
- d. For beneficiaries not served in Residential, the primary case management duties (which include care coordination, and service coordination) will be provided by the SUD treatment provider. The primary case manager must collaborate in the transitioning of a beneficiary to a lower or higher level of care.
- e. LOC transitions for non-residential providers will occur within five (5) to ten (10) business days. The exception to this will be when an individual requires residential treatment— for this the initial authorization process will be in effect.
- f. At Program exit, whether due to a change in LOC based on re-assessment, or treatment completion, the SUD treatment provider staff from the existing program will coordinate with the “new” SUD treatment provider in order to help facilitate transfer of care and provide support while the beneficiary engages in the new LOC services. It is expected that the treatment provider’s case managers ensure “warm hand-offs” between LOC, which may require collaboration from staff at both SUD programs. This collaboration may include, but is not limited to, communication through emails or phone calls, transportation or other practical supports.
- g. For beneficiaries exiting the DMC-ODS, i.e. not transitioning to a new SUD program or level of care, to the extent appropriate and based on client consent, the treatment provider should coordinate and communicate with



other care providers or care managers serving the beneficiary for the purpose of facilitating a “smooth landing” and to prevent negative outcomes such as victimization, crisis, or homelessness.



Monitoring Plan for Care Coordination

In order to monitor care coordination and continuity of care across the DMC-ODS, ACBH will require all SUD contracted service providers to enter beneficiary records into Clinicians Gateway (CG), the county's centralized electronic health record system (EHR). CG captures beneficiary's SUD treatment services from the initial point of contact, first call and first offered appointment, referral, intake/assessment and determination of medical necessity, treatment planning, progress notes, transition planning for Recovery Support Services and discharge planning. For purposes of tracking and monitoring care coordination and service coordination, SUD treatment providers authorized to provide case management will be required to use specially developed procedure codes in CG to track time spent performing these case management activities on behalf of beneficiaries. The two case management codes will be as follows:

Care Coordination – Activities associated with providing for seamless transitions of care for beneficiaries in the DMC-ODS system of care without disruption of services.

Service Coordination – Services that assist beneficiaries to access needed medical, mental health, housing, educational, social, prevocational, vocational, rehabilitative or other community services.

ACBH contracted SUD treatment providers must ensure that beneficiaries are supported through continuity of care through the provision of individual case management services. The following procedures will take place to monitor care coordination and continuity of care:

- ACBH SUD operations team – will review CG reports/dashboards to determine whether care coordination and service coordination is occurring, and address deficiencies where they exist. This team will also monitor timely access to intake assessment, residential waitlist and bed capacity, timely treatment plan updates.
- QA – annual chart audits of all SUD providers will monitor adherence to these procedures in such areas as re-assessment periodicity, thoroughness of assessment including health conditions and co-occurring conditions, adequate provision of or support for linkages to services for needs identified, proper releases of information in place, and evidence of coordination of services as detailed in these procedures.
- Bi-Weekly operational meetings – will address and identify operational challenges within these procedures. Meetings will include representatives from SUD Operations, Center Point Care Management, Drug Court representative, and Utilization Management
- Regular Meetings with County's Medi-Cal Managed Care Plans - ACBH coordinates with the managed care plans (Alameda Alliance and Anthem Blue Cross). The health plans will designate an individual to serve as the liaison to ACBH regarding SUD services. The purpose of these meetings will be to review referral, care coordination across systems (managed care plan and SUD Plan), and information exchange protocols and processes.



Utilization Management Program

Utilization Management Components

Prior Authorization for Residential Services

INTRODUCTION:

Residential Treatment Services are the only SUD services in Alameda County that require prior authorization, which is an approval for service prior to treatment services being rendered. Please note that prior authorization is not a guarantee of payment. Authorized services are subject to post-service retrospective payment review, which may include verification of a beneficiary's continued eligibility status and that documentation continues to meet medical necessity. Prior authorization is provided by the ACBH Utilization Management Program (UM). The primary goals of the ACBH UM prior authorization process is:

- To provide the least restrictive beneficiary access to services
- To ensure beneficiaries only remain at the residential level of care for as long as clinically indicated and transition to the appropriate lower level of care; thereby creating a system in which beneficiaries assessed to warrant the residential level of care are able to access services and in a timely fashion

To achieve the primary goal of providing the least restrictive beneficiary access to services, after a beneficiary has been assessed/referred to residential treatment services by one of the portals, the initial prior authorization for residential services may occur in the below two scenarios:

- Scenario 1: Beneficiary assessed by residential provider and determined to meet medical necessity/ASAM residential level of care; anticipated admission date determined
- Scenario 2: Beneficiary assessed and admitted to a residential provider on the same day

Please note that Scenario 1 utilizes prior authorization in full. Scenario 2 utilizes a combination of an initial retrospective authorization and prior authorization for services yet to be rendered.

The initial authorization contains two phases, which may result in a total maximum of thirty (30) authorized days. For Phase 1, UM may authorize up to a maximum of five (5) days. For Phase 2, UM may authorize for additional days up to a maximum of thirty (30) days. For example, UM during Phase 1 authorizes five (5) days and then in Phase 2 authorizes an additional twenty-five (25) days, totaling thirty (30) days (i.e. $5 + 25 = 30$). For continuing



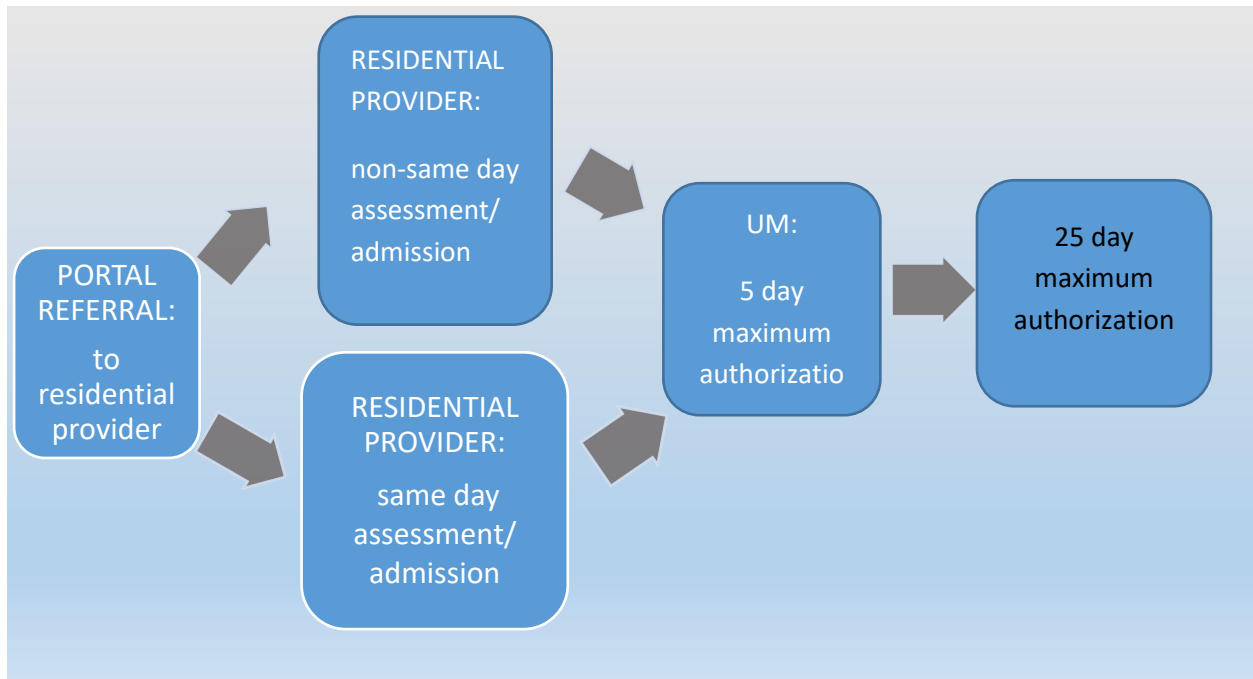
authorizations, UM may authorize up to a maximum of thirty (30) days. See below grid:

RESIDENTIAL AUTHORIZATIONS

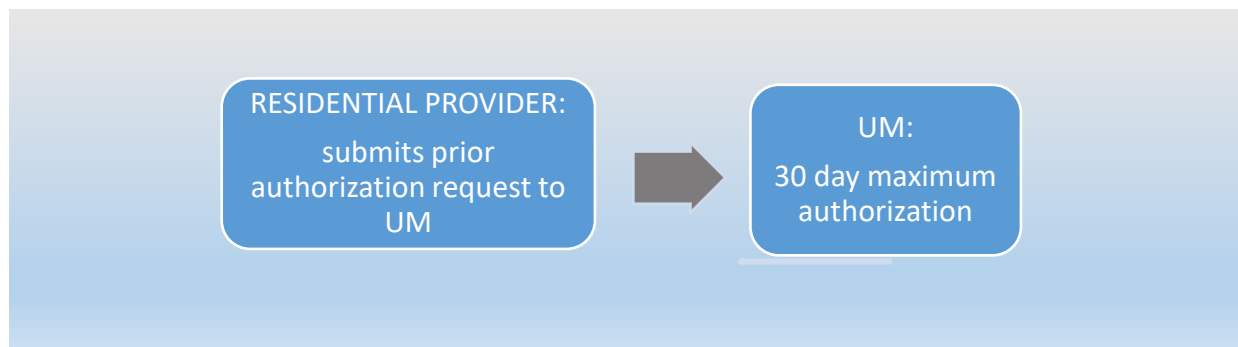
INITIAL AUTHORIZATION		TOTAL MAXIMUM AUTHORIZED DAYS
Phase 1	Phase 2	
5 day maximum	25 day maximum	30
CONTINUING AUTHORIZATIONS		30

GENERAL OVERVIEW: INITIAL AND CONTINUING AUTHORIZATION FLOW

INITIAL AUTHORIZATION UM:



CONTINUATION AUTHORIZATION



RESIDENTIAL PROVIDER PRIOR AUTHORIZATION REQUEST

SUD treatment providers must notify UM staff of the request for prior authorization by E-Fax in order to begin the prior authorization review process. Providers must, at a minimum, by the fifth day of Residential treatment, complete an ASAM assessment and the Initial Medical Necessity – SUD Criteria Form. An SUD Intake and Assessment and Initial Treatment plan must be completed by 30 days after admission. Providers must submit a Request for Prior Authorization for residential services prior to initiation of services. Requests for continuation of services that require pre-authorization must be submitted at least five (5) calendar days in advance of the end date of current authorization. Required documentation is detailed below, and includes, at a minimum, a completed Prior Authorization Request, current treatment plan, assessment information, progress notes, pertinent miscellaneous notes, and laboratory test results (if available).

UM staff will perform clinical reviews of the case being referred for Prior Authorization, based on the case review considerations listed above. Approval for initial Prior Authorization Request is based on medical necessity and ASAM level of care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment.

If a decision determination cannot be made due to insufficient documentation, UM staff will return the authorization request and notify the provider that additional information is needed to process the request.



Lengths of stay in Residential Treatment are governed by Drug Medi-Cal Service Limits as detailed in Table A.

Table A: Residential Prior authorization and Reauthorization Service Limits

Age Group	Initial Residential Prior authorizations	Residential Reauthorizations	Drug Medi-Cal Service Limits
Adults ages 21+	Phase 1: 5 day maximum + Phase 2: 25 day maximum = Total of 30 day maximum	30 day maximum	Maximum DMC reimbursable residential length of stay is 90 calendar days, with one 30 calendar day extension in a one-year period, for a total of two (2) residential admissions per year, authorization based on medical necessity
Perinatal Adults	Phase 1: 5 day maximum + Phase 2: 25 day maximum = Total of 30 day maximum	30 day maximum	Maximum DMC reimbursable residential length of stay is for duration of pregnancy, plus 60 days postpartum. At the 60 day point, if client warrants further treatment, further authorization of Residential Treatment may be considered utilizing Non-DMC funding.

Residential Treatment

Residential services require Prior Authorization. This prior authorization is required for ALL patients needing residential treatment, with the following considerations:

SUD treatment providers must submit a Prior Authorization request to the UM Program, which will conduct a prospective review, and then approve or deny the request within 24 hours of receiving the completed request.

Requests for continuation of residential services must be submitted at least five (5) calendar days in advance of the end date of current authorization.

Residential Prior authorizations are required when initiating residential care, transitioning from a lower to a higher level of residential care, or transitioning from non-residential to residential levels of care.



Residential reauthorizations are not required for transitions from a higher to a lower residential level of care.

Adults age 21+

Initial residential Prior Authorizations for adults ages 21 and over will authorize no more than 30 calendar days at the outset of residential services. In other words, residential services for all adult populations ages 21 and over require reauthorization after 30 calendar days and 60 calendar days to assess for appropriate level of care utilization, if adult clients are determined to require longer lengths of residential care.

For adults ages 21 and over, the length of residential services ranges from one (1) to 90 calendar days with a 90 calendar day maximum, unless medical necessity authorizes a one-time extension of up to 30 calendar days on an annual basis.

For adults ages 21 and over, one extension of residential services up to 30 calendar days beyond the maximum length of stay of 90 calendar days may be authorized for one continuous length of stay in a one-year period.

Adolescents ages 12 and under 21

Initial residential Prior Authorizations for adolescents ages 12 and under 21 will authorize no more than 30 calendar days at the outset of residential services. In other words, residential services for all adolescent populations ages 12 and under 21 require reauthorization after 30 calendar days and 60 calendar days to assess for appropriate level of care utilization, and if adolescent clients are determined to require longer lengths of residential care.

For adolescents ages 12 and under 21, the length of residential services ranges from one (1) to 60 calendar days with a 60 calendar day maximum, unless medical necessity authorizes a one-time extension of up to 30 calendar days on an annual basis.

For adults ages 12 to under 21, one extension of residential services up to 30 calendar days beyond the maximum length of stay of 60 calendar days may be authorized for one continuous length of stay in a one-year period.

Special Adult Populations

Perinatal clients

Perinatal clients may receive longer lengths of stay in residential settings based on medical necessity. Following initial residential Prior authorization, perinatal clients may be authorized for extensions of residential services every 30 calendar days up to the length of the pregnancy and postpartum period, which is up to 60 calendar days after the pregnancy ends, based on medical necessity.



Required documentation for initial Prior Authorization for the first five days for residential services for all populations must, at a minimum, include:

Prior Authorization Request and Full Screening Assessment (completed by Portal staff)

Required documentation for initial Prior Authorization for next twenty five days for residential services for all populations must, at a minimum, include:

- Prior Authorization Request
- Full ASAM assessment information with LPHA signature
- Initial Medical Necessity – SUD Admission Criteria

Required documentation for continuing Prior Authorization at 30 days for residential services for all populations must, at a minimum, include:

- Prior Authorization Request
- SUD Intake and Assessment
- Treatment Plan
- Progress Notes
- SUD ASAM ALOC Brief Reassessment

Required documentation for continuing Prior Authorization at 60 days (and 90 days if a one-time 30 day extension is requested) for residential services for all populations must, at a minimum, include:

- Prior Authorization Request
- Treatment Plan
- Progress Notes
- SUD ASAM ALOC Brief Reassessment

Residential clients must receive regular assessments of their progress within their initial 30 and 60 calendar day residential authorizations.

Given the fluid nature of clinical progression, the expectation will be that clinical progress notes / miscellaneous notes document progress on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower level of care as soon as clinically indicated. Required treatment plan updates every 30 calendar days in the residential setting will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate. Please see *Documentation* section for additional details on treatment plan requirements.

Approval for initial authorization requests is based on medical necessity and ASAM level of care guidelines, as well as generally accepted standards of clinical practice. Consideration



for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment. If after careful consideration of all case information UM staff determines that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the QI and UM programs, services and reimbursement will be authorized and the provider will be notified.

If upon clinical review, either during a focused or random retrospective review, a residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services, and require transition to an appropriate lower level of care. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied.

SUD treatment providers will be responsible for ensuring successful care coordination during all level of care transitions.



Quality Assurance – Practice Guidelines

Regulatory Framework

In health care, quality assurance refers to activities and programs intended to achieve improvement and maintain quality of care. Oftentimes, these activities involve ensuring compliance with regulations established by governmental and/or administrative entities. In all cases, key components of quality assurance involve:

- Assessing or evaluating quality
- Identifying problems or issues with care delivery and designing quality improvement activities to overcome them
- Follow-up monitoring to make sure activities achieve their intended aims

Confidentiality

All SUD treatment programs must operate in accordance with legal and ethical standards. Federal and state laws and regulations protect the confidentiality of patient records maintained by all ACBH contracted providers. Maintaining appropriate confidentiality is of paramount importance. All ACBH contracted providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter 1, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, the Health Information Technology for Economic and Clinical Health (HITECH), and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records. When these regulations differ, the stricter requirement must be followed. ACBH has developed three (3) releases of information (ROIs) for use by providers. These ROIs are available on the DMC-ODS transition website. The ACBH release has been approved by Alameda County Counsel for use in the SUD system. Even when information sharing is allowed by law, best practices inform providers to obtain ROIs regardless.

SUD Programs ROI – Required before providing any services or opening the beneficiary in InSyst or CG. This ROI allows basic information sharing across the Alameda County SUD system. Opening services in InSyst or CG before this is signed by the beneficiary would be in violation of 42 CFR, Part 2. If a beneficiary wants SUD treatment, but refuses to sign this ROI. Contact ACBH immediately. Do not open the beneficiary to treatment services or provide any services until consultation with ACBH QA has concluded.

Emergency Contact ROI – Required for use for all emergency contacts of beneficiaries receiving SUD treatment in Alameda County. This ROI is not required when a beneficiary does not provide an emergency contact. In these cases, document in the medical record that an attempt was made to collect beneficiary's emergency contact information.



Emergency contact information should be periodically assessed for updates, an updated ROI is required with the new contact's information.

Criminal Justice ROI - Required for use when communicating with the court/criminal justice system. A separate ROI is required for each individual at the court.

42 CFR Part 2 – Confidentiality of Alcohol and Drug Patient Records

Confidentiality regulations cover all records relating to the identity, diagnosis, and/or treatment of any patient in a SUD program that is conducted, regulated, and/or assisted in any way by any federal agency. This includes all programs that are directly and indirectly funded by the federal government.

- For a summary of 42 CFR Part 2, Final Rule please see [:https://www.ecfr.gov/cgi-bin/ECFR?page=browse](https://www.ecfr.gov/cgi-bin/ECFR?page=browse)
- Subpart A includes an introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc.)
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, and minor patients, etc.)
- Subpart C covers disclosures allowed with the patients' consent (e.g., prohibition on re- disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs, etc.)
- Subpart D covers disclosures that do not require patient consent (e.g., medical emergencies, research, evaluation, and audit activities)
- And Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc.)

HIPAA – Health Insurance Portability and Accountability Act

- Provides data privacy and security provisions for safeguarding medical information. A summary of the HIPAA privacy rule can be found here: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>. For more general information on HIPAA, please see: <http://www.hhs.gov/ocr/privacy/index.html>. For more specific information concerning covered entities, consumer information and health information technology, please see <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>.

A duality exists within substance use treatment services. In one regard, these laws and regulations must not be used as barriers to provide coordinated and integrated care. Provided that the appropriate patient releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care, and also across systems of care (physical and mental health, etc.). In another regard, providers must also take into consideration understandable client privacy concerns, given the illegality of many substances used by individuals seeking treatment.



Taking into consideration both the client privacy protections and limits of confidentiality, within the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the SUD system must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

[HITECH – Health Information Technology for Economic and Clinical Health Act](#)

All confidential breaches occurring on or after September 23, 2009 must be reported to DHCS and/or California Department of Public Health (CDPH) (immediately if 500+ individual cases; annually if fewer) and the patient must be notified without unreasonable delay (but no longer than 60 days).

A breach of PHI occurs when the acquisition, access, use or disclosure of protected health information (PHI) in a manner not permitted under the following regulations: 45 CFR 164; SB 541; AB 211; and the ARRA/HITECH ACT, compromises the security or privacy of the personal health information. Call: 1-844-729-7055 Fax: (510) 639-1346 Email: ProgIntegrity@acgov.org Mail: 2000 Embarcadero, Suite 400, Oakland, CA 94606 Attn: QA Office

[General Management of Medical Records \(Applies to All Provider Contracts\)](#)

Record Storage

Clinical records contain Protected Health Information (PHI) covered by both state and federal confidentiality laws. Providers are required to safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons. (CFR1) (CFR2) (CC1) Alameda County ACBH requires that clinical records be stored in a “double locked” manner (e.g., in a locked filing cabinet located within a locked office). If records must be transported, maintain the “double locked” and safeguarding requirement (e.g., transported in a locked box in a locked vehicle trunk and not left in an unattended vehicle).

The following record storage procedures are consistent with good clinical practice: (HS2) (CC2)

- A controlled record check-out or retrieval system for access, accountability and tracking.
- Safe and confidential retrieval system for records that may be stored off-site or archived.
- Secure filing system (both physical plant and electronic safeguards used, when applicable). (See above regarding “double locked” storage.)

With respect to Electronic PHI/PI, providers must use appropriate administrative, physical and technical safeguards, and comply with the Security Rule and HIPAA Security Regulations (BAEE). It is recommended that each provider consult with an IT expert



knowledgeable about HIPAA/HITECH requirements and NIST compliance standards for protection of PHI/PI. Currently all workstations and laptops that store PHI/PI either directly or temporarily must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk. All electronic files that contain PHI/PI must be encrypted when stored on any removable media or portable device; encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

Record Retention

Per federal law and state contract requirements, ACBH is required to maintain client records as follows:

- For all clients, records (paper and electronic) must be maintained for a minimum of: ten (10) years after the last service OR ten (10) years after their eighteenth (18th) birthday whichever is later. CA WIC § 14124.1. As well:
- If later, records must also be retained until DHCS does a final cost settlement with ACBH for the FY in which the last date of service occurred. The last cost settlement which has been finalized occurred for FY 07/01/08-6/30/09.
- On the date of the ten year anniversary (after no services, or the client's 18th birthday—whichever is later), the record shall be retained until the then current DHCS contract with ACBH expires. The current contract terminates 6/30/2018 and the following contract terminates 6/30/23.
- Audit situations: Records shall be retained beyond the ten (10) year period if an audit involving those records is pending, until the audit findings are resolved. The obligation to maintain the records beyond the ten (10) year period exists only if the DMC ODS notifies the Contractor of the commencement of an audit prior to the expiration of the ten (10) year period.

Example:

- Minor client last seen in 2006 has their 18th birthday on 1/7/2007.
- Their 10 year anniversary date (past last service date of 18th birthday—whichever is later, is 1/6/2017
- ACBH has finalized their cost settlement with DHCS for January 2007 (FY 2006-2007)
- None of these clients' records have been requested for an audit.
- As of 1/6/2017 the then current ACBH/DHCS contract expires 6/30/18.
- The client record, per ACBH Record Retention Policy, may be destroyed no sooner than 6/30/2018.

Given the above extensions beyond the 10 year period it is highly recommended that all providers simply maintain their client's records for fifteen (15) years after the last service OR fifteen (15) years after their eighteenth (18th) birthday whichever is later.

Third party: If a provider uses a third party to perform work related to their ACBH contract,



the provider must require the third party to follow these same standards. ACBH also requires that all contractors that have access to PHI sign a Business Associates Agreement (BAA) annually. The BAA outlines the security and privacy standards with which the contractor must comply, including record retention and disposal/destruction requirements.

Provider out of business: In the event a provider goes out of business or no longer provides mental health services, the provider is still obligated to make arrangements that will assure the accessibility, confidentiality, maintenance, and preservation of clinical records for the minimum retention time as described above.

Record Storage and Destruction

ACBH requires that paper clinical records be stored in a “double lock” manner (e.g., in a locked filing cabinet located within a locked office). Electronic Health Records (EHR) must be stored in a password-protected computer or server located within a locked room. Refer to “Record Storage and Retention” ACBH Policy for more detail. Clinical records are to be destroyed in a manner to preserve and assure client confidentiality.

Applicable Regulations

42 CFR, Part 438 – Managed Care

Alameda County’s participation in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, the administrative entity that is ACBH becomes a managed care plan responsible for overseeing the SUD system. As a component of becoming a managed care entity, ACBH and its SUD network must abide by the 42 Code of Federal Regulations (CFR), Part 438 managed care requirements.

In general, one of the primary aims of 42 CFR, Part 438 is to achieve delivery system and payment reforms by focusing on the following priorities:

- Network adequacy and access to care standards (e.g., timeliness of services, distance standards)
- Patient/consumer protections
- Quality of care

22 CCR § 51341.1 Drug Medi-Cal and the DMC-ODS Special Terms and Conditions

Prior to the implementation of the DMC-ODS waiver, [22 CCR § 51341.1](#) provided the majority of regulatory guidance with regard to DMC substance use treatment in CA. While 22 CCR § 51341.1 remains legally active, counties that participate in the DMC-ODS are guided by regulations set forth in the [CA Intergovernmental Agreement](#) and the [Special Terms and Conditions \(STCs\)](#). Both of these documents are available on the [DHCS DMC-ODS website](#).



California Code of Regulations (CCR) Title 9 Counselor Certification

CCR Title 9, Section 13035, Certifying Organizations provides minimum requirements on the level of credentials counseling staff secure prior to conducting services. The minimum standards are designed to ensure a baseline quality of treatment services and effectiveness. The County has built on these requirements and established minimum staffing standards specific to Alameda County.

For additional information, please see Alameda County's Guidelines for SUD Scope of Practice Credentialing on the ACBH website.

DHCS provides an up to date website listing current Counselor Certifying Organizations, visit it at:

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

9 CCR, Division 4, Chapter 4 Narcotic/Opioid Treatment Services)

To address the expanded needs of Medi-Cal beneficiaries suffering from opioid addiction, existing opioid treatment services are in the process of undergoing rapid changes. Traditionally medication-related opioid treatment has consisted of replacement therapy with controlled narcotic medications, such as Methadone or LAAM. LAAM, however, formerly available in the United States under the brand name ORLAAM®, has been withdrawn from the market by the manufacturer and is not currently produced in or imported into the United States. Recently, additional medications such as Naltrexone, Disulfiram, Buprenorphine, and Naloxone have been authorized by DHCS to be available from OTPs. The primary regulations guiding Opioid Treatment Programs (OTPs) are the higher standard of 9 CCR, Division 4, Chapter 4, Intergovernmental Agreement, and 42 CFR, Part 8.

Documentation Standards

Clinical documentation refers to anything in the patients' health record that describes the care provided to that patient, and its rationale. It is observational and narrative in content, and is written by SUD Counselors and LPHAs to document and analyze the process and contents of patient encounters. Note that opioid MAT providers' treatment and documentation standards are guided through a combination of 9 CCR regulations along with other SUD regulations. Much of the information described in this section will be relevant to OTPs, however some of the specifics may be different. A separate section for OTPs has been developed to clarify these differences.

Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

- 1) Ensure comprehensive and quality care –** The process of writing initial



assessments and proper progress notes requires thought and reflection. Preparing proper clinical documentation serves an important role of helping assure quality patient care by giving practitioners an opportunity to think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work, and weigh alternative approaches to the care. Good clinical documentation helps one organize clinical details into a case formulation that can then be used for treatment planning and is an essential element of professional practice and of the provision of quality clinical services. It also helps to assure appropriate utilization of team members from multiple disciplines in order to leverage interdisciplinary competencies and maximize the quality of services provided.

2) Ensure an efficient way to organize and communicate with other providers –

The documentation of clinical care helps to provide structure and efficiency to clinical communications with other providers who may be involved in the care of shared patients. This assures coordinated rather than fragmented treatment/service delivery.

3) Protect against risk and minimize liability – Accurate and comprehensive clinical documentation is not only important in terms of quality care, but is also essential in risk management. Detailing and justifying the thought processes that contributed to the clinical decision-making process helps to support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan, and demonstrates the application of professional skills and knowledge toward the provision of professional services.

4) Comply with legal, regulatory and institutional requirements – Good clinical documentation practices help to assure compliance with recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations, and rules. It also helps to ensure that documentation meets the standards set by specific accreditation programs (e.g., CARF, Joint Commission), when applicable, and by health care institutions, facilities and agencies.

5) Facilitate quality improvement and application of utilization management –

Clinical documentation provides an opportunity to explain the process and substance of assessments, treatment and service planning, clinical decision-making, medical necessity, and the effectiveness of treatments and other services provided. As a result, it is essential for the utilization review process because clinical documentation helps to substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services. From a quality perspective, clinical documentation facilitates supervision, consultation, and staff/professional development, and helps to improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be taken. Appropriate recordkeeping



also provides data for use in planning educational and professional development activities, policy development, program planning and research in agency settings.

6) Completeness of Documentation - Clinical documentation must be credible and complete, and is protected via HIPAA and 42 CFR Part 2. It encompasses every aspect of clinical care, including initial assessments, progress notes, and relevant encounters that occur outside of established appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment and reflects a comprehensive biopsychosocial approach. Progress notes are written during/after follow up appointments in order to gauge clinical progress and assess to determine if patient needs have changed and if modifications to the treatment approach/plan are required. The style of documentation is expected to be consistent and standardized throughout the agency/institution (e.g., everyone uses the same progress note format).

In general, clinical documentation includes the following characteristics:

- Notes that are dated, signed, and legible
- Patient name and identifier are included on each page of the clinical record
- Patient's race, ethnicity, and primary language spoken
- For patients with limited English proficiency, documentation if interpreter services were offered and provided, and an indication of the patient's response
- Referral information
- Sources of information are clearly documented
- Patient strengths and limitations in achieving goals
- Limited use of abbreviations and, when used, abbreviations are from Alameda County standard abbreviations list or defined within the same document
- All relevant clinical information and reflects a biopsychosocial approach to the assessment process
- Patient self-report of experiences
- Reflects changes in patient status including response to and outcome(s) of the intervention(s), progress towards goals and completion of objectives, and transitions in care
- The counselor's/clinician's professional assessment and continued plan of action
- Documentation of changes in patient status are documented (e.g., change in level of care provided or discharge status)
- Description of how services provided reduced impairment, restored functioning, and/or prevented significant deterioration as outlined in the treatment plan

Intake/Beneficiary Admission

The Intake/Admission process is the beneficiary's first contact for the episode of treatment.



For some beneficiaries, they are returning to treatment after relapse or risk to relapse. As relapse is a part of the recovery process, it is common that beneficiaries require multiple courses of substance use disorder treatment. For other beneficiaries, this may be the first and only time they access services. Regardless, the admission process is an opportunity to engage a beneficiary in their treatment, potentially at a time where they be more amenable to substance use treatment services. In many ways the admission/intake process is the foundation of treatment that the rest of treatment builds on.

Each provider is required to develop policies, procedures, and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at minimum:

- DSM-5 diagnosis
- Use of alcohol/drugs of abuse
- Physical health status
- Documentation of social and psychological problems

When a beneficiary requests SUD services, the intake and admission process is initiated. The intake process has multiple components and differs slightly depending on the type of SUD services being provided. The intake and admission process is a multiple part process that may take several sessions with the beneficiary to complete. Outpatient providers have up to 30 days to complete the intake process. . Not all beneficiaries that request SUD services meet medical necessity for treatment. If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider. All referrals made by the provider are to be indicated in the beneficiary's medical record.

Additionally, copies of the following documents shall be provided to the beneficiary upon admission:

- Share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.
- Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:
 - A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay;
 - Complaint process and grievance procedures;
 - Appeal process for involuntary discharge; and
 - Program rules and expectations.
 - ACBH Informing Materials Packet

Where drug screening is deemed medically appropriate the program shall:

- Establish procedures which protect against the falsification and/or contamination of any urine sample
- Document test or analysis results in the beneficiary's file



- Claiming for time spent collecting the specimen may occur during intake or ongoing as part of an individual counseling session. Providers may not claim DMC for specimen analysis.

Health Questionnaire

All programs that are AOD licensed or certified are required upon intake to have the beneficiary complete, at a minimum, the components present in DHCS 5103 (v.06/16). This questionnaire is a beneficiary self-report of important health-related information. Some beneficiaries may need assistance in completing this form, for most individuals though this form should be completed on their own prior to the intake/assessment process. The SUD Counselor or LPHA completing the assessment then uses the information contained in this form to inform the Medical and Health section of the assessment. This form is not a Medical or Health assessment, it is a questionnaire the beneficiary completes as part of their admission packet. It is highly recommended for use by all Alameda County subcontracted SUD providers, regardless of AOD license/certification.

Informed Consent for Treatment

Alameda County requires that all beneficiaries receiving behavioral health care treatment review and sign the *ACBH Informing Materials* packet. The provider must insure that each beneficiary understands, to the best of their ability, the benefits, risks, and limitations of treatment. Providers shall review the *Alameda County ACBH Informing Materials* packet with the beneficiary during the admission process and annually. All checkboxes on the signature page must be completed and the beneficiary must sign and date the signature page as well. The signed page must be kept in the medical record and the informing materials packet is provided to the beneficiary. This packet is available on the *ACBH Provider* website.

Beneficiary Record

Providers of SUD treatment services in Alameda County are required to use Alameda County's EHR, Clinician's Gateway (CG) for SUD (please see CG manual). At this time, OTPs are only required to document ASAM LOCs in CG. CG has a number of invaluable features that are intended to improve the quality of beneficiary care, improve compliance, and increase documentation efficiency. A specific Clinician's Gateway for SUD manual will address these features. Built into CG are the following requirements related documentation of personal information:

- Information specifying the beneficiary's identifier
- (i.e., name, number).
- Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, beneficiary's next of kin or emergency contact.

Additionally, the medical record must contain specific documentation of treatment episode



information (all activities, services, sessions, and assessments), including but not limited to all of the following:

- Intake and admission data, including, if applicable, a physical examination
- Treatment plans
- Progress notes
- Continuing services justifications
- Laboratory test orders and results
- Referrals
- Counseling notes
- Discharge plan
- Discharge summary
- Contractor authorizations for Residential Services
- Any other information relating to the treatment services rendered to the beneficiary

Establishing Medical Necessity

Medical Necessity must be established for all beneficiaries of Substance Use Disorder services within timeframes required by the specific modality. Under the DMC-ODS waiver, Medical Necessity must be established by a LPHA.

Medical Necessity for SUD services in Alameda County is established through two components. Both components are required in order for the beneficiary to have met medical necessity for SUD treatment.

1. An Included SUD diagnosis

Beneficiaries accessing SUD treatment services must meet criteria for at least one of the diagnoses from Alameda County's SUD included list. The most up to date SUD included list can be found on the ACBH provider website from the QA tab. Beneficiaries may only receive treatment for diagnoses that they have been given and are on this included list. In the medical record, other relevant behavioral or physical health diagnoses should be indicated when appropriate, but may not be the primary focus of treatment or unrelated to the included diagnosis.

Diagnoses and corresponding written basis, must be completed by an LPHA within their scope of practice and training to establish a SUD diagnosis. At a minimum the LPHA must be registered or waived with their respective board, but do not have to be licensed. When the LPHA is not licensed, their diagnosis and written basis for the diagnosis must be reviewed and approved by a licensed LPHA. The licensed LPHA confirms their review and approval by co-signing the Medical Necessity form.

The written basis for each SUD diagnosis being treated must include specific signs and



symptoms and their timeframes. Criteria for SUD diagnoses, including remission diagnoses, are specified by the DSM-5. Please refer to the DSM-5 or consult with a qualified individual regarding questions related to diagnosing.

To document the DSM-5 diagnosis and the written basis, all ACBH subcontracted SUD providers must use the *Initial Medical Necessity* or the *Continuing Services Justification* form. The Initial Medical Necessity form is only required when establishing the diagnosis at the outset of treatment. For ongoing updating of the diagnosis use the *Continuing Services Justification* form. The diagnosis must be reevaluated 5 – 6 months from the EOD, and then every 5 – 6 months from the date of the last *Continuing Service Justification*. See the following table for specific timeframes:

Table F: IMN and CSJ Due Dates

Type of SUD Service	Initial Medical Necessity	Continuing Services Justification
OTP/NTP	OTP – First day of treatment	5 - 6 months from EOD and then every 5 – 6 months from the last CSJ
WM RES	WM RES – 24 – 48 hours from EOD	5 - 6 months from EOD and then every 5 – 6 months from the last CSJ
RES	RES – 5 days from EOD	5 - 6 months from EOD and then every 5 – 6 months from the last CSJ
OS/IOS/RSS	OS/IOS/RSS – 30 days from EOD	5 - 6 months from EOD and then every 5 – 6 months from the last CSJ

The record must document the following:

- 1) A Medi-Cal covered (included) Substance Use Disorder.
 - a) The LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record All Alameda County subcontracted SUD providers must use the *Initial Medical Necessity* or *Continuing Services Justification* form for this purpose
- 2) The written basis for the diagnosis must include specific, individualized signs and symptoms of the diagnosis. This must be written by an LPHA.
- 3) The diagnosis must be a Medi-Cal eligible DSM-5 SUD diagnosis. Refer to the ACBH SUD Included list for a full list of covered diagnoses.



- 4) The LPHA shall type or legibly print their name, credentials, and sign and date the diagnosis documentation.
- 5) That SUD treatment services are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

If a SUD Counselor conducts the intake/assessment, then the LPHA assigned to establish medical necessity must meet either face-to-face with the beneficiary or with the intake SUD Counselor. ACBH recommends and has determined that is it best practice for the individual making the diagnosis and establishing medical necessity to meet face-to-face with the beneficiary. It is common practice across the field of behavioral health treatment that the treatment provider making a diagnosis meet that individual in person.

A registered or waived LPHA may complete the diagnosis and establish medical necessity, if a licensed LPHA, acting within their scope of practice, reviews and co-signs the Initial Medical Necessity Form.

2. ASAM Level of Care

ASAM criteria is used to determine the type of SUD services provided. The ASAM must represent the presentation of the beneficiary at the time of completion. ASAMs that are not reflective of the beneficiary's presentation at the time of the assessment may result in medical necessity not being established. When done accurately, ASAMs may indicate a different level of care than what is desired by the beneficiary. Other times, due to structural factors of the SUD system of care, the level of care indicated by the ASAM may not be available to the beneficiary (e.g. geographical limitations). In these situations, ASAM allows for some flexibility and beneficiary agency. The medical record should clearly document the reason and justification for a level of care different than is indicated by the ASAM LOC. Note that, a beneficiary may only be referred to a level of care equal or lower than their ASAM indicated level of care.

For all levels of care, an initial ASAM must be completed by the assessment due date. Periodic ASAM updates are required on a schedule throughout treatment. Unscheduled ASAM updates based on the beneficiary's presentation may be done anytime clinically indicated. When a beneficiary transitions between levels of care a transition ASAM must be completed within the last 14 days of current treatment modality, including at discharge. See Table B below for specific dates for required and scheduled ASAMs for each type of SUD service.

After establishing a diagnosis and documenting the basis for diagnosis, the ASAM Criteria shall be applied to determine placement into the level of assessed services. (I.A. III.B.2.4)



Table B

ASAM Timeline					
	Outpatient	Intensive Outpatient	OTP/NTP	Residential	WM RES (3.2)
Pre-Admission	N/A	N/A	N/A	Referring portal completes screening ASAM prior to referral	Referring portal completes screening ASAM prior to referral
Admission	30 days from EOD	30 days from EOD	28 days from EOD	5 days from EOD	By EOD
Updates	Every 90 days from date of previous ALOC	Every 60 days from date of previous ALOC	Every Treatment Plan update	Every 30 days	Every 14 days
Discharge/Transition to Lower Level of Care	Within the last 14 days of modality	Within the last 14 days of modality	Within the last 14 days of modality	Within the last 14 days of modality	Same day as discharge

The ASAM Initial or ASAM Review may not indicate a level of care, or indicate a referral to a different level of care than what is available at the assessing provider. In these cases, the provider may not provide additional treatment services after the date of the ASAM. If a different ASAM level of care is determined, the provider may only provide Discharge and Case Management services to transition the beneficiary to the appropriate level of care. Anytime the ASAM indicates a different level of care than to which the beneficiary is being referred, the SUD Counselor or LPHA must describe this difference in the medical record.

Reassessments and level of care transitions and initial/relevant progress note documentation are based on the ASAM criteria and include the following information:

- Date ASAM placement criteria were used.
- Documentation of the name, location and primary contact at referral site.
- Format of ASAM criteria used (software or paper-based).
- Justification of discrepancy if the level of care suggested by ASAM criteria is not recommended by counselor/clinician.
- Justification of discrepancy if the discussed level of care is not agreeable to patient.
- Justification of discrepancy if the level of care the patient was referred to does



not match the level of care suggested by the ASAM criteria.

As such, ACBH requires that the multidimensional components of the ASAM criteria be incorporated into initial documentation of the first full assessment, and that progress notes for both individual and group sessions follow the B/PIRP format.

Assessment

For each beneficiary the provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment. This assessment shall include at a minimum a comprehensive assessment of the following categories:

- Drug/Alcohol use history
- Medical history
- Family history
- Psychiatric/psychological history
- Social/recreational history
- Financial status/history
- Educational history
- Employment history
- Criminal history, legal status
- Previous SUD treatment history

The intake process must include an evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.

There are several expected outcomes and intentions of the intake/admission process. As noted, medical necessity must be established for all beneficiaries receiving SUD services. Additionally the intake/assessment process allows for building of trust between the counselor/therapist and the beneficiary, it helps to establish and develop the treatment relationship, the micro and macro issues for the beneficiary are identified and explored, goals for treatment are established, and the initial framework for treatment is established.

The medical director or LPHA shall review each beneficiary's personal, medical and substance use history if completed by a counselor. They must confirm their review of these components by co-signing the relevant documents.

Intake/Assessment Due dates



OS/IOS	RES	WM RES (3.2)	OTP/NTP
30 days from EOD	10 days from EOD	24 – 48 hours from EOD	1) H&P prior to admission 2) Psychosocial due 28 days from EOD

Physical Examination Requirements

Understanding beneficiaries’ physical health needs is a vital component to whole person care. Physical health needs can shape treatment in profound and important ways. This is especially true for our most vulnerable and at risk clients, many who may not have had, or had access, to consistent health care services. Substance use by nature involves the use of powerful chemicals and substances, that have both known and unknown consequences on the individual. When coupled with potentially severe health challenges that may or may not be related to the beneficiary’s substance use, having a full clinical picture of a beneficiary is invaluable to providing effective and efficient high-quality care. Whenever gathering, or otherwise attempting to understand a beneficiary’s physical health history, or any personal information for that matter, great care must be taken into consideration. As providers, we must understand that while having access to a beneficiary’s personal history and information may, from the provider’s perspective facilitate treatment there are many reasons why a beneficiary may be hesitant to share personal information. We must understand that a beneficiary has a right to keep their personal information private, even if the provider believes sharing is in the best interests of the beneficiary.

DMC-ODS regulations allow for three options with regard to meeting the physical examination requirements of beneficiaries. Providers must document their efforts to fulfill the physical examination requirements in each beneficiary’s medical record, as progress notes. These three options are presented below:

- (1) If a beneficiary had a physical examination within the twelve month period prior to the beneficiary's admission to treatment date, the physician, registered nurse practitioner, or physician’s assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within 30 calendar days of the beneficiary's admission to treatment date.
 - A) If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.
- (2) If a beneficiary has not had a physical exam or there is no documentation of a previous physical exam, then the physician or physician extender may perform a physical examination of the beneficiary within 30 calendar days of the beneficiary's admission to treatment date.



- (3) If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination within 30 days from the date of admission or the provider does not perform a physical examination of the beneficiary, then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met. This goal, like any goal, may not be carried over without documentation of good faith efforts by the provider to have the beneficiary complete the physical exam requirements.

Treatment Plans

Treatment planning combines information and treatment needs identified during the assessment phase, the counselor/therapist's working knowledge, and the treatment motivations of the beneficiary. Patient-centered care is critical and requires that beneficiaries be an active stakeholder in the treatment planning process. To that end, treatment plans shall be individualized to meet the specific treatment needs of the beneficiary.

As beneficiaries advance through treatment, the corresponding treatment plan should be reviewed and updated according to the treatment needs of the beneficiary. Some beneficiaries, depending on the severity of their symptoms and lability of functioning, may require more frequent treatment plan updates. Others may only require treatment plan updates on the established timeframes. Regardless, treatment plans must be updated if there is a notable event in the beneficiary's life that is not addressed in the current plan.

See **Tables C and D** for additional detail regarding minimum requirements for treatment plan due dates and signature requirements. **It is important to note that these are maximum timeframes and the ideal scenario is to complete and sign the treatment plan as expeditiously and close to the treatment admission date as possible.**

Table C: Initial Treatment Plan Due Dates and Signature Requirements

Type of Service	Initial Plan Due / Counselor Signature	Beneficiary Signature	LPHA Signature
Outpatient Services	30 days from admission	30 days from admission	15 days of counselor signature AND by 30 days from admission date.
Intensive Outpatient Services	30 days from admission	30 days from admission	15 days of counselor signature AND by 30 days from admission date.
Opioid Treatment Services	28 days from admission	28 days from admission	Primary Counselor must sign plans by their due dates. All plans require supervising counselor and Medical Director signature within 14 days of primary counselor.



Residential Services	10 days from admission	10 days from admission	10 days from admission.
-----------------------------	------------------------	------------------------	-------------------------

Table D: Treatment Plan Update Due Dates and Signature Requirements

Type of Service	Plan Update Due / Counselor Signature	Beneficiary Signature	LPHA Signature
Outpatient Services	At least every 90 days from counselor/LPHA signature of previous plan.	30 days from counselor/LPHA signature.	15 days of counselor signature AND within 90 days from date counselor signed the previous plan.
Intensive Outpatient Services	At least every 90 days from counselor/LPHA signature of previous plan.	30 days from counselor/LPHA signature.	15 days of counselor signature AND within 90 days from date counselor signed the previous plan.
Opioid Treatment Services	At least every 3 months from date of admission.	By plan due dates.	Primary Counselor must sign plans by their due dates. All plans require supervising counselor and Medical Director signature within 14 days of primary counselor signature AND within 3 months of date primary counselor signed the previous plan.
Residential Services	90 days from date client signed the previous plan.	90 days from date client signed the previous plan.	90 days from date client signed the previous plan.

If a patient’s condition does not show improvement at a given level of care or with a particular intervention, then a treatment plan modification should be made in order to improve therapeutic outcomes. Changing the level of care or intervention should be based on a reassessment and modification of the treatment plan in order to achieve an improved therapeutic response.

For all SUD services, except OTPs, the patient shall review, approve, type or legibly print their name, sign and date the initial treatment plan, indicating whether the patient participated in preparation of the plan, within 30 calendar days of signature by the counselor or provider. If the patient refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider’s strategy to engage the patient to participate in treatment.

If a counselor has completed the plan, the LPHA shall determine the services in the treatment plan are medically necessary, by legibly printing their name and, signing and dating the updated treatment plan, within 15 calendar days of signature by the counselor or provider.

It is important note, when medications are included in the treatment plan, LPHAs who sign off on treatment plans must be licensed prescribers, whether in OTP settings or non-OTP settings. For treatment plan requirements for beneficiaries receiving opioid treatment services, refer to [OTP Treatment Plan section](#).



Treatment plans must meet the requirements specified in the AOD certification standards, Title 22, CCR, Section 51341.1 (h)(2)(A), or for Opioid Treatment Programs, Title 9, CCR, Section 10305, as specified in Title 22, CCR, Section 51341.1(h)(2)(B).

At a minimum, treatment plans shall include the following components:

1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
2. Goals to be reached which address each problem. Goals should be mutually established between patient and provider for each identified problem.
3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
4. Target dates for the accomplishment of action steps and goals.
5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
6. The assignment of a primary therapist or counselor.
7. The beneficiary's diagnosis as documented by the Medical Director or LPHA. Both ICD-10 Code and DSM-5 name are required. See the most recent ACBH SUD Included list.
8. 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.
9. 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.

Planned and Unplanned Services

One of the required elements of a treatment plan, as noted above is that plans are required to include a description of the services, including the type of counseling. Service can be categorized into two types, those that are planned and those that are unplanned. Planned services are ones that are specific to the individualized treatment needs of the beneficiary and need to be included in the plan. *Unplanned* services are ones that do not need to be in the plan in order to be provided as they are ones every beneficiary needs regardless of their individualized needs. *Crisis Intervention* services and *Physician Consultation* are also considered unplanned due to their unpredictability of need. Planned Services may be provided initially, but must be in the current plan in order to be provided beyond the initial plan due date. See Table E for a full list of *Planned* and *Unplanned* Service types.

Table E: Planned Services – Required in the plan in order to be provided

OS/IOS	Residential	Recovery Support Services
--------	-------------	---------------------------



Individual Counseling	Residential Day 3.1	Individual Counseling
Group Counseling	Residential Day 3.5	Group Counseling
Collateral	WM Residential Day 3.2	Case Management Care Coordination
Collateral Family Contact (Adolescent beneficiaries only)	AND	Case Management Service Coordination
Family Therapy	Case Management – Care Coordination	Recovery Monitoring / Substance Use Assistance
Medication Services	Case Management – Service Coordination	
Patient Education		
Group Education		
Group Multi-Family Counseling (Adolescent beneficiaries only)		
Case Management Care Coordination		
Case Management Service Coordination		

Table F: Unplanned Services – Not required in the plan to be provided

For all Services
Physician Consultation
Screening & Engagement (Adolescent beneficiaries only)
Crisis Intervention
Intake/Assessment
Treatment Planning



Additional Perinatal Treatment Plan Requirements

It is important to develop an individual treatment plan for each pregnant and parenting woman with a SUD. This helps to ensure that pregnant and parenting women are receiving the most effective care for SUD.

Providers offering perinatal services shall address treatment issues specific to the pregnant and parenting women. Perinatal-specific services shall include the following:

1. Mother / Child habilitative and rehabilitative services, such as parenting skills and training in child development;
2. Access to services, such as arrangement for transportation;
3. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and,
4. Coordination of ancillary services, such as medical/dental, education, social services, and community services.

Progress Notes

Progress Notes are the evidence of a provider's services to or on behalf of a beneficiary and relate to the beneficiary's progress in treatment. Notes are maintained in the clinical record and must contain the clinical details to support the claimed service and the service's relevance to the treatment plan. Progress notes are narrative summaries that relate to the client's progress in treatment and include only the information required. Progress Notes become part of the clinical record, which may be requested by the client at any time. Standardized documentation by SUD treatment providers assist with increasing treatment consistency, quality of care, and reduces reimbursement disallowances.

In order to submit a service for reimbursement, there must be a complete and signed Progress Note for that service. Reimbursement submission is attestation that the required criteria for claiming are met.

In order to receive reimbursement for documentation time, each progress note documenting the service must include the beneficiary's name, date of service, date documentation was completed, and the start/end time of the documentation. Only the following activities may claim associated documentation time: time spent completing progress notes for claimable services, time for completing/writing the assessment and plan, time completing continuing services justification. In all cases the content of the note must justify the documentation time claimed.

Travel time may also be claimed when it is directly related to a beneficiary's treatment.

Behavior/Purpose, Interventions, Response, and Plan (BIRP) describes the structure of a specific style of progress note documentation. The B/PIRP format improves the quality and continuity of patient services by providing a consistent and organized framework of clinical



documentation to enhance communication among health care professionals and better recall the details of each patient’s case. This format allows providers to identify, prioritize and track patient problems so they can attend to them in a timely and systematic manner. It also provides an ongoing assessment of both the patient’s progress and the treatment interventions. While a full review of the SOAP note format is beyond the scope of this document, **Table E** outlines a summary of its components and providers may refer to additional resources for more information.

For patients with multiple health problems, the problems can be numerically prioritized according to severity and treatment need in the plan section of the progress note

Table E: BIRP Progress Note Format	
B	Behavior – Patient statements that capture the theme of the session and provider observations of the patient. Brief statements as quoted by the patient may be used, as well as paraphrased summaries that closely adhere to patient statements. Provider observations may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished, etc.), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
I	Intervention – Provider’s methods used to address the patient’s statements, the provider’s observations, and the treatment goals and objectives.
R	Response – The patient’s response to intervention and progress made toward individual plan goals and objectives.
P	Plan – The treatment plan moving forward, based on the clinical information acquired and the assessment.

Documenting Outpatient Services: OS, IOS, RSS, and Naltrexone Treatment Services (NTS).

- A progress note is required for each claimable service (e.g. individual, collateral, crisis, group).
- All claims must have an associated progress note
- The LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
- The LPHA or counselor shall type or legibly print their name, indicate their credentials, and sign and date the progress note within seven (7) calendar days of the service.
- When documenting the non-face-to-face time spent establishing medical necessity, treatment providers should use the Intake/Assessment code.

The required components of OS, IOS, NTS, and RSS progress notes are:

1. The topic of the session or purpose of the service.



2. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
3. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
4. Identify if services were provided in-person, by telephone, or by telehealth.
5. If services were provided in the community, identify the location and how the provider ensured confidentiality.

Documenting Residential Treatment Services (ASAM 3.1, 3.5)

In order for residential treatment to be reimbursed on a daily basis, the residential program must provide a contracted service activity for each date of billing. The components of residential treatment are:

- Intake
- Individual
- Group Counseling
- Patient Education (not considered a clinical service)
- Family Therapy
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment (not considered a clinical service.)
- Discharge Services

Residential providers must provide at least one (1) contracted service hour, called structured therapeutic activities, per claimed day for ASAM 3.1. Both ASAM 3.1 and ASAM 3.5 must provide a total of twenty (20) hours of structured therapeutic activities each week. For ASAM 3.1, at least five (5) of the twenty (20) required hours must be for clinical services. For ASAM 3.5 at least twelve (12) of the required twenty (20) hours must be for clinical services and at least one (1) hour of clinical services must be provided each day.

Structured activities that are available in residential treatment, including patient education, are not considered clinical interventions, and are not subject to a limitation in regard to the number of participants.

The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build behavioral patterns within a community. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems.

Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve problems. Goals include preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.



Residential providers have two options for documentation of services. Each day of claimed residential services must have the documentation requirements as described in this section. Claimed service days without adequate documentation are not allowed.

Option 1) A daily service note of clinical and structured therapeutic activities and a comprehensive weekly narrative summary. The weekly summary documents services from Sunday to Saturday and must be completed within the following calendar week. The daily progress note must be completed within seven (7) days of the date of service. The date of service is considered the first day. Providers have the option to include a narrative note along with the daily log, but this is not required when completing the weekly summary. The daily note must be completed by a treatment staff who provided one of the claimable services for the day claimed. The weekly narrative summary must be completed by a staff who provided a claimable service during the week, and ideally is their primary.

Option 2) A daily note of clinical and structured therapeutic activities plus a daily narrative summary. The daily note, including the narrative summary must be completed for each day of residence and by an individual who provided one of the reimbursable services. These daily notes must be completed within seven (7) days from the date of service. The date of service is considered the first day. Residential Withdrawal Management providers are required to document services using this option due to brief length of services.

Regardless of the above options, the narrative summaries describe the beneficiary's presentation, clinically relevant events, and the beneficiary's progress on their treatment plan objectives. These notes are intended to provide a comprehensive overview of the beneficiary's functioning that day or week, their current needs, staff interventions, the beneficiary's response to treatment interventions, and a plan for the future.

Regardless of the residential documentation method, the required components of SUD Residential progress notes are:

1. A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals. Required daily if not completed weekly.
2. A record of the beneficiary's attendance at each claimable service including the date, start and end times and topic of the counseling session or service.
3. 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.
4. The LPHA or counselor must type or legibly print their name, indicate their credentials, and sign and date progress notes within the aforementioned timeframes..



Documenting ASAM 3.2 Residential Withdrawal Management Services

Individuals access 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 comprehensive 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. Upon discharge, individuals may be referred to additional SUD services based on the ALOC. The components of Withdrawal Management are explained below:

Intake: 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.

Treatment Planning: Developing individualized treatment plans with the beneficiary based on issues identified during the assessment.

Observation: 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.

Discharge 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.

ASAM 3.2 Residential Withdrawal Management Services are documented through a Daily Progress Note. In this daily note, providers document the individual treatment services the beneficiary has received that day, along with a written narrative summary of their day. This progress note is maintained in the beneficiary's record along with other treatment documents.

Documenting Case Management Services

Case Management services are an essential component of SUD treatment services in Alameda County. Depending on the beneficiary's individualized treatment plan, case management needs will vary. *Case Management* services may be provided initially prior to



the plan being completed, however in order to be provided beyond the initial treatment plan due date, *Case Management* must be indicated as a service type in the current plan.

For all specified service types, OS, IOS and Residential treatment, *Case Management*, must be claimed as a separate service. For Residential providers, *Case Management* services are provided in addition to the components of Residential Day and are reimbursed separately. All specified providers are to use the *Single Service Progress Note* template in Clinician's Gateway to document *Case Management* services.

The LPHA or SUD Counselor who provided the case management service shall record a progress note. The LPHA or counselor must complete, legibly print their name, indicate their credentials, sign, and date the progress note within seven (7) calendar days of the case management service.

Case Management Progress notes must include all of the following:

1. Beneficiary's name.
2. The purpose of the service.
3. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
4. Date, start and end times of each case management service.
5. Identify if services were provided in-person, by telephone, or by telehealth.
6. If services were provided in the community, identify the location and how the provider ensured confidentiality.

At this time Case Management services are not allowed at Opioid Treatment Programs, unless specifically indicated in the contract. Individuals who require both opioid treatment and case management services should either be referred to one of Alameda County's OTPs who are contracted to provide both services or referred to an outpatient SUD provider who may provide only Case Management services as long as the beneficiary is receiving SUD treatment services at the OTP. In order to receive Case Management Services, the beneficiary must also be participating in SUD treatment services.

Documenting Physician Consultation Services

Physician Consultation Services consist of DMC Physicians' consultation with BHCS approved external addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. These services are designed to assist provider physicians by allowing them to seek expert advice when developing treatment plans for specific DMC-ODS beneficiaries. Additionally, these services may address medication selection, dosing, side effect management, drug interactions, or level of care considerations.

ACBH is in the process of identifying consultants for this service.

When allowed for physician consultation services, additional medication assisted treatment, and withdrawal management, the medical director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and



keep in the beneficiary's file. The medical director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service. Progress notes shall 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.

Non-Billable Notes

Certain activities are not claimable to DMC-ODS as they are reimbursed through other payment mechanisms. These activities however, represent a vital part of the beneficiary's medical record. Documentation of these activities provides important information, links together parts of treatment, and/or provides context for aspects of the clinical record. As a result they are helpful for other providers and are a necessary component of documentation.

Documentation Time

The time spent completing documentation related to claimable activities. The time claimed for documentation must be reasonable and content supports the amount of direct service time claimed. Reasonableness will be based on the expected time for an experienced treatment staff to complete the documentation. This is typically considered ten (10) minutes for every fifty (50) minutes of direct service, but may vary based on complexity of the service.

Documentation time includes the time spent writing and composing progress notes and also time spent writing such required documents as the Intake Assessment, ASAM LOCs, Medical Necessity Form, Treatment Plans/Updates. If the LPHA or Counselor while meeting with the beneficiary, writes one of the aforementioned documents in the session with the beneficiary, then this time is included in direct service time, not documentation time. Documentation time is only when the beneficiary is not present.

When claiming for documentation time, the start and end times and date of the documentation must be included in the progress note. An individual reviewing the note must be able to determine how the time is calculated for each component of the note (e.g. direct service, documentation time, travel time, etc.).

Travel Time

When providing services in the community the time the treatment staff travels to meet the beneficiary and returns to the office is eligible for reimbursement. If the beneficiary is present, the service is either a treatment service or transportation. Travel time is when the beneficiary is not present. In the progress note, the treatment staff is required to indicate the start and stop time(s) of the travel, the start and end point(s) of the travel, and the reason for the travel. Occasionally, trips may take longer than is typical or expected based on travel or road conditions. When this occurs, the note author is required to provide a brief



explanation why the time is in excess of expected times.

Beneficiary Transportation

Beneficiary transportation is only reimbursable for 3.1 and 3.5 residential treatment providers at this time. This transportation is included as part of their Residential Day rate. When a residential provider provides a case management service that includes transportation, the provider must not include the transportation time in the case management claiming. This is because transportation is an included component of the residential day rate.

Group Sign-In Sheets

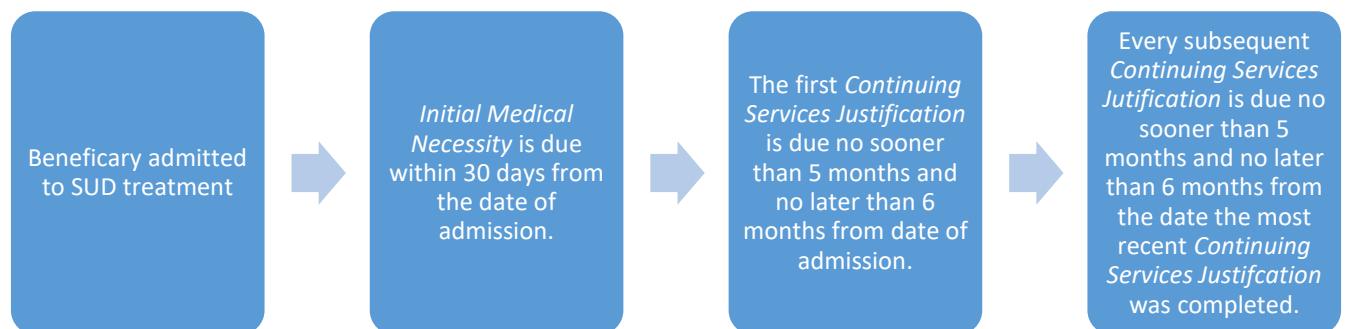
Group sign-in sheets are proof that the beneficiary attended the claimed service. For confidentiality purposes, as group sign-in sheets contain multiple beneficiaries personal information, the sign-in sheets must be maintained separately from the individual medical record. Providers will be required to provide a beneficiary's group sign-in sheets when requested during an audit. Non-compliant group sign-in sheets may cause service disallowance for the entire roster of client names. For that reason, it is recommended that providers develop and maintain a PHI compliant organization system. At a minimum Group Sign-In sheets must contain the following information:

1. All sign-in sheets must contain the typed or printed name and signature of the LPHA(s) and/or counselor(s) facilitating the group. By signing they are attesting that the sign-in sheet is accurate and complete.
2. The date of the counseling session.
3. The topic of the counseling session.
4. The start and end time of the counseling session.

A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

Continuing Services Justification

For Case Management, Intensive Outpatient Treatment, Naltrexone Treatment, and Outpatient Services continued justification of services must be completed no sooner than five (5) months and no later than six (6) months from the date of admission for each



beneficiary of substance use services. Additional *Continuing Services Justification* are required to be completed no sooner than five (5) months and no later than six (6) months from the date of the previous *Continuing Services Justification*. See the flow chart below for additional information:

Within these established timelines, the SUD counselor or LPHA must review the beneficiary's progress and eligibility to continue to receive treatment services and make a recommendation about continued treatment. The medical director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the medical director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:

1. The beneficiary's personal, medical and substance use history.
2. Documentation of the beneficiary's most recent physical examination.
3. The beneficiary's progress notes and treatment plan goals.
4. The LPHA's or counselor's recommendation as noted above.
5. The beneficiary's prognosis.

The medical director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed.

If the medical director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to an appropriate level of treatment services.

Residential services length of stay shall be in accordance with established limitations.

Discharges and Transfers

Discharge of a beneficiary from substance use treatment may occur on a voluntary or involuntary basis. Discharge may happen suddenly for some beneficiaries and for others, discharge from treatment will be a carefully planned process. It is important for the provider to individualize the discharge process and planning based on the unique needs of each beneficiary. Due to the nature of substance use disorder, many beneficiaries, in the course of their recovery, may relapse. For many, relapse is a vital part of the recovery process. Because of this, discharge may not be the final service provided, but instead an opportunity for reengagement in case relapse, or risk of relapse, occurs.

For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in IA Article II.G.2 and 42 CFR § 438.10. Please see the Grievance and Appeal Section of this manual for additional requirements related to Timely and Adequate Notice of Adverse Benefit.



For every beneficiary that is discharged from substance use treatment discharge documentation must be completed by the LPHA or counselor. The Discharge Plan shall be completed for every beneficiary, except for a beneficiary with whom the provider loses contact. For a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30 calendar day lapse in treatment services.

Table F: Comparison of Discharge Documentation Requirements	
Discharge Plan	Discharge Summary
The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary	The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary
A description of each of the beneficiary's relapse triggers	The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment
A plan to assist the beneficiary to avoid relapse when confronted with each trigger	The reason for discharge
A support plan	A narrative summary of the treatment episode
During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan	The beneficiary's prognosis
A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record	The date of the discharge (9 CCR § 10420)

Minimum/Maximum Service Requirements

Adult Outpatient Services

No minimum service requirements. Beneficiaries may receive up to 9 hours per week of medically necessary services.

Adolescent Outpatient Services

No minimum service requirements. Beneficiaries may receive up to 6 hours per week of medically necessary services.

Adult Intensive Outpatient Services

Beneficiaries must receive between 9 and 19 hours per week of structured programming services consisting primarily of counseling and education about addiction-related problems. More than 19 hours per week may be provided when medically necessary. LPHA must document clinical reasoning in the chart and the treatment plan must be updated to reflect the need for expanded IOS hours.

Adolescent Intensive Outpatient Services

Adolescent beneficiaries must receive between 6 and 19 hours per week of



structured programming services consisting primarily of counseling and education about addiction-related problems. More than 19 hours per week may be provided when medically necessary. LPHA must document clinical reasoning in the chart and the treatment plan must be updated to reflect the need for expanded IOS hours.

Residential Treatment Services

Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five (5) hours of clinical service a week to prepare beneficiary for outpatient treatment. The length of residential treatment services ranges from 1 to 90 days. See Residential Authorizations section of this manual for additional information about Residential authorization processes. The average length of stay is expected to be 30 days per 365 day period.

Adults, ages 21 and over, may receive up to two continuous short-term (up to 90 days) residential regimes per 365 day period. Additionally, adults may receive up to one 30 day (maximum) extension in a 365 day period. The maximum time an adult can be in residential services in a 365 day period is 210 days (two non-continuous 90 day stays, plus one 30 day extension). Clinical documentation justifying extension of residential services must be documented in the medical record.

Perinatal beneficiaries may receive Perinatal Residential Services for the duration of pregnancy, plus 60 days postpartum.

Adolescents, under the age of 21, may utilize residential services for a maximum of 30 days, plus are allowed a one-time 30 day extension in a 365 day period. Regardless, if medically necessary, adolescents may receive a longer length of stay. Clinical documentation justifying extension of residential services must be documented in the medical record.

Recovery Support Services (RSS)

Recovery Support Services (RSS) is a critical component to ensuring a client's commitment to their Recovery Plan after completion of their formal course of treatment. RSS promotes the client's role in managing their own health by developing effective internal coping and self-management resources, and building an external network of support to sustain recovery. Peer support refers to **support from a person who has knowledge from their own experiences as a person in recovery and who engages in a professional relationship with the client as the client's mentor and/or advocate**. Components of RSS can include:



Recovery Support Services (RSS) - Outpatient Counseling (LPHA/SUD Counselor) & Peer Support Services:

Provided by an LPHA or SUD Counselor is in the form of comprehensive assessment and periodic reassessment of individual needs to clinically justify the need for the continuation of case management services:

- **Plan** Development of Recovery Support Plan that includes periodic review/revision/development and includes measurable service activities.
- **Assessment(s)** Transition to higher or lower level of care as determined by on-going assessments and medical necessity.
- **Group** Counseling to stabilize the client, then reassess if further care is needed. SUD Peer Support Specialists may provide ACBH approved components of Recovery Services as they support the client process through their individualized Recovery Support Plan.
- **Case Management Services** (must be indicated on Client Recovery Plan as a service type):
 - **Support for Education and Job Skills:** Includes linkages to life skills, employment services, job training, and education services.
 - **Family Support:** Includes linkages to childcare, parent education, child development support services, and family/marriage education.
 - **Support Groups:** Includes linkages to self-help and faith-based support.
- **Monitoring** the Peer Support Specialist provides clients with dedicated guidance and recovery management skills includes recovery coaching and monitoring via telephone/telehealth.
- **Substance Abuse Assistance** the Peer Support Specialist provides clients with dedicated guidance to help identify client's relapse triggers and develop relapse prevention strategies'.

Recovery Support Services are provided by SUD ACBH contracted DMC certified outpatient service (OS) or intensive outpatient service (IOS) providers and service providers claim according to approved scope of practice. RSS procedure billing codes are as follows:

Outpatient Services (OS)	Code	Intensive Outpatient Services (IOS)	Code
Description		Description	
Individual Counseling, Intake/Assessment, Recovery Support Planning, Discharge	677	Individual Counseling, Intake/Assessment, Recovery Support Planning, Discharge	278
Group Counseling	680	Group Counseling	281
Case Management Care Coordination	684	Case Management Care Coordination	284
Case Management Service Coordination	685	Case Management Service Coordination	285



Monitoring / Substance Abuse Assistance-Peer Support Specialist	689	Monitoring/ Substance Abuse Assistance-Peer Support Specialist	289
---	-----	--	-----

SUD Peer Support Specialists provide the following services:

Peer Support Specialists (PSS) provide a broad array of mentoring, strength-based support, non-formalized/colloquial communication, and client advocacy that assists the client in reaching their stated Recovery Support Plan goals.

- The PSS models principal based behavior and may assist clients in their decision making process “smart choices” and development of healthy decisions skills.
- The PSS regularly work with clients to help establish habits and behaviors that encourage and reinforce a healthy lifestyle.
- The PSS engages with the client in a different way than treatment staff.
 - PSS are not qualified to provide diagnose or provide clinical treatment for addictive disorders.
- The PSS is responsible for establishing a recovery based relationship with the client and meeting the client where they are at.
- The PSS develops trust, provides encouragement and support from client’s perspective.
- The PSS provides a bridge between the safe and secure world of treatment to the real world where all the old temptations lie in wait, ready to sabotage recovery.
- The PSS may participate in the delivery of clinical services only when the LPHA/SUD Counselor approve and are in attendance of the clinical services.
- The PSS schedules regular meetings with the client in the field or at the treatment clinic.

Recovery Support Services and Documentation Requirements

Authorized Service Providers include SUD Counselors and LPHAs. Peer Support Specialist may *only* provide approved components of Recovery Support Services. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community. Appropriate settings must maintain client confidentiality. All Services must be clinically justified and frequency noted in the client RSS Plan.

- Pre-Discharge from TX the ALOC justification for RSS must be present
 - If more than 30 days from discharge the new ALOC for RSS must be completed and document clinical justification for RSS
- InSyst Registration and Episode Opening into RSS RU
- RSS Intake/Assessment within 30 days of EOD:
 - Review and updates to the Intake document from the previous treatment episode, with the same provider, may be used along with the RSS Discharge Plan. The case formulation and medical necessity must be updated to reflect the current needs of the client.
 - When the client is referred to a new provider, the provider must conduct and document a new Intake/Assessment, Initial Medical Necessity and RSS Client Plan.



- When the intake for RSS is with the same treatment provider and is beyond 30 days from last date of service, the Provider and client must complete a new ALOC that clinically justifies RSS and must be completed prior to completion of the Client RSS Plan
- Discharge Planning sessions occur 30 days prior to last date of service
 - Provider must verify validity of Discharge Plan – indicate contact with service provider in PN
- IMN complete within 30 days of RSS EOD
 - “In remission” diagnosis required for RSS
 - SUD Counselor & LPHA documentation and signatures requirements are the same and need to be done by established due date.
- ALOCs, at a minimum, are required between 5 - 6 months from EOD or from most recent ALOC.
- RSS Client Recovery Plan completion required within 30 days of EOD and reviewed & updated every 90 days thereafter.
 - SUD Counselor & LPHA documentation and signatures requirements and timeframes are the same as all other clinical services.

Eligibility for RSS requires the client meets medical necessity with an “in-remission” diagnosis.

SUD Peer Support Specialists Training

SUD Peer Support Specialists certified by Alameda County must complete a 7 week training provided through Alameda County’s Office of Consumer Empowerment, followed by a 6 month internship in an SUD provider agency.

The 7 week training is conducted by a contractor with the Office of Consumer Empowerment and ACBH’s SUD System of Care. The training includes core competencies including recovery and peer support principles, communication skills, ethics, boundaries, substance abuse, trauma and resilience, and conflict resolution. ACBH’s SUD System of Care training components include DMC-ODS overviews; case management and RSS overviews; clinical documentation standards; motivational interviewing; ASAM overviews; and privacy trainings.

Upon completion of the 7 week training course, trainees must then complete a 6 month SUD internship. Only after the completion of both the training and internship are graduates considered certified as SUD Peer Support Specialists, ready to be employed by OS/IOS providers for Recovery Support Services.

Peer Support Specialists Supervision

SUD Peer Support Specialists can be hired by Alameda County’s contracted outpatient/intensive outpatient programs. Programs are required to provide clinical supervision to SUD Peer Support Specialists under their organization. Minimum supervision elements include:



- Supervision must be provided by an LPHA or Certified SUD Counselor;
- Supervision must occur, at a minimum,
 - once every week,
 - one hour per week for individual supervision or two hour groups with a supervisory ratio of 1-8;
- Supervision sessions must include a review of the PSS current client caseload including, but not limited to, a review of pressing issues/challenges, and discussion of areas for PSS growth and personal development;
- Supervision and the Continuous Quality Review Process will ensure that the client RSS chart is properly organized and compliant with respect to ACBH Clinical Documentation Standards in terms of progress notes, recovery plan, assessment, and other locally developed quality standards.

Substance Abuse Assistance and Monitoring

Peers who have completed the ACBH Peer Training Course and who qualify for the 6-month SUD internship may provide Substance Abuse Assistance and Monitoring services for clients enrolled into Recovery Support Services.

SUD Lockouts

Lockouts are situations when a service activity is not reimbursable through due to the beneficiary's benefits being suspended or they received duplicate Medi-Cal services that same time. Locked out services may be provided during lockout situations, but these are not reimbursable.

DMC -ODS Same Day Lock Out Reasons:

- Recovery Services cannot be billed in combination with non-Recovery Services on the same day
- Recovery Services cannot be billed in more than one level of care on the same day
- Services with "Daily" or "Visit" Units of Services cannot be billed in combination with other services with "Daily" or "Visit" Units of Service on the same day
- Case Management, Physician Consultation, or MAT Services for one level of care cannot be billed in combination with services in another level of care on the same day
- Buprenorphine cannot be billed on the same day with either Buprenorphine or Vivitrol
- Disulfiram cannot be billed on the same day with Disulfiram, Vivitrol, or Acamprosate
- Naloxone (Narcan) cannot be billed on the same day with Naloxone
- Vivitrol cannot be billed on the same day with Vivitrol, Buprenorphine, Disulfiram, or Acamprosate
- Acamprosate cannot be billed on the same day with Acamprosate, Disulfiram, or Vivitrol



- Methadone cannot be billed on the same day with Methadone, Buprenorphine, Vivitrol or Acamprosate
- NTP individual and group counseling cannot be billed on the same day as non-NTP services, excluding ODS case management, ODS physician consultation, ODS ODF individual counseling, ODS ODF group counseling, or ODS MAT services, which are allowed on the same day
- Residential Withdrawal Management services cannot be billed with another service on the same day, excluding additional MAT, methadone dosing, case management and physician consultation, which are allowed on the same day
- Ambulatory Withdrawal Management services cannot be billed with another service on the same day, excluding additional MAT, methadone dosing, case management and physician consultation, which are allowed on the same day.

Same Day Billing (DHCS IN 17-039)

In an attempt to ensure correct placement a beneficiary may receive more than one service per calendar day by various providers. Services will be allowed to have a multiple billing in the same day when the combination of services does not have a conflict. An example of same day billing that would not be allowed is for two residential daily rates, or any combination of daily rates. The *DMC-ODS Same Day Billing Matrix* below illustrates by procedure code which exceptions to this general policy exist. Exceptions to this framework are due to the incompatibility of certain services being offered in combination with other services, or the incompatibility of certain medications being dosed at the same time. These instances are denoted with an “N” in the applicable cell on the billing matrix. In the case of Narcotic Treatment Program (NTP) services, methadone dosing, individual counseling, and group counseling are available on the same day as any other DMC-ODS service to ensure payment to all providers when a beneficiary requires methadone as part of their treatment plan.



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	Methodone 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	55000/55001	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			
Methodone 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																		

Due Dates and Signatures

For all SUD Services, documents signed according to requirements are essential. All signed documents must include the printed name, legible signature, signature date, and credentials of the treatment staff completing or co-signing the document. Beneficiaries should be encouraged to print and sign legibly, to the best of their ability, and date the document. If the beneficiary forgets the date, or indicates the incorrect date, the provider may make a notation and indicate the date signed. As well, signed documents must indicate the date signed. Dating signed documents and earlier date is prohibited. For most signed documents, Clinician’s Gateway will assist with signature requirement compliance. Forms that require the client to sign them, are required to be finalized by all required individuals prior to the beneficiary’s signature. Once the beneficiary signs a document, such as the treatment plan, it may not be altered. A new treatment plan is required whenever changes in



treatment or treatment objectives are required.

Documentation due dates						
	OS	IOS	RSS	RES	WM RES	OTP
ACBH Informing Materials						
Beneficiary and staff co-sig.	30 days from EOD	30 days from EOD	30 days from EOD	10 days from EOD	24 – 48 hours from EOD	28 days from EOD
SUD Programs ROI						
Beneficiary and staff co-sig.	On or before EOD	On or before EOD	On or before EOD	On or before EOD	On or before EOD	On or before EOD
Health Questionnaire						
Beneficiary completes with staff co-sig.	30 days from EOD	30 days from EOD	30 days from EOD	10 days from EOD	24 – 48 hours from EOD	28 days from EOD
Initial Medical Necessity Form						
LPHA Signature (w/licensed co-signature if required)	30 days from EOD	30 days from EOD	30 days from EOD	5 days from EOD	24 – 48 hours from EOD	Physician signature required by EOD
ALOC Initial						
SUD Counselor or LPHA	30 days from EOD	30 days from EOD	30 days from EOD	5 days from EOD	24 – 48 hours from EOD	28 days from EOD
ALOC Review						
SUD Counselor or LPHA	90 days from previous ALOC	60 days from previous ALOC	Every 6 months from EOD	30 days from previous ALOC	N/A	90 days from previous ALOC



H&P/Physical Exam						
	New physical or copy of one from last 12 months by 30 days from EOD or goal in the plan	New physical or copy of one from last 12 months by 30 days from EOD or goal in the plan	New physical or copy of one from last 12 months by 30 days from EOD or goal in the plan	New physical or copy of one from last 12 months by 30 days from EOD or goal in the plan	New physical or copy of one from last 12 months by 30 days from EOD or goal in the plan	Physician or Physician Extender (w/physician co-sig.) must conduct a physical by EOD
Physician, NP, PA review of external physical exam	30 days from EOD	30 days from EOD	30 days from EOD	30 days from EOD	24 – 48 hours from EOD	N/A
Intake/Assessment						
SUD Counselor or LPHA who conducts the intake	30 days from EOD	30 days from EOD	30 days from EOD	10 days from EOD	24 – 48 hours from EOD	28 days from EOD
LPHA review (if required)	30 days from EOD	30 days from EOD	30 days from EOD	10 days from EOD	24 – 48 hours from EOD	Physician review by 14 days from completion date
Initial Treatment Plan						
SUD Counselor or LPHA who authors the plan	30 days from EOD	30 days from EOD	30 days from EOD	10 days from EOD	24 – 48 hours from EOD	28 days from EOD
LPHA co-signature (if required)	15 days from author's signature	15 days from author's signature	15 days from author's signature	15 days from author's signature	24 – 48 hours from EOD	Counselor supervisor co-signature required 14 days from author's



						signature
Beneficiary Signature	30 days from EOD	30 days from EOD	30 days from EOD	30 days from EOD	24 – 48 hours from EOD	30 days from plan author's signature
Physician Signature	Not required	Not required	Not required	Not required	Not required	14 days from author's signature
Treatment Plan Update						
SUD Counselor or LPHA who authors the plan	Every 90 days from date of counselor signature on previous plan	Every 90 days from date of counselor signature on previous plan	Every 90 days from date of counselor signature on previous plan	Between every 5 - 6 months from EOD	N/A	At least every 3 months from EOD
LPHA co-signature if required	15 days from author's signature	15 days from author's signature	15 days from author's signature	15 days from author's signature	N/A	14 days from author's signature
Beneficiary signature	30 days from author's signature	30 days from author's signature	30 days from author's signature	30 days from author's signature	N/A	30 days from author's signature
Continuing Service Justification						
LPHA who completes the CSJ	Between 5 - 6 months from EOD, then every 5-6 months from previous CSJ	Between 5 - 6 months from EOD, then every 5-6 months from previous CSJ	Between 5 - 6 months from EOD, then every 5-6 months from previous CSJ	Between 5 - 6 months from EOD, then every 5-6 months from previous CSJ	N/A	Requires annual physician review. Additional year 2 continuation



						of services review, then annually thereafter.
Licensed LPHA co-signature if required	By due date of CSJ	By due date of CSJ	By due date of CSJ	By due date of CSJ	N/A	By due date of CSJ
Discharge Summary / Plan						
SUD Counselor or LPHA who completes the discharge	Within 30 days of last face-to-face	Within 30 days of last face-to-face	Within 30 days of last face-to-face	Within 30 days of last face-to-face	Within 30 days of last face-to-face	Within 30 days of last face-to-face
Progress Notes						
	7 days from date of service	7 days from date of service	7 days from date of service	7 days from date of service or	7 days from service date for daily notes. Within the next calendar week for weekly notes (Sun to Sat).	7 days from date of service. Also, Medical Director must co-sign all notes within 14 days of note completion.

Opioid Treatment Services (formerly Narcotic Treatment Programs)

Opioid Treatment Programs (OTPs) services and regulatory requirements shall be provided in accordance with: Alameda County’s DMC-ODS Intergovernmental Agreement; Title 9, Chapter 4; CA Health & Safety Code, Division 10.5, Chapter 10; Part 2, Chapter 10, 42 CFR, Part 8. This section attempts to provide a synthesized, condensed review of applicable documentation requirements from each of these regulatory standards related to OTPs. Due to the complicated regulatory framework additional regulations not described in this manual likely apply. Regardless of information provided in this manual, providers of OTP services are required to follow all regulatory requirements. It must be noted that other parts of this documentation manual may apply to OTP providers, but items in this section apply only to Opioid Treatment Providers. Attempts will be made to make sure it is clear

The Opioid Treatment Programs use a combination of medication assisted treatment (MAT)



and counseling treatment services to alleviate the symptoms of withdrawal from opioids. In addition to MAT services, each client must receive a minimum of fifty (50) minutes of face-to-face counseling sessions (individual/groups) with a therapist or counselor. Counseling services beyond 200 minutes per month may be provided based on medical necessity, when clearly documented in the medical record (IN 15-028). Components of replacement Opioid treatment include:

- Intake
- Individual Counseling
- Group Counseling
- Patient Education
- Transportation Services
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Medical Psychotherapy
- Discharge Services

Overview of Opioid Treatment Services

Medication Assisted Treatment (MAT) is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of specific substance use disorders (SUD). Research shows that a combination of MAT and behavioral therapies is a successful method to treat SUD. In particular, opioid and alcohol dependence have well-established medication assisted treatment (MAT) options. DMC-ODS counties must require through contract that providers have procedures and protocols in place to assure care coordination and linkage to other services and supports for beneficiaries receiving MAT. Provider staff shall maintain regular communication with the physicians of the clients who are prescribed these medications, unless the client chooses not to consent to signing a 42 CFR, Part 2 compliant release of information for this purpose. Residential and outpatient facilities cannot deny a patient utilizing or needing MAT from program participation.

Required MAT services under DMC-ODS include Opioid Treatment Program (OTP) services provided in OTP-licensed settings. Counties contracting to participate in DMC-ODS are required to cover and ensure access to OTP services. OTPs participating in DMC-ODS are required to offer and prescribe medication to patients covered under the DMC-ODS formulary, including methadone, buprenorphine, naloxone, and disulfiram. Services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of California requirements.

Detoxification Treatment is the treatment modality whereby replacement narcotic therapy is used in decreasing, medically determined dosage levels for a period not more than 21 days, to reduce or eliminate opiate addiction, while the patient is provided treatment services.



Maintenance Treatment is the treatment modality whereby replacement narcotic therapy is used in sustained, stable, medically determined dosage levels for a period in excess of 21 days, to reduce or eliminate chronic opiate addiction, while the patient is provided a comprehensive range of treatment services.

OTP Programs Licensing Requirements

All OTP Programs operating in the State of California must be licensed by the California Department of Health Care Services (DHCS) (9 CCR § 10010). Medication Units are required to additionally have approval from the FDA (9 CCR § 10020).

Per Title 9 CCR § 10055, 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.

OTP Staff Roles and Responsibilities

Opioid Treatment Programs employ a range of staff, each with distinct and overlapping responsibilities. This section provides 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, date of employment, resumes, applications and/or transcripts documenting work experience and/or education, written documentation of licensure/certification/registration, a signed copy of the staff's respective Code of Conduct.

Medical Director (9 CCR § 10110)

Each program must have a medical director who is a physician licensed in the State of California. Additional medical director responsibilities will be set forth in the program protocol. These additional duties may be delegated to another licensed physician, or physician extender, except the following:

- Signing patient record notes
- Placing patients in treatment
- Initiating, altering, and terminating replacement narcotic therapy medications and dosage amounts.
- Supervising the administration of dispensing medications
- Planning and supervising provision of treatment including regular review notes in the patients' records.



Program Physician (9 CCR § 10115)

Must be a physician licensed in the State of California. *Program Physicians* may delegate their duties to other appropriately licensed staff members. Delegation of duties such as this must be set forth in the program protocol prior to initiation.

Physician Extenders (9 CCR § 10120)

Are registered nurse practitioners and physician assistants. Certain medication/medical related activities may be delegated to *Physician Extenders* when set forth in the *Program Protocol*.

Counselors (9 CCR § 10125)

Counselors may be 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.

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)

SUD Counselors are required to have an active certification or registration with a DHCS approved Counselor Certification Organization when providing the service. The DHCS website provides a listing of currently accepted organizations, only organizations on this list will be accepted as valid certifying organization.

<https://www.dhcs.ca.gov/provgovpart/pages/counselorcertificationorganizations.aspx>

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, patients, 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, patients, or residents, their family members or other persons who are significant to them;
- Engaging in sexual conduct with current participants, patients, residents, their family members, or other persons who are significant to them;
- Verbally, physically, or sexually harassing, threatening, or abusing any



participant, patient, resident, their family members, other persons who are significant to them, or other staff members.

Each patient must be assigned to a counselor (9 CCR § 10150)

OTP Content of Patient Records (9 CCR § 10165)

The treatment records of all beneficiaries receiving Opioid treatment must contain, at a minimum the following elements:

- Information specifying the beneficiary's identifier (e.g. name, number)
- **Date of birth**
- Address
- Phone number
- Gender Identity/Expression
- Sexual Orientation
- Race and/or ethnic background
- Next of kin or emergency contact (with ROI)
- **Physical examination information (including laboratory tests and results)**
- **Date of admission and other admission data**
- **Criminal history including incidence of arrest**
- 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)
- The presence of any illicit drugs or abuse of other substance including alcohol
- Evidence of current opiate use

All treatment records also must include documentation of 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: ASAMs, assessments, medical necessity, treatment plans, progress notes, continuing services justification, and discharge plan/summary.

Beneficiaries receiving *Detoxification* treatment must also include documentation of periodic review or evaluation of drug tests or analysis results by the Medical Director. Medical records of beneficiaries receiving *Maintenance* treatment must also include the following:

- Documentation of prior addiction and prior treatment failure
- Documentation of Medical Director's review or evaluation of drug test or analysis results. This must be done at least annually.
- Documentation by Medical Director of circumstances justifying continued treatment. This is required prior to continuing services beyond two years from the date of the first services, and then annually thereafter. Specific information about the requirements for continued services is available in the OTP Continuing Service Requirement section.
- Documentation of the reasons for changes in medications and dosage levels, when applicable.



- Discharge documentation, when applicable. Additional information provided in OTP Discharge Requirements section.

Documentation that the beneficiary received a copy of the program rules and instructions. The beneficiary must receive a written copy of these rules and instructions prior to the program accepting the applicant into the program. Documentation for this requirement must be dated either prior to the date of admission or the same day as admission. Requirements for program rules and instructions are described in 9 CCR § 10170.

Documentation of Care Coordination

When the program becomes aware that a patient has been hospitalized, the program physician must attempt to cooperate with the attending physician and the hospital staff in order for the hospital to continue a patient's replacement narcotic therapy. The physician must document in the medical record their coordination efforts with the attending physician and hospital staff. They must also, at a minimum, document the date of the hospitalization, reason(s), and circumstances involved in the hospitalization. (9 CCR § 10185)

When the program becomes aware that a patient has been incarcerated, the program physician must attempt to cooperate with the jail's medical officer in order to ensure the necessary treatment for opiate withdrawal symptoms (whenever possible). The program physician must document coordination efforts with the jail, the date(s) of incarceration, reason for incarceration, and circumstances involved. (9 CCR § 10190).

OTP Multiple Registration Guidelines (9 CCR § 10205)

Due to concern of beneficiaries receiving multiple doses of controlled narcotic replacement medications, 9 CCR imposes strict rules on monitoring and preventing of unauthorized multiple registrations. For all beneficiaries, at the time of admission, checks for multiple registrations must be conducted as described in this section.

Detection of Multiple Registrations

At admission, providers are required to notify the beneficiary requesting treatment services that they may not simultaneously receive opioid therapy from multiple providers. Each beneficiary requesting opioid MAT must complete a written attestation documenting whether they are currently receiving opioid MAT treatment at another provider. If the beneficiary affirms that they are receiving opioid MAT from another provider, then the new provider must assist the beneficiary and confirm that treatment services at the other provider(s) have closed, prior to providing any treatment services. If the beneficiary denies receiving current opioid MAT at another provider, then the program must review the initial test or analysis to determine the presence of methadone or its metabolites. Beneficiaries may be admitted to the program and begin to receive dosing prior to initial test or analysis result have returned from the authorized testing laboratory.

To assist the provider in completing the multiple registration check, the following



information shall be gathered prior to admission and retained in the beneficiary's medical record:

- i. Full name and any aliases
- ii. Month, day, and year of birth
- iii. Mother's maiden name
- iv. Sex
- v. Race
- vi. Height
- vii. Weight
- viii. Color of hair
- ix. Color of eyes
- x. Distinguishing markings, such as scars or tattoos
- xi. Additionally, the program must request the beneficiary voluntarily provide their Social Security number

If a beneficiary refuses to complete written attestation, or refuses to sign an authorization (ROI) to allow the provider to contact other OTPs in a 50 mile radius, they cannot be admitted to treatment.

Procedures When Initial Test or Analysis Results are Positive for Methadone or Metabolites

If the initial test or analysis results are positive for methadone or its metabolites, and the beneficiary has denied receiving current opioid MAT at another provider, the program must discuss these results with the beneficiary. The program shall ask the beneficiary if they received medication while hospitalized or if they were discharged from an inpatient narcotic treatment program in the preceding 72 hours.

If the beneficiary confirms hospitalization, then the provider must take steps to ensure that replacement treatment has concluded at that facility. The beneficiary must sign a ROI to allow the current treatment provider to confer with the previous provider regarding their recent admission and discharge. Once a valid ROI has been signed, the previous program shall be contacted by telephone to notify them that the individual has applied for admission for replacement therapy. Services must be discontinued prior to the new provider starting replacement therapy. To facilitate client's transition to a new provider, the previous provider shall provide written documentation (letter or discharge summary) of the client's discharge within 72 hours of receiving the request. In the medical record the new provider must document the name of the program contacted, the date and time of contact, name of staff contacted, and the results of the contact.

When the beneficiary does not endorse recent hospitalization in the preceding 72 hours, yet has a positive analysis result, the provider shall have client sign a release of information allowing the program to contact opioid treatment programs within a 50 mile radius. Once this consent to disclosure has been signed, the assessing provider must contact each opioid replacement therapy program in a 50 mile radius to determine if the beneficiary currently has any open treatment services. Each program contacted must



provide a response to the requesting provider within 72 hours of receipt of the notification.

Resolving Multiple Registrations

When it is determined that a beneficiary is actively receiving replacement therapy at one or more providers simultaneously, the all of the providers must confer to determine who will be assuming treatment responsibility for the individual. All programs must immediately revoke the beneficiary's take home medication privileges and notify the DHCS Narcotic Treatment Program's Licensing Branch within 72 hours of determination.

Each of the other programs involved must immediately discharge the individual and document in their medical record why they were discharged. Moreover, within 72 hours of the discharge the previous providers must provide the new program with written documentation of discharge (summary or letter) of the discharge and send written notification to ACBH and DHCS of the circumstances of the abrupt discharge.

In the medical record the inquiring program shall document the names of each program contacted, the date contacted, the time of the contact (if made by telephone), the name of program staff contacted, and the results of the contact.

Ongoing Detection of Multiple Registrations

DHCS has developed an automated patient data system that checks and analyzes registered individuals who are currently receiving opioid replacement therapy. Data is collected and reported to DHCS monthly. DHCS then analyzes this data and will notify providers of potential duplicate registrations. When multiple registrations are identified via this system providers have 72 hours to respond if they are no longer providing services and close the treatment episode. When multiple active treatment episodes are identified this way, providers are required to confer and address concerns of multiple registrations as identified in the preceding paragraphs.

Detection of Multiple Registrations using InSyst

Can InSyst include checks to prevent multiple registrations and claiming for the same client at different OTP clinics? InSyst check would only work for clients who are open in InSyst. Private pay clients would not be caught in this check.

Resolution of Multiple Registrations

There may be times when beneficiaries are identified as having multiple concurrent, active replacement treatment episodes and providers are unable to resolve who will assume sole responsibility for the individual's treatment. In these situations DHCS must be informed promptly (within 72 hours). They will review the circumstances of registration and make a determination of designation of sole responsibility. At that time, the remaining programs will immediately cease to provide replacement therapy, close the treatment episode, and discharge the beneficiary as described in the preceding paragraphs.



Controlled Substance Utilization Review and Evaluation System (C.U.R.E.S.)

<https://oag.ca.gov/cures>

CURES 2.0 (Controlled Substance Utilization Review and Evaluation System) 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 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and confidentiality and disclosure provisions of California law cover the information contained in CURES 2.0.

Access to CURES 2.0 is limited to licensed prescribers and licensed pharmacists strictly for patients in their direct care; and regulatory board staff and law enforcement personnel for official oversight or investigatory purposes.

Visiting Patient Requirements

There may be times when a beneficiary is unable to receive their prescribed dosing, perhaps due to travel to another area, at their OTP treatment provider. In these cases, temporary or short-term replacement therapy may be allowed for visiting patients, provided the elements described in this section are established prior to providing any replacement therapy. Note that, short-term or temporary replacement therapy may not exceed 30 days

Prior to the beneficiary receiving replacement therapy at another OTP provider, the medical director or program physician must complete documentation indicating that the beneficiary is approved to receive services on a temporary basis. Documentation must include a medication change order by the referring medical director or program physician permitting the patient to receive services on a temporary basis from the other program for a length of time not exceed 30 days. The beneficiary must sign and date a release of information/consent to disclose for the temporary OTP provider. Additionally, the medical record must contain information confirming that the medical director or program physician of the temporary provider accepted responsibility to treat the visiting patient. When the beneficiary presents at the temporary provider, the primary provider should be contacted to ensure that overlapping dosing does not occur during the identified time period. In the medical record, the temporary provider must document this contact including the name of the program contacted, the date and time of the contact, the name of the program staff member contacted, and the result of the contact. A beneficiary must receive approval from their primary provider before temporary replacement therapy at another provider.

OTP Patient Identification (CCR § 10240)

For any medication assisted treatment it is vitally important that the beneficiary who is prescribe the medication, receives it along with the correct dose. This becomes especially important when medication has the potential for abuse and/or street value, such as controlled narcotic/opioid replacement medications. Providers are required to have in place a formal, described in their program protocol, a patient identification system to insure that each patient receives the correct dose and the medication is not administered or dispensed to another person. Each program



must supply their patients with a laminated identification card that includes the following information:

- Patient's full name
- Patient's record number (numbered consecutively based on admission date/time)
- Patient's physical description
- Patient's signature
- A full-face photograph of the patient
- The program's name, address, 24 hour phone number, and signature of the program director (or designee)
- The issuance and expiration date of the card

Additional requirements for issuing, monitoring, and reclaiming patient identification cards are described in Title 9 CCR § 1024 0 to 10250.

Administration or Dispensing of Medications (9 CCR § 10260)

The program physician is responsible for administering and dispensing medications to all patients receiving replacement narcotic therapy. Under the program physician's direction, other appropriately licensed individuals may administer or dispense medications. Guidance for these individuals' scope of practice with regard to dispensing of replacement narcotic medication is within Health & Safety Code § 11215. Staff physician/surgeon may administer and dispense replacement narcotic medication independently. Under the program physician's direction and instruction, the staff described below are able to administer and dispense replacement narcotic medications (note that medications such as methadone may only be administered in diluted oral liquid formulation):

- Registered Nurse
- Licensed Physician Assistant
- Licensed Psychiatric Technician
- Licensed Vocational Nurse
- Licensed Pharmacist

OTP Admission / Patient Selection Requirements (9 CCR § 10270)

Before admitting an applicant to *detoxification* or *maintenance* treatment the medical director (licensed physician) must conduct a medical evaluation. An agency's program protocol may authorize a physician extender to complete the initial medical evaluation. When this occurs the medical director must document their review of and concurrence with the medical evaluation. At a minimum the initial medical evaluation must include the information described in this section below. All of the required information must be documented in the beneficiary's medical record.

- 1) A medical history, including the individual's history of illicit drug use
- 2) Laboratory tests for determination of narcotic drug use, tuberculosis and syphilis (unless the medical director has determined the individual's subcutaneous veins are severely damaged to the extent that a blood specimen cannot be obtained)
- 3) A physical examination including, at minimum, the following:
 - i. An evaluation of the individual's organ systems for possibility of



- infectious diseases; pulmonary, liver or cardiac abnormalities; and negative dermatologic impacts of addiction
 - ii. A record of the individual's vital signs (temperature, pulse, blood pressure and respiratory rate)
 - iii. An examination of the individual's head, ears, eyes, nose, throat (including thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin and general appearance
 - iv. An assessment of the individual's neurological system
 - v. A record of the physician's overall impression which identifies any medical condition or health problem for which treatment is warranted
- 4) In addition, before a client may be admitted to *detoxification* or to *maintenance* treatment, the medical director (licensed physician) must:
- i. Document the evidence, or review and concur with the physician extender's documented evidence, used from the medical evaluation to determine physical dependence and addiction to opiates.
 - ii. Document their final determination concerning physical dependence and addiction to opiates.
 - iii. For patients that have resided in a penal or chronic care institution for one (1) month or longer may be admitted to maintenance treatment within one (1) month of release without documented evidence to support findings of physical dependence, provided the person would have been eligible for admission before they were incarcerated or institutionalized, and in the clinical judgement of the medical director program physician, treatment is medically justified.
 - iv. Also, previously treated patients who voluntarily detoxified from maintenance treatment may be admitted back into maintenance treatment without documentation of current physical dependence when the program is able to document prior maintenance treatment of six (6) months or more and, in the clinical judgment of the medical director or program physician, treatment is medically justified. Patients admitted under these circumstances, at the discretion of the medical director or program physician, be granted the same take-home step level they were on at the time of discharge.

Additional Detoxification Treatment Admission Items

1. A staff physician must certify the patient's fitness for *detoxification* treatment. The physician conducting the review and certification of fitness must document this in the medical record.
2. Additionally, in order for a beneficiary to meet admission criteria for detoxification treatment, the physician must determine that the beneficiary is currently physically dependent on opiates. There are two components required to make this determination. First, the physician shall note and document any observed signs of physical dependence. The results of the initial test or analysis may be used to determine physical dependence on opiates, but this component may be required after detoxification treatment has commenced as these results may not be available immediately. When these results become available, the physician must review the results and document this in the medical record.
3. Unless legally emancipated, patients under the age of 18 must have the written



consent of their parent/guardian prior to the administration of the first detoxification medication dose.

4. Patients must not have previously had detoxification services in the past seven days. A written/signed patient's statement, if deemed reliable, may be used to meet this requirement.
5. Pregnant individuals in the last trimester are not eligible for detoxification services.

Additional Items Required for Maintenance Treatment Admission

The requirements for admission into *maintenance* opioid treatment are more vigorous than *detoxification* treatment because of the longer-term nature of replacement therapy for individuals with long-term addiction. Each of the following items must be documented in the beneficiary's medical record as part of their determination for admission.

1. **Confirmed documented history of at least two years of addiction to opiates.**
The methods used to make this confirmation must be described in each treatment program's protocol. The documents used to make this confirmation (such as arrests, treatment failures, etc.) are required to be maintained in the patient's medical record. Statements from friends or relatives are not sufficient to establish a history of opiate addiction. For patients where two years of documented history of opiate addiction cannot be established through means identified in the protocol, exceptions may be made by the program physician. In these cases, prior approval from DHCS is required and the physician must clearly explain in the documentation who withholding treatment constitutes a life-or-health endangering situation.
2. **Confirmed history of two or more unsuccessful attempts in withdrawal treatment with subsequent relapse to illicit opiate use.**
3. **Individuals must be at least 18 years old to receive maintenance treatment.**
4. **Certification of fitness by a staff physician to receive maintenance treatment based on the physical examination, medical history, and test/analysis findings.**
5. **Evidence of observed signs of physical dependence.** Applicants who have been incarcerated or in a chronic care institution for one (1) month or longer do not have to have signs of physical dependence as long as they would have previously met this criteria and in the judgment of the treating physician treatment is medically justified. Additionally, previously patients who voluntarily detoxified from maintenance treatment may be admitted without documentation of current physical dependence, within six (6) months from the date of discharge. For these patients, the program must document prior maintenance treatment of six (6) months or more and in the clinical judgment of the medical director or physician, treatment is medically justified. When all of these criteria are met, patients may be admitted (at the discretion of the medical director or program physician) at the same take home step-level they were on at the time of their previous discharge.
6. **Pregnant patients who are currently physically dependent on opiates and have a documented history of opiate addiction, may be admitted to maintenance therapy.** Documentation of addiction does not need to prove two (2) year addiction history or two (2) year prior treatment failures. Admission of pregnant patients is dependent on the medical director or program physician determining that treatment is medically justified. Pregnant patients must be reevaluated by the program physician no later than sixty (60) days following the



end of the pregnancy (birth or otherwise) to determine if treatment is appropriate to continue.

Medical director has conducted a medical evaluation consisting of at a minimum a medical history that includes a history of client's illicit drug use; lab tests for determination of narcotic drug use, tuberculosis, infectious diseases, and syphilis; and a physical examination as specified under Title 9 §10270 as evidenced by written documentation in the client's individual patient record?

Medical director has documented the evidence used in the medical evaluation to determine physical dependence and addition to opiates.

Patient Orientation and Informed Consent (9 CCR § 10280)

At a minimum, the information regarding the following topics are required to be included in patient orientation materials. Receipt and acknowledgment of communication of this information must be documented in the medical record.

- The addicting nature of medications used in replacement narcotic therapy
- The hazards and risks involved in replacement narcotic therapy
- The patient's responsibility to the program
- The program's responsibility to the patient
- The patient's participation in the program is wholly voluntary and the patient may terminate his/her participation in the program at any time without penalty
- The patient will be tested for evidence of use of opiates and other illicit drugs
- The patient's medically determined dosage level may be adjusted without the patient's knowledge, and at some later point the patient's dose may contain no medications used in replacement narcotic therapy
- Take-home medication which may be dispensed to the patient is only for the patient's personal use
- Misuse of medications will result in specified penalties within the program and may also result in criminal prosecution
- The patient 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

Additional orientation requirement for female patients of childbearing age (identified by the CDC as 15 to 44 years of age)

- Knowledge of the effects of medications used in replacement narcotic therapy on pregnant women 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 patient and/or unborn child.



- The patient should consult with a physician before nursing.
- The child may show irritability or other ill effects from the patient's use of these medications for a brief period following birth.

Patient Consent

As part of individualizing care for each beneficiary, each beneficiary's need for assistance in understanding informed consent to treat will vary. Providers are required to insure that the beneficiary reads and/or understands each of the components of informed consent. Providers shall clearly and thoroughly explain program rules and treatment expectations. Some beneficiaries may need additional support with regard to understanding the elements of informed consent, this is expected and will vary based on the individual's needs. Copies of the consent form and program rules must be provided to the individual at the time of signing. Additionally, it is important that each patient admitted to opioid treatment attest that they are voluntarily participating in the program.

For all Alameda County subcontracted behavioral health providers, both MH and SUD, the ACBH Consent to Treat/Informing Materials is required. This document is available on the ACBH website. Only the completed signature page is required to be maintained in the medical record. The additional information in the packet is to be provided to the beneficiary upon review.

Minimum Patient Absence

Detoxification

Treatment programs may discharge a patient if they miss three (3) consecutive days or more without notifying the program. Treatment may continue if a legitimate reason for the absence is provided and if continuing treatment is medically indicated. The medical director or physician must document these reasons why in the medical record.

Maintenance

Treatment programs may discharge a beneficiary if they miss two weeks or more without notifying the program. If, after being discharged, the beneficiary returns and is readmitted into the program, they shall return as a new patient. Documentation in the medical record for readmitted beneficiaries will be as if they were a new admission.

OTP Needs Assessment (9 CCR § 10305 (d))

For individuals admitted for maintenance therapy treatment a comprehensive needs assessment is required within 28 days of the date of admission. This assessment is to be completed prior to completing the individualized treatment plan as the information gathered is used to inform treatment plan goals.

The needs assessment process serves multiple treatment purposes and is an essential component of comprehensive, individualized whole-person treatment. Documentation of the required information must be included as part of the treatment record. Ideally this information will be part of a needs assessment document. The assessment process can



often be emotionally difficult for individuals who seek behavioral health and substance treatment. As such, great care, patience, and skillful professionalism is required. Attempts shall be made to gather the required information, but individuals may decline to share details of their experience. The treatment record shall indicate that an attempt or attempts were made to gather the required information. As treatment progresses, and trust between the individual and counselor/program grows it is common that components of the assessment not initially able to be gathered will be ascertained. This occurs both naturally as part of the treatment process and through follow-up by program staff when the admission needs assessment is incomplete. Additionally, the medical director and supervising counselor must review and co-sign the needs assessment within fourteen (14) of the completion date and within the twenty-eight (28) day due date (9 CCR § 10305 (g/h)). By co-signing the *Needs Assessment* the supervising counselor and medical director signify they concur with the findings. At a minimum the biopsychosocial assessment of needs must include the following:

1. Assessment of the patient's psychological and sociological background, including their educational and vocational experience, family history and current involvement, financial history, criminal/legal status, previous SUD treatment history.
2. An assessment of the patient's needs for:
 - a. Health care as recorded within the overall impression portion of the physical examination
 - b. Employment and education history. Current status and future plans also should be assessed
 - c. Psychosocial, vocational rehabilitation, economic, and legal services

ASAM Requirements for Opioid Treatment Programs

Opioid treatment programs are required to complete ACBH's American Society of Addiction Medicine Level of Care (ALOC). ACBH's ALOC is identical across the entire SUD system. Both *ALOC Initial* and *ALOC Review* are identical except in name; the information gathered is exactly the same between documents. All SUD providers subcontracted by Alameda County are required to complete the ASAM according to established timelines. For OTP providers, the *ALOC Initial* is due within 28 days from admission. The *ALOC Review* is due at every treatment plan update. Qualifications and experience required to complete the ASAM/ALOC is the same as for other SUD providers and is outlined in that section of this manual.

The ASAM criteria when completing the ALOC must be applied irrespective of the *Level of Care* of the provider. The LOC indicated in the ALOC must be congruent with the beneficiary's presentation (as indicated in the assessment documents and ALOC document). Either because of beneficiary preference, clinical, or structural considerations the level of care indicated by the ALOC may not be appropriate or desired by the beneficiary at the time of the assessment. The reasons for this difference must be documented in the ALOC form along with the *Actual Level of Care* and referral information. When a beneficiary indicates their preference for referral is different than what was assessed in the ALOC, the provider may only refer the beneficiary to a lower level of care than indicated. Beneficiaries at OTP providers, may have up to three (3) ASAM levels of care indicated by the individual's presentation. The three (3) possible levels of care are, 1) OTP - Level 1, 2) another non-OTP SUD provider (e.g. OS, IOS, RES, RSS), and a SUD



Recovery Residence. For additional information about the ASAM LOC and associated requirements, see the [ASAM Level of Care](#) in this manual.

OTP Treatment Plan Requirements

Opioid Treatment Programs must comply with treatment plan documentation requirements that are similar to those for other treatment modalities. Current DHCS regulations require OTP providers to comply with requirements for initial and updated treatment plans that are found in Section 10305, Title 9, CCR including:

Treatment plans are required to be individualized documents intended to help guide treatment. As much as is possible, development of treatment plans must be a process of collaboration between the individual and program staff. The most effective plans for treatment are developed in conjunction with the beneficiary. Program treatment staff utilize their knowledge, training, and expertise to guide development of the treatment plan. They do this while at the same time engaging and considering fully the treatment desires of the individual. Treatment is provided to meet the individual's treatment desires and needs. In situations where the treatment program staff and beneficiary's treatment expectation differ, staff must use their skills to develop the beneficiary's desire for treatment into workable treatment goals.

Detoxification Treatment Plan Requirements

Due to the focused and short-term modality of detoxification treatment, plans for detoxification therapy must include, at a minimum, individualized versions of the following components.

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

Maintenance Treatment Plan Requirements

Initial treatment plans for individuals receiving maintenance therapy must be completed after the needs assessment and initial ASAM Level of Care (ALOC) and within twenty-eight (28) days from the date of admission. The information gathered during the intake and assessment process is used by the primary counselor to inform the goals and tasks of the plan. It is required that the primary assigned counselor develop the plan with the beneficiary. The initial treatment plan must include at a minimum the following elements:

- A statement of client needs to be addressed including a summary of client's initial psychological and sociological background including education and vocational experience, health care, employment, education, psychosocial, vocational rehabilitation, economic, and legal services
- Short-term goals (less than 90 days to achieve) and long-term goals (specified time of greater than 90 days to achieve) to be achieved by the client based on needs identified



- Identified needs that are not included as active plan goals must be indicated as deferred.
- Target dates for the accomplishment of short-term and long-term goals
- Specific behavioral tasks that will be taken by the client to complete each short-term and long-term goal
- A description of the type and frequency of counseling services to be provided to the client
- An effective date based on the day the primary counselor signed the initial treatment plan
- The plan must indicate who is the assigned primary counselor (IA)

The initial treatment plan is considered complete when all required signatures are present on the plan. Plan signatures, like all signatures for DMC-ODS, must include the signature, printed name, and signature date of the individual signing. Treatment staff must also include their credentials when signing. The effective date of the plan is the date the primary counselor signs the plan. Both the supervising counselor and the medical director are required to review, approve, and co-sign the plan within fourteen (14) calendar days of the effective date of the plan. Their signatures on the plan indicates their concurrence with the plan and its findings. When deemed medically appropriate the medical director may make amendments to plan. The beneficiary must sign the plan within the due date of the plan and within fourteen (14) calendar days of the primary counselor's signature. If the beneficiary refuses to sign the plan, the provider shall document the reason for refusal and indicate their strategy to engage the beneficiary's participation in treatment.

Once a plan has been signed by the client, no changes may be made to the plan document. Plan amendments must occur prior to the beneficiary signing the plan. Spelling errors may be corrected with a single line drawn through the text. The individual making the correction may only be one of the individuals who signed the plan and is required to initial and date the correction. When a beneficiary accomplishes a treatment goal, the primary counselor may indicate the date the goal was met. Any other types of corrections require a plan revision or update, along with new signatures.

The provider must provide the beneficiary with a copy of the signed plan and document this in the medical record.

OTP Treatment Plan Update Requirements

Updates to the beneficiary's treatment plan is required whenever necessary and once every three (3) months from the date of admission. Like the initial plan, plan updates are a collaborative process between the beneficiary and program treatment staff. The primary counselor is the individual responsible for coordinating and completing the plan update. The effective date for the plan update is the primary counselor's signature on the plan. The medical director and supervising counselor must review and co-sign the updated plan within fourteen (14) days from the effective date and within the plan due date. By co-signing the updated plan the medical director and supervising counselor are attesting their concurrence with the plan and proposed treatment. As part of their review the medical director may amend the plan when medically appropriate. The beneficiary must sign the plan within the



due date of the plan update and within fourteen (14) calendar days of the primary counselor's signature. If the beneficiary refuses to sign the plan, the provider shall document the reason for refusal and indicate their strategy to engage the beneficiary's participation in treatment. Plan update signatures, like all signatures for DMC-ODS, must include the signature, printed name, and signature date of the individual signing. In addition to the components of the initial plan, updated treatment plans also must include the following elements:

1. A summary of the client's progress or lack of progress toward each goal identified on the previous treatment plan
2. New goals and behavioral tasks for any newly identified needs or related changes in the type and frequency of counseling services to be provided to the client
3. An effective date based on the day the primary counselor signed the updated treatment plan

The provider must document that the beneficiary was provided a signed copy of the updated plan. For pregnant patients, treatment plans must be updated by the primary counselor within fourteen (14) days from date the medical directory confirmed the pregnancy. See section on additional treatment plan requirements for pregnant women for specific requirements. (9 CCR § 10360).

OTP Counseling Services (9 CCR § 13045)

Once the initial plan has been developed with the beneficiary and completed, the primary counselor must arrange for the beneficiary to receive a minimum of fifty (50) minutes and up to 200 minutes of counseling services per calendar month at the treatment provider's program. The medical director may adjust or waive at any time after admission, by a medical order, the required counseling times. The treatment staff member providing the counseling must have the qualifications for and experience in treating individuals with opiate addiction. The Counselors section of these guidelines describe specific program staff and licensing/certification requirements for individuals providing counseling services. To ensure confidentiality counseling sessions must be conducted in a private setting in accordance with all applicable federal and state regulations regarding confidentiality.

Counseling services, as defined by 9 CCR § 13005, consist of the following activities:

- Evaluating participants', patients', or residents' AOD treatment or recovery needs, including screening prior to admission, intake, and assessment of need for services at the time of admission
- Developing and updating of a treatment or recovery plan
- Implementing the treatment or recovery plan
- Continuing assessment and treatment planning
- Conducting individual counseling sessions, group counseling sessions, face-to-face interviews, or counseling for families, couples, and other individuals significant in the life of the participants, patients, or residents



- Documenting counseling activities, assessment, treatment and recovery planning, clinical reports related to treatment provided, progress notes, discharge summaries, and all other client related data.

The format of the counseling session must be one of the following:

- Individual session, with face-to-face discussion with the patient, on a one-on-one basis, on issues identified in the patient's treatment plan.
- Group session, with a minimum of four patients and no more than ten patients and having a clear goal and/or purpose that is a common issue identified in the treatment plans of all participating patients.
- Medical psychotherapy session, with face-to-face discussion conducted by the medical director on a one-on-one basis with the patient, on issues identified in the patient's treatment plan.

The following activities do not qualify as a counseling session or as part of a 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 required patient orientation sessions
- Administrative intervention regarding payment of fees.

OTP Documentation of Services

Only the counselor conducting the counseling session may be the individual documenting and claiming for the session. All counseling services must be documented in the patient's record as a progress note within seven (7) calendar days of the date of session. At a minimum the progress note must contain the following information:

- Date, start and end time of each counseling session
- Type of counseling format (i.e., individual, group, or medical psychotherapy)
- The duration of the counseling session in ~~ten-minute intervals~~, excluding the time required to document the session as required in Subsection (d)(4) of this regulation
- Summary of the session, including one or more of the following:
 - i. Patient's progress towards one or more goals in the patient's treatment plan.
 - ii. 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.
 - iii. New issue or problem that affects the patient's treatment.
 - iv. Nature of prenatal support provided by the program or other appropriate health care provider.
 - v. Goal and/or purpose of the group session, the subjects discussed, and a brief summary of the patient's participation.

Opioid Treatment Programs groups may only have between 2 and 12 participants. Claiming



for groups that are smaller or larger, regardless of the ratio of counselors/LPHAs to participants, is not allowed.

The medical director shall assume the medical responsibility for all program patients by co-signing patient record notes with fourteen (14) days of the completion of the note.

Dosing may only be administered by staff with the proper training, experience, and scope of practice to do so. Only medical providers and nursing staff may administer medications. When claiming for the dosing service, the individual providing the service is the individual indicated on the claim.

Documentation Requirements Related to Dosing

For the initial dose of replacement narcotic therapy, due to risk of adverse reaction to controlled substances, the program physician must administer or supervise administration of the initial dose. After administering the initial dose, the program physician or medical director determines the specific period of time that the beneficiary must be observed or monitored. The medical director or physician may delegate the task of observing or monitoring the individual's initial dose to another authorized medical staff (a staff who may administer or dispense medications). This medical staff must immediately notify the medical director or program physician immediately if any adverse effects from the medication are noted. When documenting the outcome of the initial dose, medical staff must also include the length of time between the first dose and any adverse reaction and description/outcome of the observation. (9 CCR § 10350)

The medical director or program physician must individually determine each beneficiary's medication schedule based on criteria outlined in 9 CCR § 10350 (1). Any changes to the beneficiary's dosage schedule must be documented in the medical record. In these situations, the medical director or program physician shall record, date, and sign in the patient's records each change in the dosage schedule with reason for such deviations.

For both *Detoxification* and *Maintenance* treatment the total dose of methadone for the first day may not exceed 40 milligrams unless the medical director or program physician determines that 40 milligrams is not sufficient to suppress the patient's opiate abstinence symptoms. If either of these conditions occur the medical director or program physician must document in the medical record the basis of their determination. Note that, first day or initial dosage amounts must be divided into smaller doses when above 30 milligrams.

For beneficiaries receiving *Maintenance* treatment, the program protocol must set forth procedures for determining a medically stable dosage level. Procedures for determining a stable dosage level must consider the following elements: 1) Minimizes sedation; 2) Decreases withdrawal symptoms; (3) Reduces the potential for diversion of take-home medication. Deviations from established procedures must be explained and documented in the beneficiary's medical record. Additionally, any deviations from medication usage as described in the approved labeling must be justified by the medical director or program physician in the beneficiary's medical record.

As *Maintenance* treatment progresses, the beneficiary's dose level may increase in order to



suppress the beneficiary's opiate abstinence symptoms. The medical justification for daily dose amounts above 100 milligrams must be documented by the medical director or program physician in the medical record. Regardless of dosage amount, the medical director or program physician must review each patients' dosage level at least every three (3) months.

Regarding documentation of beneficiaries receiving LAAM therapy, dosage levels above 140 milligrams must be documented in their medical record.

Expanded MAT under DMC-ODS

Licensed Opioid Treatment Programs may provide federally approved controlled substances to patients with an opioid use disorder for the purpose of Narcotic Replacement Therapy (NRT). These NRT controlled substances include full agonist medication (methadone) and partial agonist medication (buprenorphine products). Additionally, recently the FDA has approved medications that are not controlled substances for the purposes of providing medication assisted treatment (MAT) for individuals with a substance use disorder. These MAT medications include Naltrexone, Disulfiram, Acamprosate, and Naloxone. Under DMC-ODS, OTPs are required to have available, at a minimum Methadone, Buprenorphine, Disulfiram, and Naloxone. Prior to providing the additional required medications must submit an amended protocol in writing to DHCS in accordance with 9 CCR § 10035 and DHCS IN 18-004. New medications approved by the FDA to treat opioid use disorder in the future would also be allowed to be utilized by OTPs.

Administration of medications for Expanded MAT services shall be the responsibility of the medical director or appropriately licensed program personnel under the direction of the medical director. Expanded MAT Program Requirements Administration of medications for Expanded MAT services shall be the responsibility of the medical director or appropriately licensed program personnel under the direction of the medical director. NTPs are subject to existing laws and regulations governing documentation, medication, and record keeping at treatment facilities. Specifically, each NTP providing Expanded MAT shall: 1. Maintain accurate records of medications used in Expanded MAT traceable to specific patients, showing dates and quantities dispensed, prescribed, and/or administered; 2. Maintain adequate security over stocks of medications used in Expanded MAT to guard against theft; and, 3. Develop and maintain procedures that require administering and/or dispensing all medications associated with Expanded MAT in accordance with the approved product labeling for each medication. (DHCS IN 18-004).

Additional Requirements for Pregnant OTP Patients (9 CCR § 10360)

Women who are physically dependent on opiates and have a documented history of addiction to opiates may receive replacement treatment when the medical director or program physician determines treatment to be medically justified. See admission section for full requirements for pregnant patients. Women who are receiving opioid treatment services and become pregnant may also continue to receive services.

Within fourteen (14) calendar days from the date of the primary counselor's knowledge that the patient may be pregnant, as documented in the patient's record, the medical director



shall review, sign, and date a confirmation of pregnancy. Also within this time frame, the medical director must document their: 1) Acceptance of medical responsibility for the patient's prenatal care; or 2) Verification that the patient is under the care of a physician licensed by the State of California and trained in obstetrics and/or gynecology.

When considering LAAM treatment for pregnant women, the medical director must document in a medical order their rationale for determining LAAM to be the best choice of therapy for the patient prior to placing a pregnant applicant on LAAM therapy or continuing LAAM therapy after confirmation of a patient's pregnancy. The medical director shall conduct a physical examination of this patient prior to documenting a medical order to continue LAAM therapy.

The primary counselor and beneficiary must collaborate to update the treatment plan within fourteen (14) calendar days from the date the medical director confirmed the pregnancy. The nature of prenatal support reflected in subsequent updated treatment plans shall include at least the following services:

- (1) Periodic face-to-face consultation at least monthly with the medical director or physician extender designated by the medical director;
- (2) Collection of patient body specimens at least once each calendar week in accordance with collection procedures specified in Section 10310.
- (3) Prenatal instruction as specified in paragraph (d) of this section.

In addition to the treatment plan update, the medical director or licensed health personnel designated by the medical director must document the beneficiary was instructed on each of the following prenatal topics:

- (1) Risks to the patient and unborn child from continued use of both illicit and legal drugs, including premature birth.
- (2) Benefits of replacement narcotic therapy and risks of abrupt withdrawal from opiates, including premature birth.
- (3) Importance of attending all prenatal care visits.
- (4) Need for evaluation for the opiate addiction-related care of both the patient and the newborn following the birth.
- (5) Signs and symptoms of opiate withdrawal in the newborn child and warning that the patient not share take-home medication with the newborn child who appears to be in withdrawal.
- (6) Current understanding related to the risks and benefits of breast-feeding while on medications used in replacement narcotic therapy.
- (7) Phenomenon of postpartum depression.
- (8) Family planning and contraception.
- (9) Basic prenatal care for those patients not referred to another health care provider, which shall include instruction on at least the following:
 - a. Nutrition and prenatal vitamins
 - b. Child pediatric care, immunization, handling, health, and safety.
- (10) If a patient repeatedly refuses referrals offered by the program for prenatal care or refuses direct prenatal services offered by the program, the



medical director shall document in the patient's record these repeated refusals and have the patient acknowledge in writing that she has refused these treatment services.

Within fourteen (14) calendar days after the date of birth and/or termination of the pregnancy, the medical director must document the hospital's or attending physician's summary of the delivery and treatment outcome for the patient and offspring. If no response was received from the hospital following the request of this information, evidence of the request must be documented in the beneficiary's medical record and that no response was received.

Following the birth and/or termination of the pregnancy the treatment plan must be updated again. The nature of pediatric care and child immunization shall be reflected in subsequent updated treatment plans until the child is at least three (3) years of age.

OTP Take-Home Medication Documentation Requirements

Regulations for opioid treatment allow, when certain circumstances are met, for beneficiaries to take home a specific amount of medication. The information in this section only covers the documentation requirements related to take-home medications. For full requirements related to take-home medications please carefully review Title 9 CCR §, Sections 10365 through 10400.

Documenting Eligibility for Take-Home Medication Privileges (9 CCR § 10370)

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

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

The medical director or program physician may place a patient on one of the six take-home medication schedules when the criteria below has been met. Refer to Title 9 CCR § 10375 for a full description of each take-home schedule.

1. Documentation in the patient's record that the patient 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 patient's daily attendance at the program would be incompatible with such activity

2. Documentation in the patient's record that the current monthly body specimen collected from the patient is both negative for illicit drugs and positive for the narcotic medication administered or dispensed by the program
3. No other evidence in the patient's record that he or she has used illicit drugs, abused alcohol, or engaged in criminal activity within:
 - i. The last 30 days for those patients being placed on step level schedules I through V
 - ii. The last year for those patients being placed on step level schedule VI

Documenting Exceptions to Take-Home Medication Restrictions (9 CCR § 10385)

The medical director or program physician may grant an exception to take-home medication criteria and dosage schedules when the following conditions occur:

1. The patient has a physical disability or chronic, acute, or terminal illness that makes daily attendance at the program a hardship. The program must verify the patient's physical disability or illness, and include medical documentation of the disability or illness in the patient's record. The patient shall not be given at any one time, more than a two-week take-home supply of medication.
2. The patient has an exceptional circumstance, such as a personal or family crisis, that makes daily attendance at the program a hardship. When the patient must travel out of the program area, the program shall attempt to arrange for the patient to receive his or her medication at a program in the patient's travel area. The program shall document such attempts in the patient's record. The patient shall not be given at any one time, more than a one-week take-home supply of medication.
3. The patient 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 than an increased dosage level.

Prior to granting an exception the medical director or program physician must determine that the patient is responsible in handling narcotic medications on a take-home basis as previously specified. The medical director or program physician must document in the patient's record the granting of any exception and the facts justifying the exception. Additionally, The Department (DHCS) may grant additional exceptions to the take-home medication requirements as described in this section in the case of an emergency or natural disaster, such as fire, flood, or earthquake.



Documenting Revocation or Restriction of Take-Home Medication Privileges (9 CCR § 10390)

The medical director or program physician must restrict a patient's take-home medication privileges by moving the patient back at least one step level on the take-home medication schedule for any of the reasons described below. Any changes to take-home medication privileges must be documented by the medical staff making the determination, along with a description of the rationale and evidence for the change. In situations such as these, it is clinically appropriate to review the beneficiary's presentation, level of functioning, and effectiveness of their current treatment plan. When necessary to meet their changing treatment needs a treatment plan revision must occur.

1. Patients 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.
2. Patients 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.
3. Patients, 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.
4. The patient is no longer a suitable candidate for take-home medication privileges as presently scheduled, based on consideration of the criteria specified earlier in this section.

A medical director or program physician, may at any time, for any reason, may order a revocation of a patient's take-home medication privileges. Additional possible reasons that may prompt rescinding of a beneficiary's take-home medications include, but are not limited to, the following:

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

The medical director or program physician must order the revocation or restriction of a beneficiary's take-home privileges within fifteen (15) days from the date the program obtained relevant evidence.



Documenting Restoration of Restricted Take-Home Medication Privileges

The medical director or program physician, when restoring each step of a patient's restricted take-home medication privileges, must determine and document that the following conditions have been met, based on the circumstances of their restriction. Note that when restoring take-home privileges, no individual may be advanced to a step level beyond the level they were at prior to their restriction.

When restoring step level schedules I through V when restricted due to drug-screening test or analysis results, the medical director or program physician making the determination must document that the following conditions have been met:

- The beneficiary has demonstrated responsibility in handling take-home medications [as previously described](#)
- The beneficiary must complete at least a 30-day restriction
- Their most recent monthly body specimen collected must be both negative for illicit drugs and positive for the narcotic medication administered or dispensed by the program.

When restoring step level schedule VI when restricted due to drug-screening test or analysis results, the medical director or program physician making the determination must document that the following conditions have been met:

- The beneficiary has demonstrated responsibility in handling take-home medications [as previously described](#)
- The previous three (3) consecutive monthly body specimens collected from the patient are both negative for illicit drugs and positive for the narcotic medication administered or dispensed by the program

When restoring any step which was restricted due to an unexcused absence after receiving a supply of take-home medication, the medical director or program physician making the determination must document that the following conditions have been met:

- The beneficiary has demonstrated responsibility in handling take-home medications [as previously described](#)
- The previous three (3) consecutive monthly body specimens collected from the patient are both negative for illicit drugs and positive for the narcotic medication administered or dispensed by the program

OTP Drug Analysis / Testing

The OTP's program protocol is required to outline guidelines for collection of body specimen for testing or analysis of illicit substances. Every beneficiary in maintenance treatment, must be randomly tested for illicit substances at least monthly. For beneficiary's in detoxification treatment, testing or analysis must occur at the time of admission and any other time deemed necessary by the attending physician.



Records of tests or analysis for illicit substances must include, at a minimum, the following information: (9 CCR § 10330)

1. The date the patient body specimen was collected
2. The test or analysis results
3. The date the program received the result of the test or analysis

When a patient fails to provide a body specimen when required, the program shall proceed as though the patient's sample from their body specimen disclosed the presence of an illicit drug(s). Any failure of a test or analysis of illicit substances must be documented in the medical record. 9 CCR § 10335

OTP Continuing Service Requirements for Maintenance Treatment (9 CCR § 10410)

At least annually the medical director must conduct a review of the beneficiary's services and treatment provided, including results of tests or analyses for illicit drug use.

Documentation of this review and the medical director's conclusions must be present in the medical record.

After two (2) years of consecutive maintenance treatment, and then at least annually thereafter, the medical director or physician must discontinue an individual's treatment unless they document in the medical record:

- Their evaluation of the beneficiary's progress or lack of progress in achieving treatment goals in the progress notes.
- The determination, in their clinical judgment, that the beneficiary's current status indicates that such treatment should be continued for a longer period of time as discontinuance from treatment would lead to a return to opiate addiction
- The facts justifying their decision to continue maintenance treatment

OTP Discharge Requirements (9 CCR § 10415)

OTP discharge requirements and documentation are the same as other SUD services as the IA has a higher standard than Title 9 in this regard. Please refer to the [Discharges and Transfers](#) Section of these guidelines.

OTP Patient Death Reporting Requirements

If a patient dies at an *OTP Treatment Program* or if ingestion of medication used in replacement narcotic therapy may have been the cause of the patient's death, the program is required to notify ACBH and DHCS within one (1) working day. For all other patient deaths the program must submit, within ninety (90) days from the date of death, a death report which is signed and dated by the medical director to signify concurrence with the findings and any other documentation of the death. This information should be included in the beneficiary's medical record prior to closing the chart and storing the record.



Additional Information for Opioid Treatment Providers

- Narcotic treatment programs shall be staffed by a licensed nurse or other individual lawfully authorized to administer medication.
- For clients in OTP programs, medical psychotherapy sessions are defined as face-to-face discussions between the medical director and/or physician and the client on issues identified in the client treatment plan.
- Clients must receive a minimum of 50 minutes of counseling per calendar month except where the medical director adjusts or waives at any time.
- After admission provider must indicate by medical order the minimum number of minutes of counseling services per calendar month along with rationale for adjusting or waiving counseling services.
- Clients who are pregnant must be administered monthly urinalysis test/weekly.
- Provider must comply with multiple registration at time of admission requirements including physician documentation of dosage.
- Provider must comply with medication dosage level requirements including clients who are pregnant.
- Provider must comply with tuberculosis testing requirements.

OTP Definitions 9 CCR § 10000

1. Accreditation means the process of review and acceptance by an accreditation body. Accreditation body means a body that has been approved by SAMHSA under §8.3 to accredit opioid treatment programs using opioid agonist treatment medications.
2. Accreditation body application means the application filed with SAMHSA for purposes of obtaining approval as an accreditation body, as described in §8.3(b).
3. Accreditation elements mean the elements or standards that are developed and adopted by an accreditation body and approved by SAMHSA.
4. Accreditation survey means an onsite review and evaluation of an opioid treatment program by an accreditation body for the purpose of determining compliance with the Federal opioid treatment standards described in §8.12.
5. Accredited opioid treatment program means an opioid treatment program that is the subject of a current, valid accreditation from an accreditation body approved by SAMHSA under §8.3(d).
6. Certification means the process by which SAMHSA determines that an opioid treatment program is qualified to provide opioid treatment under the Federal opioid treatment standards.
7. Certification application means the application filed by an opioid treatment program for purposes of obtaining certification from SAMHSA, as described in §8.11(b).
8. Certified opioid treatment program means an opioid treatment program that is the subject of a current, valid certification under §8.11. Comprehensive maintenance treatment is maintenance treatment provided in conjunction with a comprehensive range of appropriate medical and rehabilitative services.
9. Detoxification treatment means the dispensing of an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or sustained use of an opioid drug and



- as a method of bringing the individual to a drug-free state within such period.
10. Detoxification Treatment. “Detoxification treatment” means the treatment modality whereby replacement narcotic therapy is used in decreasing, medically determined dosage levels for a period not more than 21 days, to reduce or eliminate opiate addiction, while the patient is provided treatment services.
 11. FDA. “FDA” means the United States Food and Drug Administration.
 12. Federal opioid treatment standards means the standards established by the Secretary in §8.12 that are used to determine whether an opioid treatment program is qualified to engage in opioid treatment. The Federal opioid treatment standards established in §8.12 also include the standards established by the Secretary regarding the quantities of opioid drugs which may be provided for unsupervised use.
 13. For-cause inspection means an inspection of an opioid treatment program by the Secretary, or by an accreditation body, that may be operating in violation of Federal opioid treatment standards, may be providing substandard treatment, or may be serving as a possible source of diverted medications.
 14. Illicit Drug. “Illicit drug” means any substance defined as a drug in Section 11014, Chapter 1, Division 10 of the Health and Safety Code, except:
 - a. Drugs or medications prescribed by a physician or other person authorized to prescribe drugs, pursuant to Section 4040, Chapter 9, Division 2 of the Business and Professions Code, and used in the dosage and frequency prescribed; or
 - b. Over-the-counter drugs or medications used in the dosage and frequency described on the box, bottle, or package insert.
 15. Interim maintenance treatment means maintenance treatment provided in conjunction with appropriate medical services while a patient is awaiting transfer to a program that provides comprehensive maintenance treatment.
 16. Laboratory. “Laboratory” means a drug analysis laboratory approved and licensed by the State Department of Health Services to test or analyze samples of patient body specimens for the substances named in Section 10315 for a narcotic treatment program.
 17. Levoalphacetylmethadol (LAAM). “Levoalphacetylmethadol (LAAM) also known as Levo-Alpha-Acetyl-Methadol or levomethadyl acetate hydrochloride, means the substance that can be described chemically as levo-alpha-6-dimethylamino-4, 4-diphenyl-3-heptyl acetate hydrochloride.
 18. Long-term detoxification treatment means detoxification treatment for a period more than 30 days but not in excess of 180 days.
 19. Maintenance treatment means the dispensing of an opioid agonist treatment medication at stable dosage levels for a period in excess of 21 days in the treatment of an individual for opioid addiction.
 20. Maintenance Treatment. “Maintenance treatment” means the treatment modality whereby replacement narcotic therapy is used in sustained, stable, medically determined dosage levels for a period in excess of 21 days, to reduce or eliminate chronic opiate addiction, while the patient is provided a comprehensive range of treatment services.
 21. Medical Director. “Medical director” means the physician licensed to practice medicine in California who is responsible for medical services provided by the program.
 22. Medical director means a physician, licensed to practice medicine in the jurisdiction in



- which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the medical director's direct supervision.
23. Medical and rehabilitative services means services such as medical evaluations, counseling, and rehabilitative and other social programs (e.g., vocational and educational guidance, employment placement), that are intended to help patients in opioid treatment programs become and/or remain productive members of society.
 24. Medication. "Medication" means any opiate agonist medications that have been approved for use in replacement narcotic therapy, including:
 - a. Methadone - controlled
 - b. Levoalphacetylmethadol (LAAM) – controlled
 - c. Disulfiram (Antabuse) – not controlled
 - d. Buprenorphine – not controlled
 - e. Naloxone – not controlled
 - f. Naltrexone (injectable) – not controlled
 - g. Any other medications approved by the FDA for Opioid treatment
 25. Medication Unit. "Medication unit" means a narcotic treatment facility, established by a program sponsor as part of a maintenance treatment program, from which licensed private practitioners and community pharmacists are permitted to administer and dispense medications used in replacement narcotic therapy. These medication units may also collect patient body specimens for testing or analysis of samples for illicit drug use.
 26. Medication unit means a facility established as part of, but geographically separate from, an opioid treatment program from which licensed private practitioners or community pharmacists dispense or administer an opioid agonist treatment medication or collect samples for drug testing or analysis.
 27. Methadone. "Methadone" means the substance that can be described as 6-dimethylamino-4, 4-diphenyl-3-heptanone. Methadone doses are usually administered as methadone hydrochloride.
 28. Narcotic Drug. "Narcotic drug" means any controlled substance which produces insensibility or stupor and applies especially to opium or any of its natural derivatives or synthetic substitutes.
 29. Narcotic Treatment Program. "Narcotic treatment program" means any opiate addiction treatment modality, whether inpatient or outpatient, which offers replacement narcotic therapy in maintenance, detoxification, or other services in conjunction with that replacement narcotic therapy.
 30. "Opiate" means narcotic drug substances having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability; including heroin, morphine, methadone, or any natural or synthetic opiate as set forth in the California Uniform Controlled Substances Act (Health and Safety Code sections 11000, et seq.).
 31. Opiate addiction is defined as a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opiates despite significant opiate-



induced problems. Opiate dependence is characterized by repeated self-administration that usually results in opiate tolerance, withdrawal symptoms, and compulsive drug-taking. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal.

32. Opiate Addiction. "Opiate Addiction," and the related term "addiction to opiates," mean a condition characterized by compulsion and lack of control that lead to illicit or inappropriate opiate-seeking behavior, including an opiate addiction that was acquired or supported by the misuse of a physician's legally prescribed narcotic medication.
33. Opioid agonist treatment medication means any opioid agonist drug that is approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for use in the treatment of opiate addiction.
34. Opioid drug means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.
35. Opioid treatment means the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. This term encompasses detoxification treatment, short-term detoxification treatment, long-term detoxification treatment, maintenance treatment, comprehensive maintenance treatment, and interim maintenance treatment.
36. Opioid treatment program or "OTP" means a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication.
37. Patient means any individual who undergoes treatment in an opioid treatment program.
38. Physical Dependence. "Physical Dependence," and related terms "dependence," "dependency," "dependent," and "physiological dependence," means a condition resulting from repeated administration of a drug that necessitates its continued use to prevent withdrawal syndrome that occurs when the drug is abruptly discontinued.
39. Primary Metabolite of Methadone. "Primary metabolite of methadone" means 2-ethylidene-1, 5-dimethyl-3, 3-diphenylpyrrolidine.
40. Program. "Program" means a narcotic treatment program, unless otherwise specified.
41. Program Director. "Program director" means the person who has primary administrative responsibility for operation of an approved and licensed program.
42. Program Sponsor. "Program sponsor" means the person or organization which has accepted final responsibility for operation of a narcotic treatment program. The program sponsor also may be the program director or medical director.
43. Program sponsor means the person named in the application for certification described in §8.11(b) as responsible for the operation of the opioid treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any of its medication units. The program sponsor need not be a licensed physician but shall employ a licensed physician for the position of medical director.
44. Protocol. "Protocol" means a written document which sets forth a program's treatment concept, organization, and operational procedures in the form required by the Department.



45. Rationale. “Rationale” means a rational statement of principles or the logical basis for a procedure.
46. Registered opioid treatment program means an opioid treatment program that is registered under 21 U.S.C. 823(g).
47. Replacement Narcotic Therapy. “Replacement narcotic therapy” means the medically supervised use of an opiate agonist medication that mimics the effects of endorphin, a naturally occurring compound, thus producing an opiate effect by interaction with the opioid receptor.
48. Short-term detoxification treatment means detoxification treatment for a period not in excess of 30 days. State Authority is the agency designated by the Governor or other appropriate official designated by the Governor to exercise the responsibility and authority within the State or Territory for governing the treatment of opiate addiction with an opioid drug.
49. Treatment. “Treatment” means services which will habilitate and rehabilitate patients with an opiate addiction to a basic level of social, life, work, and health capabilities that help them become productive, independent members of society; and will include:
 - i. Replacement narcotic therapy;
 - ii. Evaluation of medical, employment, alcohol, criminal, and psychological problems;
 - iii. Screening for diseases that are disproportionately represented in the opiate-abusing population;
 - iv. Monitoring for illicit drug use;
 - v. Counseling by addiction counselors that are evaluated through ongoing supervision; and
 - vi. Professional medical, social work, and mental health services, on-site or by referral (through contracted interagency agreements).
50. Treatment plan means a plan that outlines for each patient attainable short-term treatment goals that are mutually acceptable to the patient and the opioid treatment program and which specifies the services to be provided and the frequency and schedule for their provision.

Practice Standards

Evidence-Based Practices

Evidence-based practices (EBPs) are interventions that have been shown to be effective and are supported by evidence. In Alameda County, although other psychosocial approaches may be used (e.g., relapse prevention, trauma informed treatment, and psychoeducation), SUD treatment agencies must at a minimum implement Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

Providers are also expected support the use of medication-assisted treatments as an evidence- based intervention, when clinically appropriate.



Motivational Interviewing

A patient-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on patients' past successes. According to the Motivational Interviewing Network of Trainers, MI "is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

Cognitive Behavioral Therapy

According to the National Institute of Drug Abuse's *Principles of Drug Addiction Treatment: A Research-Based Guide*, "Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies.

Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations."

The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.

Other Contractor Selected Practices

Relapse Prevention

According to SAMHSA's National Registry of Evidence-Based Programs and Practices, relapse prevention is "a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide patients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a patient's overall coping capacity."



Trauma-Informed Treatment

According to SAMHSA’s concept of a trauma-informed approach, “a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in patients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.” Seeking Safety and Motivational Interviewing Enhanced are examples of evidence-based trauma-informed practice.

Psychoeducation

Psychoeducational interventions educate patients about substance abuse and related behaviors and consequences. The information provided may be broad, but is intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to patients’ lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist patients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Older Adult Substance Use Disorder (SUD) Standards of Practices and Workforce Development (effective 7/30/19)

It is the standard of Alameda County Behavioral Health (ACBH) that Substance Use Disorder (SUD) providers designated to serve Older Adults shall design, develop and implement services¹ that meet the unique needs of Older Adults 60 years old and older.

SUD Specific Practice Requirements for Older Adults

- In older adult designated outpatient programs, at least one specialized treatment group for older adults must be offered and conducted no less than once per week. The specialized treatment group must address the following:
 - Legacy (life’s achievements, and end of life plan)
 - Older adult development stages (refer to ASAM Criteria)
 - Depression
 - SUD – education on aging on using.

- Older adult designated programs need to be prepared to offer additional case management services for older adults who may need extra support navigating complex service delivery systems (e.g. CalWorks, Social Security, Housing, Food Assistance, medical care appointments, etc.) and, where appropriate, engage

¹ To be implemented within 30 days of notification from ACBH.



family members to help the older adult beneficiary effectively engage these services.

- Warm linkage to transportation resources
 - Managed Care Health Plans provide transportation to medically necessary appointments, including substance use treatment appointments.
 - Five day advance notice needed for (Anthem); three days for Alliance members
 - The use of East Bay Paratransit, and ridesharing services (Lyft, Uber).

- Assessment - Physical Health / Mental Health /SUD assessment that includes ASAM areas unique to Older Adults based on developmental stages of Older Adults (ASAM Level of Care - ALOC) (see attached), and:
 - Comorbidity Issues (Physical/Psych/ SUD)
 - Loneliness
 - Depression Screening – Older Adult questionnaire used with assessments
 - Functional/Mobility changes
 - Homelessness
 - Literacy / not sure what medications to take
 - Financial exploitation, sex exploitation, romance scams
 - Chronic Pain
 - Gambling Addiction

Field Based Treatment Services

SUD programs designated to serve older adults must be able and willing to provide field-based treatment to older adult beneficiaries who may be reluctant or unable to access clinic-based substance use services due to impaired mobility, frailty, geographic limitations or stigma associated with receiving services in a traditional clinic. This means older adult designated programs may provide treatment groups and counseling services in settings that are preferred by older adults, for example in the home of the older adult, or in other community settings such as senior centers or senior housing complexes, or primary care settings. When services are provided in the community, the provider must ensure that a confidential space is maintained and protected in compliance with 42 CFR Part 2.

Workforce/Staff Development

(To better understand and deliver services to meet the needs of Older Adults).

- Staff should have a minimum of two years of experience working with Older Adults



- Training on the developmental states of Older Adults
- SUD Counselor
- Cultural specific trainings, including Older Adults as a culture.
- Knowledge and experience involving primary care integration
- Grief/bereavement for counselors whose clients die
- Work experience
- Peer support specialists (strongly consider using peers in recovery support services).

Outreach

- On an annual basis, older adult designated programs will provide a written older adult outreach plan to ACBH SUD System of Care that describes how the SUD program will be marketed to older adults, and how older adults will learn about services available within the SUD program. The plan must specify outreach events & places where the information will be shared (e.g. community meetings, etc) It will include a networking plan, and the named staff person(s) responsible for conducting older adult outreach.
- Older adult designated programs will develop a brochure to be posted within SUD outpatient clinic lobbies that identifies Older Adult specific services offered at the program. ACBH recommends this brochure also be posted the program's website, and be used in outreach activities to older adult communities.

SUD Clinic Facility

- Must be wheelchair accessible and accessible to those with mobility impairments. (ADA compliant)
- Space must be inviting for Older Adults (e.g. pictures of older adults in lobbies, and rooms used for specialized treatment groups)
- Older adult brochures (e.g. SUD, Mental Health, others) posted in lobby or common room spaces, &/or resource tables available within the clinic.

Drug Testing Requirements for OS, IOS, Residential, Recovery Residence, Withdrawal Management (effective 07/01/19)

Background

Alameda County Behavioral Health SUD System of Care requires medically appropriate drug testing to be performed throughout the course of formal drug and alcohol treatment services within the DMC-ODS. Drug testing is an evidence based practice in the treatment of drug and alcohol addiction. It provides an objective tool used for the purpose of clinical diagnosis, treatment, and the promotion of long-term recovery. A drug test provides a key piece of data used to help determine the course and intensity of treatment services, and it



functions as a tool for monitoring treatment effectiveness² and client engagement. In general, the frequency of drug testing is based on the client's progress in treatment, is individualized, and is particularly appropriate at the onset of a course of treatment.

As with any clinical tool, it is essential to clearly articulate the purpose of drug testing to clients and for clients to understand the therapeutic utility of drug testing as part of the treatment plan. Therefore, the initial informed consent process must address the program's drug testing policy and procedures, and include an explicit statement about the role of drug testing in the treatment plan. Research shows that client self-report and behavioral monitoring by clinicians has poor correlation to current addiction status, and is a poor substitute for knowledge acquired via drug testing. In cases where there is a discrepancy between the client's subjective report and the objective drug test result, the clinician is in a position to engage the client over this discrepancy, using motivational interviewing techniques, with the goal of enhancing accuracy of the diagnosis and the appropriateness of the treatment plan. Drug testing at the onset of a course of treatment and continued monitoring as clinically appropriate serve as a deterrent to substance use and increase the likelihood of successful abstinence.

The consequence of an unexpected positive drug test should generally be intensification of treatment, at least initially. Suspension of treatment or dismissal from treatment in response to a single positive drug test is not an appropriate clinical response.

Who should be tested?

- All beneficiaries currently served in a DMC-ODS treatment program, regardless of whether or not they were court referred. The drug testing requirement also pertains to beneficiaries living in county-funded recovery residences.

Periodicity/Frequency of Testing

- Drug testing must be performed at intake as part of the clinical assessment. Drug testing provides evidence of current or recent exposure to intoxicants, which could affect the client's current status, and serves as an objective means of verifying client substance use history as reported by the client.
- In addition, during the initial stages of treatment (usually first month), ACBH requires that programs test beneficiaries on a weekly basis. Frequent testing at the outset of treatment should be used until stable abstinence is achieved, followed by less frequent testing as abstinence is maintained.

² Including such client outcome measures as drug use reduction, drug range reduction, drug use abstinence, and duration of abstinence.



- Following the first month of treatment (initial stage), or the first period during which stable abstinence is achieved, whichever is greater, drug testing is used for monitoring purposes. Accordingly, in the middle and later stages of treatment, clients must test at least twice per month during these phases of treatment and/or more as clinically appropriate
- Testing should increase in frequency if therapeutically necessary, such as, for example, in the event of a relapse.

Random Testing

Random testing is required. Drug testing is ineffective if done infrequently or in accordance with a predictable schedule. Random testing is achieved when clients do not know when, how often, and for which substances they will be tested (no patterns nor schedules).

- Ideally, clients will be randomly selected for drug testing during any day of the week (Monday – Sunday). However, in consideration of the fact that many treatment programs are not open seven days per week, it is permissible to limit body specimen collection to the days that a treatment provider is open for business, i.e., Monday – Friday.
- It is not permissible to limit testing only to the days that a client is scheduled to attend the treatment program, as this form of testing is predictable and violates the purpose of randomized testing.

Types of Drug Testing, & Conditions for Body Specimen Collection

- Urine Analysis (UA), Saliva, Hair Follicle
 - UA drug testing will only capture drug use that occurred 1-3 days prior to the test.
 - Saliva testing will only capture drug use that occurred 12-48 hours prior to the test.
 - Hair testing can look at drug use in the 90 days prior to the test, but requires multiple drug use events to come back positive.
- Treatment setting environments may dictate less personally invasive forms of body specimen collection. For example in school-based treatment settings, observed UA tests may not be appropriate due to the lack of confidential restroom facilities. In this case, saliva tests are appropriate.



- Observed UA is best practice, but if not possible due to insurmountable treatment setting circumstances (e.g. lack of a private restroom facility in school-based setting), providers should use lab testing to confirm results.
- It is recommended to limit, as much as possible, the duration of delay between sample collection and sample analysis.

Panel Testing

- At minimum, the “SAMHSA-5” panel: (Meth)Amphetamines, Cocaine, Opiates (non-MATs), PCP, and THC, plus: Alcohol, Barbiturates, Benzodiazepines, and MATs.
- THC/Creatinine ratio is recommended for Marijuana testing due to Marijuana’s long detection period.
- Drugs tested for must be clinically determined based on the client’s history with the substance and risk of use (i.e. designer drugs/similar untested drugs).
- Best practice: core panel with additional tests including the rotation of less-common drugs and tests for drugs based on client history and risk.

Guidelines for Preliminary and Confirmatory Testing

- After the “rapid” test is conducted, a preliminary (presumptive) response is generated for the specific drug (types) of choosing. In the event of a presumptive positive drug test, patient admission of use is an important piece of information to help guide a decision on confirmatory testing. It is highly advised that confirmatory testing (Gas Chromatography/Mass Spectrometry test) be done for clients who deny drug use. For clients who deny drug use after receiving a presumptive positive, confirmatory testing is essential, as it will rule out accidental/passive ingestion, such as with the consumption of poppy seeds, and increase rapport building.
- Even for those clients who admit to using drugs, whether before or after a presumptive positive test, confirmatory testing can be useful as a treatment marker for quantity reduction and drug range reduction (e.g., client reduced her use of marijuana by 50% this month *and/or* she did not use cocaine at all). As a best practice, send at least 1 out of every 20 presumptive negatives (5%) to the lab for confirmatory testing to rule out a false negative.



- Some substances have a long detection period, which can throw off results. An example of this is with Marijuana, which can come back positive even weeks after use. At weekly testing, this could mistakenly suggest that the client continues to engage in Marijuana use, when it was actually a single use event two or more weeks ago. To prevent wrongful consequences in these scenarios, which would be harmful to the therapeutic process, it is recommended to use a THC/Creatinine ratio test for circumstances in which Marijuana use is of clinical focus.

How to use drug test results

- Results should be used to inform treatment progress and goals, and to support the development of healthy behaviors.
- Frequency of drug testing, goals, objectives and action steps of drug testing must be included in the client treatment plan and updated when frequency or when other drug testing goals/objectives/action step changes occur.
- A (confirmed) positive drug test should increase the intensity of services, especially for those who have a repeat positive drug test.
- Drug testing results shown over time (monitoring) support the recognition of treatment goal achievement, and client advocacy for successful abstinence and/or adherence to treatment.
- Positive tests cannot, on their own, lead to dismissal or suspension from the program.

How is drug testing paid for in DMC-ODS?

Drug MediCal does not directly reimburse for the cost of the drug test itself, including lab confirmatory testing and processing. However, a counselor's observed collection and screening time is claimable to MediCal at Intake/Assessment, and throughout treatment as Individual Counseling. Testing is only claimable when a face-to-face is provided with the client. For example, when the UA result comes in and the counselor only enters the results into the UA template (without seeing the client face to face), that documentation time cannot be claimed unless it is reviewed with the client in individual counseling.



References

1. DuPont, Robert; Shea, Corinne, et al. “Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM)” p 1-108. October 26, 2013. American Society of Addiction Medicine, Chevy Chase, MD.
2. Hurford, Matthew, et al. “Consensus Statement: Appropriate Use of Drug Testing in Clinical Addiction Medicine” p 1-56. Adopted by ASAM Board of Directors, April 5, 2017. American Society of Addiction Medicine, Chevy Chase, MD.
3. General Practice Guidelines in the County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS). http://www.optumsandiego.com/content/dam/san-diego/docs/General_Practice_Guidelines_-_Client_Website_version.pdf

Additional Resources

Additional ASAM practice guidelines regarding drug testing:

- <https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>
- “Drug Testing: Process and Settings in Addiction Treatment Webinar (1 CME)”
<https://elearning.asam.org>

Clinical Quality Review Team (CQRT)

Clinical Quality Review Team (CQRT) Overview

All Alameda County subcontracted SUD providers are required to utilize a reoccurring internal self-authorization process, subsequently referred to as Clinical Quality Review Team (CQRT). In addition to CQRT, residential programs have additional authorization and pre-authorization procedures that are described elsewhere in this document This section provides information on minimum provider requirements for CQRT and guidance on setting up a valid authorization and self-review process. It is the obligation and requirement of Alameda County ACBH to ensure that contracted providers self-authorize services according to ACBH, DHCS, and DMC-ODS rules and regulations.

Purpose of CQRT

The CQRT process has a multitude of benefits and fulfills DMC ODS contractual authorization of services requirements. Provider facilitated CQRT is required by the DMC ODS contract to ensure that medical necessity is met for recipients of DMC-ODS services. Initially providers are required to participate in a ACBH operated CQRT. This component of the CQRT process will be explained additionally in subsequent sections. Once providers have been approved by ACBH to operate an independent internal CQRT, providers will be



responsible for self-authorizing outpatient substance use treatment services; Residential treatment services always require ACBH prior authorization for the beneficiary's initial placement and for each thirty (30) day period of treatment. Utilizing a multi-tiered, layered, and redundant authorization system is standard medical practice and helps to reduce fraud, waste, and abuse of scarce public health resources. CQRT additionally protects against claiming not supported by documentation by reviewing the relevant materials prior to the bulk of claiming occurs. By catching documentation errors related to claiming at strategic times during the documentation timeline, significant financial recoupment can be minimized. In order to have a successful CQRT system, providers must be constructively critical of their agency's work and documentation. ACBH understands that documentation is complicated and that errors and oversights can occur. However, ACBH requires that the CQRT process will consistently identify errors and omissions and take the necessary, permissible actions to address these issues. Providers must only remedy issues in legal and ethical ways; activities such as backdating or altering documents are strictly forbidden.

ACBH Quality Assurance (QA) Office Operated CQRT Participation

ACBH licensed Clinical QA staff provide monthly (or more if needed) trainings and oversight of the CQRT and Authorization process for certain providers and agencies. Newly contracted organizational providers and agencies new to DMC-ODS claiming are required to attend ACBH operated CQRT meetings for a period of time designated by ACBH. Qualified provider representatives to attend CQRT may include an SUD certified counselor or licensed, waived, registered therapist. With special QA ACBH approval, registered SUD counselors may also represent the agency. It is common for new agencies to attend ACBH operated CQRT for 1 year or longer and regular feedback to providers will be given.

Organizational providers with previous CQRT experience in Alameda County are also required to participate in ACBH operated CQRT if they develop new programs or when a Community Based Organization (CBO) that has never claimed to DMC-ODS begins to provide and claim for DMC-ODS. The following circumstances require contracted organizational providers to attend ACBH CQRT within the first 3 months of the beginning of their contract:

- A new agency
- A new program for an existing agency
- A program that is new to DMC-ODS claiming
- Providers with <95% compliance in Chart Reviews and/or other identified problems, etc.

Additionally, providers with Corrective Action Plans (CAPs), or providers that fail to (or inadequately) conduct internal CQRT may be required to return to the ACBH operated



CQRT meetings to receive additional trainings and oversight for a period of time designated by the DMC ODS. Lastly, it is recommended that providers should maintain documentation of their internal chart review process for a period of fifteen (15) years separate from the beneficiary's medical records.

Organizational providers with operational Quality Assurance practices and who also demonstrate 95% or higher compliance in ACBH System of Care chart reviews may not be required to participate in the CQRT process. It is the expectation that all SUD Providers implement internal Quality Assurance practices and that the contracted providers have sufficient experience to train their new staff.

The goals of these monthly 3-hour CQRT sessions are to provide oversight, authorization, and clinical feedback in regard to chart documentation and quality. A Provider must demonstrate consistent competency in the CQRT process and have their Internal CQRT Policy & Procedure approved by the QA office in order to be permitted to continue this monthly process independently.

Episode Opening Date (EOD) Drug Medi-Cal:

The initial period of authorization of services begins with the opening of a client's episode in the INSYST system. The date of this episode opening is referred to as the Episode Opening Date (EOD). The EOD should be the date the beneficiary is admitted to treatment and claiming has started. After that providers have 30 days for outpatient services and 5 days for residential services to establish necessity. If there is no medical necessity the client's episode must be closed. When determination of medical necessity is documented the client's episode remains open to services.

CQRT Chart Review Cycle

The months in which a specific chart must be reviewed depends on the type of provider program and the EOD. The timing of a chart review is referred to as the chart's "CQRT Review Cycle" and is coordinated with the EOD. General guidelines are such that the beneficiary's medical record is required for authorization after the required documents are completed and prior to respective due dates. The Review Cycles section below will go in to additional detail about these requirements. ACBH strongly recommends that the primary counselor or LPHA does a pre-review of required charts prior to CQRT. This helps to ensure that identifiable issues prior to CQRT are addressed. This pre-review by the provider significantly improves the overall efficiency and effectiveness of CQRT. Prior review also provides opportunities for training and accountability for chart documentation. When an episode is closed, those services have ended. Unless re-opened within 30 days, and a beneficiary returns to treatment after a previous episode has been closed, no prior dates or documentation may carry over. If opened within fifteen (15) days of the most



recent episode closing date the provider is required to either complete the entire intake/assessment packet or, after meeting with the client, review, update and date the most recent intake assessment and write a narrative case formulations that reflects changes to the client's presentation and situation(s).. New dates, timelines, documentation, Releases of Information (ROIs), etc. must be established based on the new EOD.

Review Cycles

1. Initial CQRT
 - a. For all programs initial CQRT must occur after initial documentation (client disclosures and consent packet, initial medical necessity, assessment, plan, etc.) is complete and before the due date for these items, for non-residential programs this will be before the 30th day from EOD and for residential programs initial documentation is due within 10 days of the EOD. Due to this, providers are recommended to require initial documentation to be completed prior to due dates to give ample time for CQRT and to address potential issues.
2. Ongoing CQRT
 - a. Charts are reviewed at CQRT after the treatment plan update has been completed and within ninety (90) days of counselor/LPHA signature on the most recent signed and dated treatment plan. When a plan is updated prior to the ninety (90) day cycle then a new ninety (90) day cycle is established.
 - b. Whenever the plan is updated, the chart should be reviewed in the next scheduled CQRT.
 - c. When there is a change in treatment services (goals/objectives) or modality (e.g. from OS to IOS), the plan must be updated. This chart must be reviewed at the next CQRT.
3. Justification for Continuing Treatment Services
 - a. *Justification for Continuing Treatment Services* must be completed no sooner than 5 months and no later than 6 months from the client's EOD, or the date of the previous *Justification for Continuing Treatment Services*.
 - b. Justification for Continuing Treatment Services form must be reviewed at CQRT

Chart Documentation & Preparing for the CQRT

Forms required when participating in a ACBH QA Office CQRT

The following forms are required for the CQRT process. These forms are available at www.ACBH.org/providers/:

- SUD CQRT Authorization Form



- SUD Clinical/Quality Review Regulatory Compliance Tool
- CQRT Minutes
- CQRT Disallowance Code Tracking Sheet
- CQRT Comments Sheet
- CQRT Attendance Sheet

SUD CQRT Authorization Form

Each chart to be reviewed at CQRT must have the SUD CQRT Authorization form completed by the primary counselor or LPHA. This form is an overview of medical necessity and provides context and information necessary for the CQRT reviewer to make a determination about authorization of DMC-ODS services. The counselor or LPHA and their supervisor both sign and date the form and indicate if they recommend approval of authorizing proposed services. This form is submitted along with the medical chart to CQRT. References to chart, medical record or record are interchangeable terms.

SUD Clinical/Quality Review Regulatory Compliance Tool

Each chart brought to CQRT must include a form called the *SUD Clinical/Quality Review Regulatory Compliance Tool*. This form will be used in either a Quality Review or Clinical Review to guide the CQRT process and ensure that all necessary elements are reviewed during CQRT. A Quality Review is more comprehensive and will be completed for 15% of charts required at each CQRT. The more comprehensive Quality Review monitors both elements that may result in disallowances and those related to quality of documentation. A Clinical Review includes items that will cause disallowances and other required items, such as those that verify informing materials have been properly signed.

As the CQRT Reviewer conducts their review of the medical chart they will mark each item that is in compliance as “Yes,” each item not in compliance as “No,” and each item Not Applicable as “N/A.” N/A should only be used when the item is definitively not applicable. Once the reviewer completes their review, they return to the Authorization Form, sign, date, and make their authorization recommendation. These options will be explained in further detail below.

CQRT Minutes

The provider must complete this form with the client’s name, the provider reporting unit, and the client’s INSYST number. After each review, the chairperson will indicate whether or not the chart has been approved, or is required to be returned to the next CQRT meeting due to deficiencies.

Chart Requirements

The following list of documentation categories must be easily located in any chart



brought to the CQRT. Each category has a distinct set of documentation requirements that follow the Regulatory Compliance Tool. The list is intended to guide clinicians to create and maintain a well-documented chart that meets the mandatory CA-DHCS and ACBH criteria. Charts brought to ACBH operated CQRT must contain all of the necessary documentation to complete the CQRT review. As many documents will be stored electronically in Clinician's Gateway and Laserfiche, these should be printed and organized ahead of time. Agencies, at their internal CQRT, have the option of choosing a different process.

All staff should refer to their program's policies and procedures for complete chart requirements and the ACBH SUD QA Manual.

- Pre-Admission Health Questionnaire
- ASAM Level of Care (A-LOC)
- Intake/Assessment
- Consent to Services
- Releases of Information
- Confidentiality Agreements
- Program Rules
- Client Rights and Fair Hearing
- Medical Necessity-DSM/ICD 10 Diagnosis & Criteria
- Justification of Continuing Treatment Services (if applicable)
- Treatment Plan(s)
- Progress Notes from last 60 days of services
- Discharge Plan or Discharge Summary

The CQRT Process

The CQRT process is a required review of all client charts. The CQRT process is in accordance with the California Department of Health Care Services (DHCS) policies and standards, and with policies established by ACBH. A chart with documentation deficiencies may be given a provisional 1-month approval in which to address deficiencies and be re-reviewed the next month.

The ACBH QA CQRT consists of an ACBH Chairperson and qualified representatives (SUD certified counselor, licensed, waived, registered therapist) appointed by programs to bring their charts for review and authorization. Representatives must have attended the "ACBH SUD Clinical Documentation Training" prior to participating in the CQRT.

Programs must designate a consistent person to regularly attend the CQRT as well as backup staff that are equally trained and established in both the CQRT procedures and the DMC-ODS and ACBH documentation standards. The designated staff must be either



a certified/registered SUD counselor or LPHA. During the meeting, agency representatives address questions raised about their programs' charts by other reviewers and also act as reviewers of other program's charts. Reviewers may identify documentation issues, make recommendations for corrective action and give positive feedback.

Clinical vs. Quality Reviews:

Fifteen percent (15%) of the total number of charts receive an in-depth review, also referred to as a Quality Review. This Quality Review uses the Quality Review Regulatory Compliance Tool form which lists questions regarding basic chart documentation standards. Charts receiving a Quality Review should be reviewed first. The other 85% of charts receive a Clinical Review using the Clinical Review Regulatory Compliance Tool. Both the Clinical and Quality Reviews are explained in more detail below. If a chart is being returned with corrections after a provisional 1-month authorization, it is reviewed only for those corrections.

Chart Reviews Procedures:

Whether completing a Clinical or Quality Review, as concerns or deficiencies are found, it is suggested that they be noted on a separate sheet while the review continues. When the review is completed, consultation will occur about those issues with that chart's program representative. Very often, representatives can answer questions and find documents or information that resolves the issue. If the representative cannot help, then bring the chart to the Chair for consultation. Feedback about the strengths and/or alternative clinical approaches is also welcomed.

The assigned QA- ACBH CQRT Reviewer signs the form and indicates whether or not the chart has been approved for authorization as follows:

Full Authorization/No Return: Medical necessity and documentation meet requirements. Chart/Services have been fully approved.

Provisional Authorization/30 Day Return: Medical necessity has been established; may need some further clarification or expansion. Assessment and/or Treatment Plan are present but may need updating. Issues that are present do not currently impact claiming, but if not addressed will impact quality of treatment and/or claiming. Issues need to be corrected and chart returned at the next CQRT. If a chart is being returned with corrections after a provisional 1-month authorization, it is reviewed only for those corrections. When the chart is returned in 1 month, attach the previous CQRT Request Form which notes the needed corrections.

No Authorization: The designated QA-ACBH CQRT Chairperson will determine which charts cannot continue to bill for services until the essential corrections have been completed. The CQRT Chairperson will also determine if claimed services



needs to be backed out of INSYST. The following circumstances may prohibit the chart's authorization and/or require claimed services to be backed out of INSYST:

- Medical Necessity has not been documented
- Justification for Continuing Treatment Services has not been documented
- An incomplete or absent Assessment
- An incomplete or absent Treatment Plan
- For 30-day Returns that were reviewed during the previous month's CQRT: Failure to correct items from the prior provisional 30-day authorization period.

After each chart review, the Chairperson will review the form, discuss the results, and then issue a "Full Compliance", a "30-Day to Compliance", or "Non-Compliant" notice. The Chairperson may provide comments, will indicate the date in which the chart is to be returned to CQRT, and then sign the form with a full signature.

Complaints/Grievances and Appeals Processes

Complaint/Grievance Process

PURPOSE

This policy addresses the need to ensure that all ACBH employees, volunteers, sub-contracted and contracted Substance Use (SUD) treatment and service programs operate in accordance with legal and ethical standards. Federal and State laws and regulations protect the confidentiality of patient records maintained by all Substance Abuse Block Grant and Federally funded contracted providers.

AUTHORITY

42 Code of Federal Regulations (CFR) Part 2 Confidentiality of Alcohol and Drug Patient Records; CFR Part 438 Managed Care; California Code of Regulations (CCR) Title 22 Drug Medical (DMC) and the DMC Organized Delivery System (ODS) Special Terms and Conditions (STCs); CCR Title 9 Counselor Certification; Health Insurance Portability and Accountability Act (HIPAA)

SCOPE

All ACBH county-operated programs in addition to entities, individuals and programs providing Substance Use Prevention and/or Treatment services under a contract or subcontract with ACBH.

POLICY

It is the legal and ethical responsibility of all ACBH employees, contracted providers, volunteers and subcontracted providers to use personal and confidential patient, client, employee and County business information (referred collectively as "confidential



information”) in accordance with the law and ACBH policy, and to preserve and protect the privacy rights of the subject of the information as they perform their duties.

GRIEVANCE

All consumers of services provided by ACBH and its contractors have the right to file a grievance and/or appeal and every effort should be made by providers to resolve consumer and program concerns as quickly and simply as possible. However, it is the policy of ACBH that consumers may use ACBH’ grievance and appeal process at any time and the consumer and/or family member may use ACBH’ grievance and appeal process without fear of retaliation from ACBH or its’ contractors.

All ACBH county-operated behavioral health programs, including both Mental Health (MH) and Substance Use Disorder (SUD) programs, and MHSA-funded programs in addition to entities, individuals and programs providing behavioral health and MHSA-funded services under a contract or subcontract with ACBH shall adhere to the ACBH Consumer and Family Grievance and Appeal Policy.

A **Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination described below in the Medi-Cal Appeal process. The definition specifies that grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary’s rights regardless of whether remedial action is requested, and the beneficiary’s right to dispute an extension of time proposed by the BHP to make an authorization decision. Filing Grievances:

- A. Grievances may be filed with ACBH by the consumer, their family member or other support person. This includes:
 1. Consumers age 18 or over
 2. Parents/guardians of children and youth receiving services
 3. Youth between the ages of 14 and 18 who are receiving services
 4. A consumer-designated representative (i.e. family member, friend, service provider, other client, or trained advocate) may file grievance or assist the consumer in the process at any time.
 - a. If a personal representative is not employed by ACBH or a ACBH contractor, consumer confidentiality must be protected; the consumer must give verbal consent and/or sign an Authorization for Release of Confidential Information form, available at all sites, in order to allow ACBH to discuss the issue(s) with the representative.
- B. Grievances to ACBH may be filed orally, in writing, or in person by using ACBH’ Grievance or Appeal Request form, available at all provider sites.
- C. Grievances may be filed by a consumer 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, or
At Mental Health Association, 954 60th Street, Suite 10,
Oakland, CA 94608

- D. Assistance filing a grievance may be obtained by calling the Consumer Assistance Line listed above. Grievances filed orally or in person will be entered on a grievance call form by the staff member receiving the grievance.

Processing of Grievances

Grievance processing by ACBH may take a minimum of ninety days to investigate and process.

- A. When a grievance is filed with ACBH, a written acknowledgement of receipt of the grievance will be issued to the grievant by the Consumer Assistance staff person who received the request within five (5) calendar days
1. The acknowledgement letter will include the date of receipt, as well as the name, telephone number, and address of the ACBH representative who the beneficiary may contact about the grievance.
- B. The grievance will then be assigned to the appropriate staff person to resolve it.
1. The grievance investigator must not have been involved in any previous level of review or decision-making related to the grievance being processed.
 2. Grievances that are non-clinical in nature will be handled by a Consumer/Family Assistance Specialist who has experience in resolving non-clinical consumer issues.
 3. Grievances that are clinical in nature will be handled by a licensed behavioral health professional in the ACBH Quality Assurance Office as clinical issues must be handled by a health care professional with the appropriate clinical expertise in treating the condition of the consumer filing the grievance.
 4. Grievances regarding the MHSA-related issues listed below shall be forwarded to the designated party, as appropriate, who shall process the grievance per the guidelines and timeframes listed in this policy:
 - a. Grievances regarding MHSA-funded housing services shall be referred to the ACBH Housing Services Director.
 - b. Grievances regarding input at a public meeting related to MHSA or MHSA-funded training shall be referred to the ACBH MHSA Senior Planner and/or the ACBH Training Coordinator.
 - c. Grievances regarding MHSA-funded consumer related/wellness events shall be referred to the ACBH Consumer Empowerment Manager.
 - d. MHSA-related grievances regarding family members' participation, education, and support programs shall be referred to the ACBH Family Empowerment Manager.



- C. The grievance investigation shall involve a personal contact with the grievant, whenever possible; this can take place via telephone.
- D. The Consumer Assistance Specialist or party resolving the grievance has the responsibility to provide information on request by the consumer or their representative regarding the status of the grievance.
- E. A written decision notifying the consumer and/or their representative of the outcome of the grievance, a Notice of Grievance Resolution (NGR) and date of decision shall be sent within ninety (90) calendar days from the date the grievance was received.
 - 1. If unable to contact the consumer and/or their representative, notification or efforts to notify them should be documented.
 - 2. If the grievance is not resolved within ninety (90) calendar days and an extension is not requested or determined to be in the best interest of the consumer, ACBH shall notify the consumer/representative of the delay in grievance processing using the form titled Notice of Adverse Benefit Determination (NOABD), which includes information about how to request a State Fair Hearing.
- F. The timeframe to resolve a grievance may be extended by up to fourteen (14) calendar days if the consumer/representative requests an extension or if ACBH determines that there is a need for additional information and that the delay is in the best interest of the beneficiary (consumer).
- G. The party resolving the grievance shall be responsible for notifying the Executive Director(s), or their designee, of the service provider(s) named in the grievance, of the content of the grievance and the resolution on a Notification of Disposition (Provider) form which shall be given directly to the provider or mailed by the resolution deadline.
- H. For MHSA-related grievances that have been resolved by ACBH staff other than ACBH Consumer Assistance or the ACBH Quality Assurance Office, a copy of the written decision to the consumer and Notification of Disposition letter to provider (if applicable) along with copies of any relevant supporting materials, shall be sent to the ACBH Quality Assurance Office within five (5) business days of the date of decision.

Consumer Appeals (only applies to Medi-Cal beneficiaries receiving Medi-Cal funded services)

An **Appeal** is a review of an Adverse Benefit Determination. An Adverse Benefit Determination is defined to mean any of the following actions taken by ACBH or a ACBH-contracted provider:



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.

When any of the above actions occur, the Behavioral Health Plan (BHP) is required to issue a Notice of Adverse Benefit Determination (NOABD), however, a Medi-Cal beneficiary does not need to have received a NOABD in order to request an appeal. Note: *Only Medi-Cal beneficiaries may file a Standard or Expedited Appeal regarding a NOABD for a behavioral health service. Appeals are not available to beneficiaries that are not happy with the outcome of their grievances.*

Filing and Processing an Appeal may take a minimum of sixty days

- A. Appeals may be filed with ACBH by the consumer, their family member or other support person.

This includes:

1. Clients age eighteen (18) or over
 2. Parents/guardians of children and youth receiving services
 3. Youth between the ages of fourteen (14) and eighteen (18) who are receiving services
 4. A consumer-designated representative (i.e. family member, friend, service provider, other client, or trained advocate) may file the appeal or assist the consumer in the process at any time.
 - a. If a personal representative is not employed by ACBH or a ACBH contactor, consumer confidentiality must be protected; the consumer must give verbal consent and/or sign an Authorization for Release of Confidential Information form, available at all sites, in order to allow ACBH to discuss the issue(s) with the representative.
- B. The appeal process described in this policy is only available through ACBH and is not available at the contracted-provider level.
- C. Standard Appeals to ACBH may be filed orally or in writing using ACBH' Grievance or Appeal Request form, available at all provider sites. An oral appeal must be followed up with a written appeal.



1. If the consumer received a NOABD, the appeal must be filed within sixty (60) calendar days of the date of the NOABD. If the consumer did not receive a NOABD, there is no deadline for filing; the appeal can be filed at any time.
 2. Appeals may be submitted to ACBH as follows:
 - By phone: (800) 779-0787 Consumer Assistance Line
 - Via US mail: 2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
 3. Assistance filing an appeal may be obtained by calling the Consumer Assistance Line listed above.
 4. When an appeal is filed, a written acknowledgement of receipt will be issued to the consumer/representative within five (5) calendar days.
 5. The ACBH Quality Assurance Office facilitates review and processing of all consumer appeals and shall notify the consumer or their representative in writing about the decision within thirty (30) days after the receipt of the appeal.
 6. Timeframes may be extended by up to fourteen (14) calendar days if the consumer or consumer's representative requests an extension, OR if ACBH feels that there is need for additional information and the delay is for the consumer's benefit.
- D. Expedited Appeals: If taking the time for a standard resolution of an appeal could seriously jeopardize the consumers' life, health, or ability to attain, maintain, or regain maximum functioning, an Expedited Appeal will be granted.
1. An Expedited appeal can be made orally without requiring a written appeal to follow.
 2. Expedited Appeals will be resolved by ACBH within seventy two (72) hours.
 3. If an Expedited Appeal request is denied, ACBH shall make reasonable efforts to give the consumer and/or their represented prompt oral notice of the denial and provide written notice within two(2)calendar days of the date of the denial and the appeal will follow the standard appeal procedure
 - i. The beneficiary will be notified of the right to file a grievance if the beneficiary disagrees with the extension.
- E. Aid Paid Pending: Upon request, a Medi-Cal beneficiary's benefits will continue while an Appeal or Expedited Appeal is pending if the beneficiary files the appeal within ten (10) calendar days from the date a NOA was mailed or given to the beneficiary, or should have been issued. The beneficiary will be notified of this via an "Aid Paid Pending Notice."
- F. State Fair Hearings: Medi-Cal beneficiaries have the right to a State Fair Hearing, conducted by the State of California, if they have already availed themselves of ACBH' appeal process (see section above on who can file an appeal) and are dissatisfied with the resolution. ACBH must abide by any decision reached through a State Fair Hearing.



1. ACBH shall notify the consumer of their right to a State Fair Hearing and how to request a State Fair Hearing. The “Your Rights” notice shall accompany the Notice of Appeal Resolution (NAR) sent to the consumer.
2. State Fair Hearings are not available to beneficiaries who are unhappy with their grievance outcome.
3. Request for a State Fair Hearing must be submitted within one hundred and twenty (120) days from the date of the BHP’s written Notice of Appeal Resolution or NAR.
4. To keep the same services while waiting for a hearing, the consumer must request the hearing within ten (10) days from the date the NAR was mailed or personally given to the consumer OR before the effective date of the change in service, whichever is later.
5. State Fair Hearings may be requested as follows:
 - By phone: (800) 952-5253 TTY/TDD 1-800-952-8349
 - On-line: <http://secure.dss.cahw.net.gov/shd/pubintake/cdss-request.aspx>
 - Write: Department of Social Services/State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

G. Use of the ACBH’ grievance and appeal process does not replace any existing avenues of review or redress provided by law. Consumers have all rights guaranteed under law. Any grievance relating to involuntary 5150 holds, 5250 holds and conservatorships is handled through existing legal remedies such as Patient’s Rights, rather than through this process. Patients’ Rights Advocates: 1 (800) 734-2504 or (510) 835-2505.

Consumer Information Requirements

Providers are required to post the requirements as follows

A. Posting and Informing

1. Providers shall post the Grievance and Appeals Process poster in all threshold languages in a highly visible location for consumers (e.g., waiting room).
2. The forms used for filing a grievance (Grievance and Appeals Process & Request Form) and self-addressed envelopes shall be made readily available at all provider sites for a consumer to pick up without having to make a verbal or written request to anyone. This material shall be made available by providers in all threshold languages.
3. Consumers shall receive written and oral information from their service provider(s) regarding the grievance and appeal process. Informing consumers



- means explaining the process to them in their primary language and reminding them of the process when they express wanting to file a grievance or appeal.
4. Providers shall inform consumers about the grievance and appeal process:
 - a. at the initial face-to-face visit and at admission to any new program or provider,
 - b. annually during treatment reauthorization, and
 - c. when services are modified, denied, or terminated.
 5. The following materials related to this policy are available on the ACBH Provider Website in the QA Manual, Section 10: Beneficiary Rights Informing Materials:
 - a. ACBH Grievance and Appeal Process Information Flyer and Forms (*Available in the County's threshold languages and extra-large font to accommodate persons with visual problems*)
 - b. ACBH Grievance and Appeal Process Poster (*Available in the County's threshold languages*)
 - c. ACBH "Informing Materials – Your Rights and Responsibilities" (*Available in the County's threshold languages*)
 - d. ACBH Policy and procedure: *Consumer Grievance and Appeal Processes* (Shall be made available at all direct treatment programs for review by clients upon request)

B. Documenting

1. Providers shall document that consumers have been informed about the grievance and appeal process at the initial face-to-face evaluation and at admission to any new program or provider.
2. Documentation will be indicated by the check-off box on the ACBH *Informing Materials—Your Rights and Responsibilities Acknowledgement of Receipt* which shall be placed in the consumer's chart.
3. Providers shall also review the grievance and appeal procedure annually with the consumer as part of reviewing all information in the ACBH *Informing Materials – Your Rights and Responsibilities* and document this on the *Acknowledge of Receipt* which shall be placed in the consumer's chart.

Contracted Provider

Internal Consumer Grievance Processes complies with State and Federal regulations and guidelines.

- A. If a ACBH-contracted provider has an internal grievance process for consumers, the process shall be in compliance with all State and Federal regulations and guidelines



and the ACBH policy regarding grievance processes including, but not limited to, grievance resolution timelines, notices to consumers, records retention, and logging. Contracted provider may refer to the ACBH Consumer Grievance and Appeal Manual posted in the Quality Assurance Manual accessible via the ACBH Provider Website for guidelines and notice templates.

- B. Contracted provider shall not require that consumer use or exhaust their internal grievance process prior to accessing ACBH's grievance process.
- C. Appeals as described in the Consumer Appeals section above, may only be filed with and resolved by ACBH and contract providers shall direct consumers who wish to file an appeal to the ACBH Consumer Assistance Line.
- D. Contractor shall maintain a grievance case file for each consumer grievance which, at a minimum, contains all information and documents listed under Retention of Records, Section C below.
- E. Upon resolution of a grievance, contracted provider shall transmit a copy of all information and documents listed under Retention of Records, Section C below within five (5) days of the grievance resolution date.
 - 1. Submit grievance case files to the ACBH Quality Assurance Office Consumer Assistance:
 - By FAX: (510) 639-1346
 - By Secure Email: qaoffice@acgov.org
 - Via US mail: 2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
- F. Contractor shall maintain a grievance log that is kept current and contains all the information listed under Retention of Records, Section B below.
- G. ACBH Quality Management shall monitor that contracted providers' consumer grievance processes including, but not limited to, reviewing provider's consumer grievance resolution policy, grievance log, and/or grievance case files are in compliance with Federal and State regulations and guidelines and this ACBH policy.

Retention of Records

Retention of records is required for seven years, from the date of the original grievance, is required.

- A. The ACBH Quality Assurance Office shall retain a copy of all grievances in locked administrative files, or stored in a secure electronic file, for seven years from the date the original grievance was received unless there are program specific requirements that demand a longer retention period.



B. As required by the Department of Health Care Services (DHCS), the ACBH Quality Assurance Office shall maintain a log of all Medi-Cal grievance/appeals and MHSA-related grievances. Any non-Medi-Cal or non-MHSA grievances shall also be captured on the log for tracking purposes and for use in the annual patterns report to the ACBH Quality Improvement Committee. The log shall contain at least the following information on each grievance or appeal:

1. Name of grievant and grievant's representative, if applicable
2. Date received
3. Medi-Cal ID/Social Security Number for Medi-Cal Beneficiaries
4. A general description of the reason for the appeal or grievance
5. Agency/program name or individual provider name
6. Date received
7. Date of each review and/or review meeting
8. Date acknowledgment letter was mailed out
9. Resolution of appeal and/or grievance
10. Date the letter of decision/notification to beneficiary was mailed out
11. Date of resolution
12. Date letter of extension was mailed out (if applicable)
13. Date Notice of Adverse Benefit Determination was mailed out (if applicable)
14. Date the letter of decision/notification to provider was mailed out
15. Whether program was funded by MHSA/MHSA issues identified

C. Each grievance or appeal shall have an individual case file that includes copies of the following documents:

1. Name of the beneficiary
2. INSYST #
3. Staff name who resolved the grievance/appeal and credentials
4. Documentation of Request for investigation of Grievance or Appeal from Beneficiary or Representative
5. Authorization of Release of Information from Beneficiary
6. Letter of Acknowledgment
7. Provider Notice (Grievance/Appeal) Letter (if appropriate).
8. Investigation Notes
9. Notice of Grievance or Appeal Resolution to Beneficiary with Language Access and Beneficiary Non Discrimination Notice attachments
10. Notification of Grievance or Appeal Disposition to Provider (if appropriate)
11. Supporting Documentation and additional correspondence (emails/records)
12. Letter of Extension (if issued)
13. NOABD (if time frame exceeded)
14. Aid Paid Pending criteria met/Written notice sent to beneficiary (if applicable)



Quality Improvement and Reporting

Quality Improvement activities are conducted and managed by the Quality Management Team of ACBH.

- A. The ACBH Quality Management Program shall track the timeliness of responses to consumer grievances and appeals, the number of cases submitted, types of issues, number of unresolved grievances and appeals and reasons, and number of resolved grievances and appeals.
- B. On an annual basis the ACBH Quality Assurance Office will prepare and submit the Annual Beneficiary Grievances and Appeals Report (ABGAR) for grievances and appeals related to Medi-Cal beneficiaries and mental health services to the California Department of Health Care Services.
- C. On a quarterly basis the ACBH Quality Assurance Office will prepare and submit a report for grievances and appeals related to Medi-Cal beneficiaries and services provided by the ACBH Drug Medi-Cal Organized Delivery System (DMC-ODS) to the California Department of Health Care Services. The report shall follow the DHCS reporting requirements.
- D. At least annually, the ACBH Quality Assurance Office shall present a report on grievances and appeal patterns to the ACBH Quality Improvement Committee (QIC) that is charged with making policy recommendations and developing quality improvement activities to ensure that ACBH consumers are receiving appropriate care. Issues identified as a result of grievance and appeal processes will be transmitted to the QIC to be discussed and, if needed, brought to the attention of the ACBH Executive Team or another appropriate body for further consideration.

Workforce

Increasingly, systems are moving toward a chronic disease and public health model of SUD care that requires a diverse, skilled, and highly trained workforce.

Medical Director

Each SUD treatment site must have a DMC Medical Director that has been approved by the California Department of Health Care Services (DHCS) by submitting Form 6010.

The Medical Director or his/her physician designee must be on site for **at least 8 hours of onsite service per month for each DMC certified program.**



It is advantageous to utilize staff at the highest level of their license and capability as a result of their education and training. Whenever possible, Medical Directors at SUD provider agencies should perform functions that others (e.g., other types of LPHAs) within the agency are unable to optimally perform.

Minimum expectations of Medical Directors of treatment sites within the SUD system:

- Comply with clinical standards of best practice, licensing, accreditation standards and other local, state, and federal regulatory and reporting requirements. Interpret and support standards and requirements to others.
- Research and maintain knowledge of evidenced-based practices, as well as updates regarding treatment of substance use disorders and recovery-based services
- Participate in ACBH-related meetings (e.g., Medical Director meetings, Provider meetings)

Recommended Responsibilities of Medical Directors

The following are some required and recommended responsibilities of Medical Directors and physicians to maximize their benefit and role within the ACSUD DMC-ODS system of care. This is not an exhaustive list, rather is meant to provide guidance on ways Medical Directors' knowledge and expertise can improve quality of care within the system.

Required

- Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a provider representative and the physician
- 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
- 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
- The substance use disorder medical director may delegate his/her 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

Recommended

- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other professional staff with challenging cases (e.g., refractory SUD, co-occurring conditions, certain special populations)
- Lead Quality Improvement functions/projects (e.g., Quality Improvement Projects, leading clinical team meetings, etc.)
- Conduct clinical trainings on issues relevant to professional staff (e.g., documentation, ASAM Criteria, DSM-5, MAT, co-occurring mental health conditions)
- Provide physical exams, when necessary
- Provide Medication-Assisted Treatment, when clinically necessary and within scope of knowledge and practice, and authorized by the DMC ODS
- Provide withdrawal management, when clinically necessary and within scope of knowledge and practice
- Provide or receive physician consultation to (or from) another physician treating client
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other professional staff with challenging cases
- Lead Quality Improvement

ACBH recognizes and values the contributions of contract providers of all sizes and capacities, and also realizes that the composition of a successful SUD system of care must reflect the diversity of needs of the population it serves. While the SUD system has traditionally been staffed by primarily SUD counselors, there is a recognized need to diversify the workforce to include various disciplines and more LPHA staff, including social workers, psychologists, nurses, and physicians, particularly given the requirement for LPHAs to verify medical necessity and eligibility for DMC services and to sign treatment plans.

In addition to ensuring the appropriate types and certifications of providers, a robust workforce must also have sufficient training to ensure that staff have the skillset necessary to meet the needs of its diverse population. As such, trainings and continuing education must be an integral component of professional development, which should include the ASAM criteria and required evidence-based practices (see *Evidence-Based Practices* for more information) for clinical staff.

In summary, it is critical that SUD treatment providers establish a business plan with a hiring



and training strategy to ensure that they have the workforce with the background and training necessary to provide high quality SUD services for their patient population.

Licensed Practitioners of the Healing Arts

A Licensed Practitioner of the Healing Arts (LPHA) is defined as one of the following professional categories:

- Physician* (MD or DO)
- Nurse Practitioner* (NP)
- Physician Assistant* (PA)
- Registered Nurse (RN)
- Registered Pharmacist (RP)
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- License-Eligible Practitioners working under the supervision of licensed clinicians

License-eligible interns or trainees (e.g., those who have not yet received their advanced degree in their respective field) that are not registered with the appropriate state board must be supervised by licensed clinicians and require appropriate co-signatures from the supervising LPHA in order to deliver billable services. Similarly, license-eligible registered interns or trainees are also unable to sign off on documents in lieu of an LPHA thus requiring a co-signature from a LPHA.

All potential licensed prescribers* (MDs, DOs, NPs, PAs) in ACBH's network of care are urged to practice at the top of their licensed capability and to receive sufficient training with MAT to be able to prescribe these medications for addiction on either a routine or case-by-case basis in order to increase client access to this core component of SUD treatment. Of note, only MDs and DOs with required training are permitted to prescribe buprenorphine for addiction, whereas other MAT options can be provided by the full spectrum of potential prescribers.

Professional staff are required to have appropriate experience and necessary training at the time of hiring. LPHAs are required to complete a minimum of five (5) hours of continuing education related to addiction medicine each year. Evidence of this requirement will be requested at time of an audit.

LPHAs are required to attend trainings on Evidence Based Practices (EBP) i.e. ASAM, motivational interviewing, cognitive behavioral therapy, relapse preventions, trauma-informed treatment and psycho-education. Personal files will be monitored for evidence of training in EBP.



Other Professional Staff

Professional staff, including SUD counselors, must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their respective scope of practice laws.

Certified SUD counselors must adhere to all requirements in the California Code of Regulations, Title 9 Chapter 8 and must be certified and/or registered by a DHCS approved credentialing organization.

Services in the withdrawal management setting may be provided by registered or certified SUD counselors or LPHA's, depending on the nature of the service with respect to their scope of practice.

Professional are required to have appropriate experience and necessary training at the time of hiring. LPHAs are required to complete a minimum of five (5) hours of continuing education related to addiction medicine each year. Evidence of this requirement will be requested at time of an audit.

SUD Counselors are required to attend trainings on Evidence Based Practices (EBP) i.e. ASAM, motivational interviewing, cognitive behavioral therapy, relapse preventions, trauma-informed treatment and psycho-education. Personal files will be monitored for evidence of training in EBP.

SUD Counselors and LPHAs who conduct assessments are required, prior to conducting assessments, to complete, at a minimum, the two e-training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Services Planning and Level of Care". All SUD Counselors and LPHAs, at a minimum must complete the module entitled "Introduction to The ASAM Criteria". ACBH will assist with access and the provision of the provider trainings.

SUD Peers Counselors

Peer counselors can provide services once they have been certified as SUD Peer Support Specialists through successful completion of Alameda County Behavioral Care's SUD Peer Support Certification program. For more information refer to section of DMC ODS Practice Guidelines on SUD Peer Support Specialists, Recovery Support Services and SUD Peer Support Specialist Training.

Non Professional Staff

Non-professional staff including clerical, billing, and facility management support shall receive appropriate onsite orientation and training prior to performing assigned duties. Non-professional staff must be supervised by professional and/or administrative leadership.



Non-professional staff are required to have appropriate experience and necessary training at the time of hiring. LPHAs are required to complete a minimum of five (5) hours of continuing education related to addiction medicine each year. Evidence of this requirement will be requested at time of an audit.

For more information on what duties each staff can perform, see the *ACBH Guidelines for Scope of Practice Credentialing* on the ACBH website.

Provider Personnel

Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:

- Application for employment and/or resume
- Signed employment confirmation statement/duty statement
- Job description
- Performance evaluations
- Health records/status as required by the provider, AOD Certification or Title 9
- Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
- Training documentation relative to substance use disorders and treatment
- Current registration, certification, intern status, or licensure
- Proof of continuing education required by licensing or certifying agency and program
- Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well
- All Providers must sign the CBO Oath of Confidentiality

Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:

- Position title and classification
- Duties and responsibilities
- Lines of supervision
- Education, training, work experience, and other qualifications for the position

Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:

- Use of drugs and/or alcohol
- Prohibition of social/business relationship with beneficiary's or their family members for personal gain
- Prohibition of sexual contact with beneficiaries
- Conflicts of interest
- Providing services beyond scope



- Discrimination against beneficiary's or staff
- Verbally, physically, or sexually harassing, threatening, or abusing beneficiary's, family members or other staff
- Protection beneficiary confidentiality
- The elements found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under
- Cooperate with complaint investigations

If a provider utilizes the services of volunteers and or interns, procedures shall be implemented which address:

- Recruitment
- Screening; Selection
- Training and orientation
- Duties and assignments
- Scope of practice
- Supervision
- Evaluation
- Protection of beneficiary confidentiality



DEFINITIONS

Term	Definition
Aid Paid Pending	Associated with Medi-Cal Appeals. Benefits for the beneficiary continue pending review (Aid Paid Pending) if the appeal or expedited appeal is filed within 10 days of when a Notice of Action (NOA) was mailed or given to a beneficiary, or when one should have been issued.
Appeal	<p>An Appeal is a review of an Adverse Benefit Determination. An Adverse Benefit Determination is defined to mean any of the following actions taken by ACBH or a ACBH-contracted provider. 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;</p> <ol style="list-style-type: none"> 1. The reduction, suspension, or termination of a previously authorized service; 2. The denial, in whole or in part, of payment for a service; 3. The failure to provide services in a timely manner; 4. The failure to act within the required timeframes for standard resolution of grievances and appeals; or 5. The denial of a beneficiary's request to dispute financial liability.
Behavioral Health	The term "Behavioral Health" is inclusive of both mental health and substance use disorder (services, treatment, programs, etc....)
Beneficiary	Anyone currently receiving ACBH care or services, or who has received ACBH care or services in the last 12 months. The term 'beneficiary' is also synonymous with 'consumer,' 'patient,'



	or 'client'.
Grievance	<p>An expression of dissatisfaction about any matter other than an Adverse Benefit Determination described below in the Medi-Cal Appeal process. The definition specifies that grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the BHP to make an authorization decision.</p> <p>The term 'grievance' is also synonymous with 'complaint.'</p>
Medi-Cal	The name of California's Medicaid program which provides health coverage to people with low-income, the aged or disabled and those with asset levels who meet certain eligibility requirements.
Behavioral health services	Medi-Cal services provided under county Behavioral Health Plans (BHPs) by behavioral health specialist, both licensed and unlicensed, such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and peer support providers.
State Fair Hearing	Medi-Cal beneficiaries have the right to a State Fair Hearing, conducted by the State of California, if they have availed themselves of ACBH' problem resolution process for NOABD's



	<p>and Appeals and are dissatisfied with the resolution. ACBH must abide by any decision reached through a State Fair Hearing.</p>
<p>Threshold language</p>	<p>Non-English languages spoken by Medi-Cal enrollees and potential enrollees based on a significant number or percentage of persons who speak each language as follows:</p> <ul style="list-style-type: none"> • A population group of mandatory Medi-Cal beneficiaries residing in the Behavioral Health Plan’s service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the beneficiary population, whichever is lower; and • A population group of mandatory Medi-Cal beneficiaries residing in the Behavioral Health Plan’s service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

