BHCS SUD FORMS

For transition to DMC-ODS Waiver

TRAINING OBJECTIVES

- Increase understanding of Alameda County SUD documentation work flow
- Be able to document SUD treatment using required BHCS SUD forms
- Understand different SUD requirements based on program type
- Introduction to CQRT

ACRONYMS USED IN SUD SERVICES

- SUD – Substance Use Disorder
- RES – Residential Services
- OS – Outpatient Services
- IOS – Intensive Outpatient Services
- RS – Recovery Services
- WM – Withdrawal Management Services
- CM – Case Management
- PC – Physician Consultation
- ALOC – ASAM Level of Care
- CG – Clinicians Gateway (EHR)
- BHCS – Behavioral Health Care Services
- IS/IT – Information Systems/Technology
- ROI – Release of Information
- OTP/NTP – Opioid/Narcotic Treatment Provider

HOW TO USE THE FORMS/NOTES

- These forms/notes are temporary until providers have been set up in Clinician's Gateway (CG)
- In order to expedite CG onboarding process, please submit all required documents to BHCS IS/IT as quickly as possible
- The forms are locked fillable Word documents based on upcoming Clinician Gateway templates
- Paper forms are designed to assist in transition to CG
- Forms contain fillable text fields and dropdown menus
  - Use dropdown menus when available
- Forms/Notes may also be printed and filled out by hand

CLAIMING USE BHCS NOTES

- In order to claim a progress note is required
- Forms are not for claiming
  - For example, if a OS SUD Counselor and a beneficiary meet to develop the treatment plan, the SUD Counselor might meet with the beneficiary to discuss treatment plan goals, then later that day or the next day the SUD Counselor sits down to write the plan. The SUD Counselor would document that this way:
    - Possible to write one note
      - Document the face-to-face session with dates and times of service
      - Include documentation date/time for writing the progress note and writing the plan

FORMS/NOTES AVAILABLE

Forms

- Initial Medical Necessity
- Assessment
- ALOCs
- ROIs
- Informing Materials
- Treatment Plan
- Continuing Service Justification
- Continuing Service Justification – Counselor Recommendation Only
- Brief Engagement Tool
- Drug Test
- Discharge Summary
- Discharge Plan

Progress Notes

- RES Single Service
- RES – Daily Note
- WM RES - Single Service
- IOS/OS/RS – Group Service
- IOS/OS/RS – Single Service
- Informational Note (non-billable)

CQRT

- QA is hosting a comprehensive CQRT Training July 19, 2018 at 2000 Embarcadero from 9a-4p
  - All SUD providers except NTP/OTP are required to attend
- QA will lead monthly CQRT meetings with all SUD providers at BHCS QA Offices
  - RES providers are scheduled for every 3rd Thursday from 9a-3p
  - OS/IOS/RS providers are scheduled for every 4th Thursday from 9a-3p

- The purpose of CQRT is to **authorize** SUD treatment services during the assessment and treatment planning phase of treatment
  - CQRT also monitors documentation requirements to ensure claims are accurately made and documented

SUD MEDICAL NECESSITY

In DMC-ODS there are two essential components to establishing medical necessity:

- Included SUD Diagnosis
- ASAM Level of Care

INCLUDED SUD DIAGNOSES

- Diagnoses that are treatable through DMC-ODS SUD treatment are indicated on the Alameda County SUD Diagnoses Included List
  - Must use the most recent list published by BHCS on 1/4/18
  - Only diagnoses on this list may be treated through SUD services
- The beneficiary must meet criteria as specified in the DSM-5 for the established diagnoses
- Only LPHAs may establish a diagnosis
  - Unlicensed LPHAs must have their diagnoses and medical necessity forms reviewed and co-signed by a licensed LPHA
  - The LPHA establishing the diagnosis must meet face-to-face or via telehealth with the beneficiary or with the SUD counselor who completed the intake

BHCS INITIAL MEDICAL NECESSITY FORM

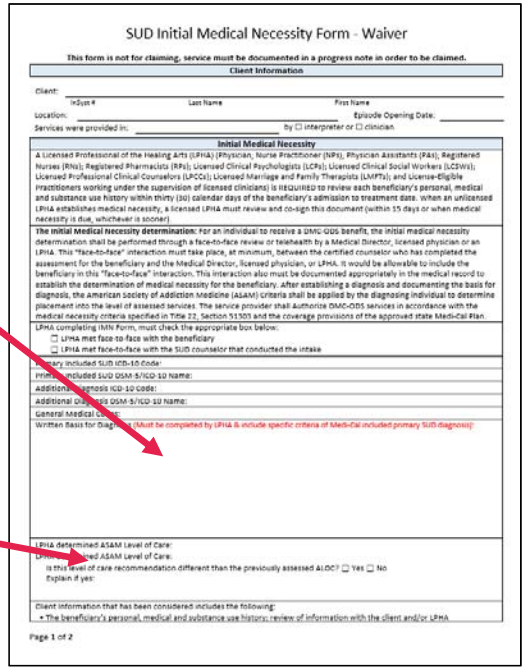
Required for all treatment modalities

- IOS/OS/RS – Due within 30 days of date of admission
- RES – Due within 5 days of date of admission
  - Part of pre-authorization packet required by BHCS UM
- WM RES (ASAM 3.2) – Due within 24 hours of admission

BHCS INITIAL MEDICAL NECESSITY FORM

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

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



SUD Initial Medical Necessity Form - Waiver

This form is not for claiming, service must be documented in a progress note in order to be claimed.

Client Information

Client:

InQuis # | Last Name | First Name

Location: | Episode Opening Date:

Services were provided in: | By ☐ interpreter or ☐ clinician

Initial Medical Necessity

A Licensed Professional of the Healing Arts (LPHA) (Physician, Nurse Practitioner (NPs), Physician Assistants (PAs); Registered Nurses (RNs); Registered Pharmacists (RPs); Licensed Clinical Psychologists (LCPs); Licensed Clinical Social Workers (LCSWs); Licensed Professional Clinical Counselors (LPCCs); Licensed Marriage and Family Therapists (LMFTs); and License-Eligible Practitioners working under the supervision of licensed clinicians) is REQUIRED to review each beneficiary's personal, medical and substance use history within thirty (30) calendar days of the beneficiary's admission to treatment date. When an unlicensed LPHA establishes medical necessity, a licensed LPHA must review and co-sign this document (within 15 days or when medical necessity is due, whichever is sooner).

The initial Medical necessity determination: For an individual to receive a DMC-ODS benefit, the initial medical necessity determination shall be performed through a face-to-face review or telehealth by a Medical Director, licensed physician or an LPHA. This "face-to-face" interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. It would be allowable to include the beneficiary in this "face-to-face" interaction. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary. After establishing a diagnosis and documenting the basis for diagnosis, the American Society of Addiction Medicine (ASAM) criteria shall be applied by the diagnosing individual to determine placement into the level of assessed services. The service provider shall Authorize DMC-ODS services in accordance with the medical necessity criteria specified in Title 22, Section 51303 and the coverage provisions of the approved state Medi-Cal Plan

LPHA completing ININ Form, must check the appropriate box below:

☐ LPHA met face-to-face with the beneficiary

☐ LPHA met face-to-face with the SUD counselor that conducted the intake

...ary included SUD ICD-10 Code:

...ries included SUD DSM-5/ICD-10 Name:

Additional ...gnosis ICD-10 Code:

Additional Di...ses DSM-5/ICD-10 Name:

General Medical C...

Written Basis for Diag... (Must be completed by LPHA & include specific criteria of Medi-Cal included primary SUD diagnosis):

LPHA determined ASAM Level of Care:

LPHA ...ed ASAM Level of Care:

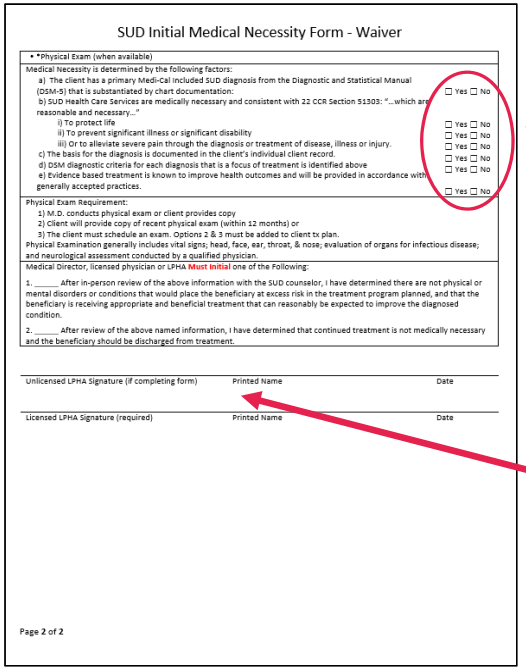
Is this level of care recommendation different than the previously assessed ALOC? ☐ Yes ☐ No

Explain if yes:

Client information that has been considered includes the following:

• The beneficiary's personal, medical and substance use history; review of information with the client and/or LPHA

Page 1 of 2



SUD Initial Medical Necessity Form - Waiver

• •Physical Exam (when available)

Medical Necessity is determined by the following factors:

a) The client has a primary Medi-Cal included SUD diagnosis from the Diagnostic and Statistical Manual (DSM-5) that is substantiated by chart documentation: ☐ Yes ☐ No

b) SUD Health Care Services are medically necessary and consistent with 22 CCR Section 51303: "...which are reasonable and necessary..."

i) To protect life ☐ Yes ☐ No

ii) To prevent significant illness or significant disability ☐ Yes ☐ No

iii) Or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. ☐ Yes ☐ No

c) The basis for the diagnosis is documented in the client's individual client record. ☐ Yes ☐ No

d) DSM diagnostic criteria for each diagnosis that is a focus of treatment is identified above ☐ Yes ☐ No

e) Evidence based treatment is known to improve health outcomes and will be provided in accordance with generally accepted practices. ☐ Yes ☐ No

Physical Exam Requirement:

1) M.D. conducts physical exam or client provides copy

2) Client will provide copy of recent physical exam (within 12 months) or

3) The client must schedule an exam. Options 2 & 3 must be added to client tx plan.

Physical Examination generally includes vital signs; head, face, ear, throat, & nose; evaluation of organs for infectious disease; and neurological assessment conducted by a qualified physician.

Medical Director, licensed physician or LPHA **Must Initial** one of the Following:

1. _____ After in-person review of the above information with the SUD counselor, I have determined there are not physical or mental disorders or conditions that would place the beneficiary at excess risk in the treatment program planned, and that the beneficiary is receiving appropriate and beneficial treatment that can reasonably be expected to improve the diagnosed condition.

2. _____ After review of the above named information, I have determined that continued treatment is not medically necessary and the beneficiary should be discharged from treatment.

Unlicensed LPHA Signature (if completing form) | Printed Name | Date

Licensed LPHA Signature (required) | Printed Name | Date

Page 2 of 2

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

Can only be completed by an LPHA

- If completed by an unlicensed LPHA, a licensed LPHA must review and co-sign the form
- If not, medical necessity will not have been established and claims will be disallowed

CONTINUING SERVICES JUSTIFCATION

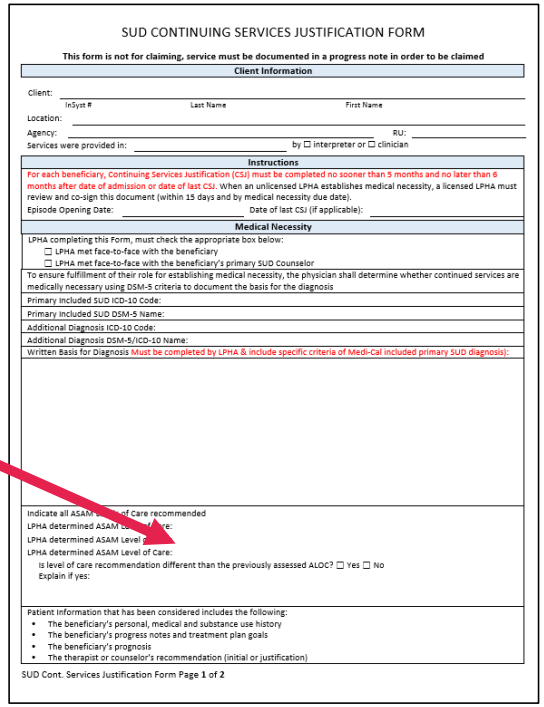
Required for all treatment modalities

- Must be completed every 5 to 6 months of treatment
  - No sooner than every 5 months and no later than every 6 months from the date of admission or most recent continuing services justification
- Similar to the Initial Medical Necessity Form
  - The LPHA establishing the diagnosis must meet face-to-face or via telehealth with the beneficiary or with the **primary** SUD counselor
  - Unlicensed LPHA requires licensed LPHA review and co-signature

CONTINUING SERVICES JUSTIFICATION FORM

Only an LPHA may complete this form.

When the beneficiary is receiving multiple levels of care, the LPHA would indicate all levels.



SUD CONTINUING SERVICES JUSTIFICATION FORM

This form is not for claiming, service must be documented in a progress note in order to be claimed

Client Information

Client: _____
InSyst # Last Name First Name

Location: _____

Agency: _____ RU: _____

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

Instructions

For each beneficiary, Continuing Services Justification (CSJ) must be completed no sooner than 5 months and no later than 6 months after date of admission or date of last CSJ. When an unlicensed LPHA establishes medical necessity, a licensed LPHA must review and co-sign this document (within 15 days and by medical necessity due date).

Episode Opening Date: _____ Date of last CSJ (if applicable): _____

Medical Necessity

LPHA completing this Form, must check the appropriate box below:
☐ LPHA met face-to-face with the beneficiary
☐ LPHA met face-to-face with the beneficiary's primary SUD Counselor

To ensure fulfillment of their role for establishing medical necessity, the physician shall determine whether continued services are medically necessary using DSM-5 criteria to document the basis for the diagnosis

Primary Included SUD ICD-10 Code:

Primary Included SUD DSM-5 Name:

Additional Diagnosis ICD-10 Code:

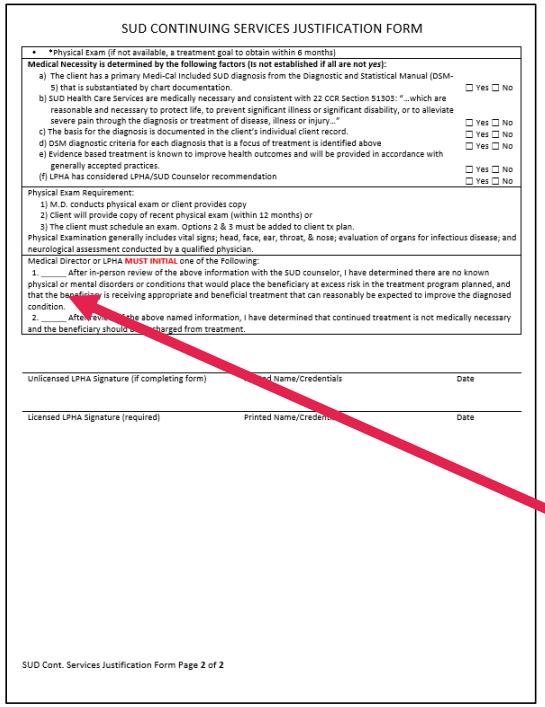
Additional Diagnosis DSM-5/ICD-10 Name:

Written Basis for Diagnosis Must be completed by LPHA & include specific criteria of Medi-Cal included primary SUD diagnosis):

Indicate all ASAM Level of Care recommended
LPHA determined ASAM Level of Care:
LPHA determined ASAM Level of Care:
LPHA determined ASAM Level of Care:
Is level of care recommendation different than the previously assessed ALOC? ☐ Yes ☐ No
Explain if yes:

Patient Information that has been considered includes the following:
- The beneficiary's personal, medical and substance use history
- The beneficiary's progress notes and treatment plan goals
- The beneficiary's prognosis
- The therapist or counselor's recommendation (initial or justification)

SUD Cont. Services Justification Form Page 1 of 2



SUD CONTINUING SERVICES JUSTIFICATION FORM

- *Physical Exam (if not available, a treatment goal to obtain within 6 months)

Medical Necessity is determined by the following factors (Is not established if all are not yes):

a) The client has a primary Medi-Cal included SUD diagnosis from the Diagnostic and Statistical Manual (DSM-5) that is substantiated by chart documentation. ☐ Yes ☐ No
b) SUD Health Care Services are medically necessary and consistent with 22 CCR Section 51303: "...which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury..." ☐ Yes ☐ No
c) The basis for the diagnosis is documented in the client's individual client record. ☐ Yes ☐ No
d) DSM diagnostic criteria for each diagnosis that is a focus of treatment is identified above ☐ Yes ☐ No
e) Evidence based treatment is known to improve health outcomes and will be provided in accordance with generally accepted practices. ☐ Yes ☐ No
(f) LPHA has considered LPHA/SUD Counselor recommendation ☐ Yes ☐ No

Physical Exam Requirement:
1) M.D. conducts physical exam or client provides copy
2) Client will provide copy of recent physical exam (within 12 months) or
3) The client must schedule an exam. Options 2 & 3 must be added to client tx plan.

Physical Examination generally includes vital signs; head, face, ear, throat, & nose; evaluation of organs for infectious disease; and neurological assessment conducted by a qualified physician.

Medical Director or LPHA **MUST INITIAL** one of the Following:

1. _____ After in-person review of the above information with the SUD counselor, I have determined there are no known physical or mental disorders or conditions that would place the beneficiary at excess risk in the treatment program planned, and that the beneficiary is receiving appropriate and beneficial treatment that can reasonably be expected to improve the diagnosed condition.
2. _____ After review of the above named information, I have determined that continued treatment is not medically necessary and the beneficiary should be discharged from treatment.

Unlicensed LPHA Signature (if completing form) Printed Name/Credentials Date

Licensed LPHA Signature (required) Printed Name/Credentials Date

SUD Cont. Services Justification Form Page 2 of 2

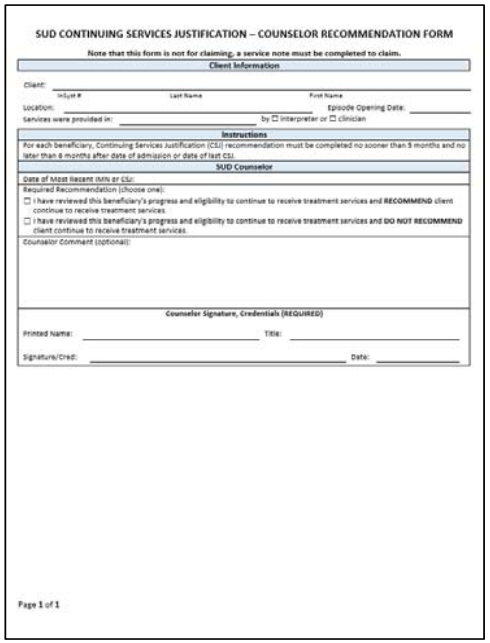
If any are determined to be 'No', medical necessity is not met

The LPHA must initial one of these two statements

CONTINUING SERVICES JUSTIFICATION COUNSELOR RECOMMENDATION FORM

This form must be completed by the Primary SUD Counselor/LPHA.

If an LPHA is the primary SUD provider, they must still complete this recommendation form prior to completing the Continuing Services Justification Form.



SUD CONTINUING SERVICES JUSTIFICATION – COUNSELOR RECOMMENDATION FORM

Note that this form is not for claiming, a service note must be completed to claim.

Client Information

Client: InSyst # Last Name First Name

Location: Episode Opening Date:

Services were provided in: by ☐ Interpreter or ☐ clinician

Instructions

For each beneficiary, Continuing Services Justification (CSJ) recommendation must be completed no sooner than 9 months and no later than 6 months after date of admission or date of last CSJ.

SUD Counselor

Date of Most Recent IMN or CSJ:

Required Recommendation (choose one):

☐ I have reviewed this beneficiary's progress and eligibility to continue to receive treatment services and **RECOMMEND** client continue to receive treatment services.

☐ I have reviewed this beneficiary's progress and eligibility to continue to receive treatment services and **DO NOT RECOMMEND** client continue to receive treatment services.

Counselor Comment (optional):

Counselor Signature, Credentials (REQUIRED)

Printed Name: Title:

Signature/Cred: Date:

Page 1 of 1

ASAM LEVEL OF CARE (ALOC)

- If the beneficiary is referred to SUD services through one of the portals a brief ALOC screening will be provided
  - Often the portals' screening will have incomplete information
  - May have been a phone screening
  - Providers must review the portals' ALOC
    - If no changes are noted the provider may use the portal ALOC for initial authorization. Providers must document their review of this ALOC in a progress note. Both the ALOC and progress note are required as part of UM authorization packet.
    - If any updates are indicated, the provider must rescore a new ASAM (*ALOC Initial Assessment Form*) and submit that to UM
- If the beneficiary has not had an ASAM prior to intake, the provider must complete the *ALOC Initial Assessment Form* according to established timeframes (see next slide)

ASAM LEVEL OF CARE (ALOC) DUE DATES

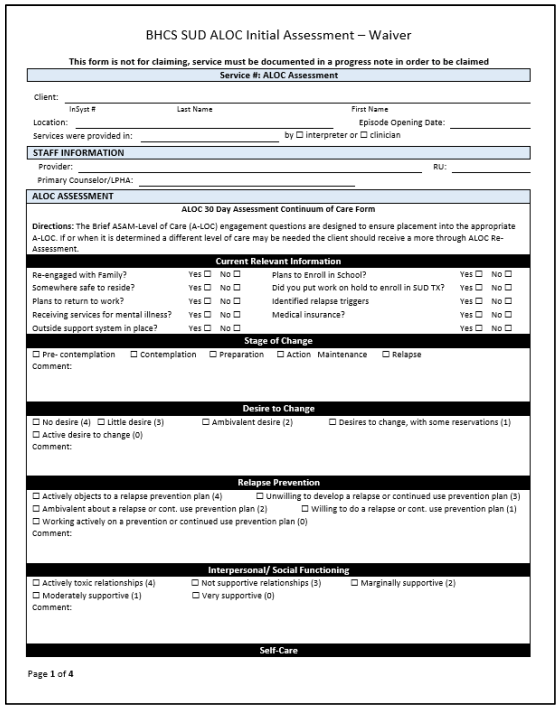
- OS/RS – Due within 30 days from date of admission and then every 90 days
- IOS – Due within 30 days from date of admission and then every 60 days
- RES – Due within 5 days from date of admission and then every 30 days
  - This is a required component of the BHCS UM authorization packet
- WM RES – Due within 24 hours from date of admission and then every 30 days

ASAM LEVEL OF CARE (ALOC)

- Portals – Use *ASAM ALOC Screening Form*
- All other providers use ASAM Level of Care Assessment (ALOC)
  - *ALOC Initial Assessment Form*
  - *ALOC Re-Assessment Form*

- These forms are identical and have different names for tracking purposes
  - Using identical ALOCs allows for direct comparison across treatment time frames

ASAM LEVEL OF CARE (ALOC)



BHCS SUD ALOC Initial Assessment – Waiver

This form is not for claiming, service must be documented in a progress note in order to be claimed

Service #: ALOC Assessment

Client: _____
InSyst # Last Name First Name

Location: _____ Episode Opening Date: _____

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

STAFF INFORMATION

Provider: _____ RU: _____

Primary Counselor/LPHA: _____

ALOC ASSESSMENT

ALOC 30 Day Assessment Continuum of Care Form

Directions: The Brief ASAM-Level of Care (A-LOC) engagement questions are designed to ensure placement into the appropriate A-LOC. If or when it is determined a different level of care may be needed the client should receive a more through ALOC Re-Assessment.

Current Relevant Information

Re-engaged with Family?	Yes ☐ No ☐	Plans to Enroll in School?	Yes ☐ No ☐
Somewhere safe to reside?	Yes ☐ No ☐	Did you put work on hold to enroll in SUD TX?	Yes ☐ No ☐
Plans to return to work?	Yes ☐ No ☐	Identified relapse triggers	Yes ☐ No ☐
Receiving services for mental illness?	Yes ☐ No ☐	Medical insurance?	Yes ☐ No ☐
Outside support system in place?	Yes ☐ No ☐		Yes ☐ No ☐

Stage of Change

☐ Pre- contemplation ☐ Contemplation ☐ Preparation ☐ Action Maintenance ☐ Relapse

Comment:

Desire to Change

☐ No desire (4) ☐ Little desire (3) ☐ Ambivalent desire (2) ☐ Desires to change, with some reservations (1)
☐ Active desire to change (0)

Comment:

Relapse Prevention

☐ Actively objects to a relapse prevention plan (4) ☐ Unwilling to develop a relapse or continued use prevention plan (3)
☐ Ambivalent about a relapse or cont. use prevention plan (2) ☐ Willing to do a relapse or cont. use prevention plan (1)
☐ Working actively on a prevention or continued use prevention plan (0)

Comment:

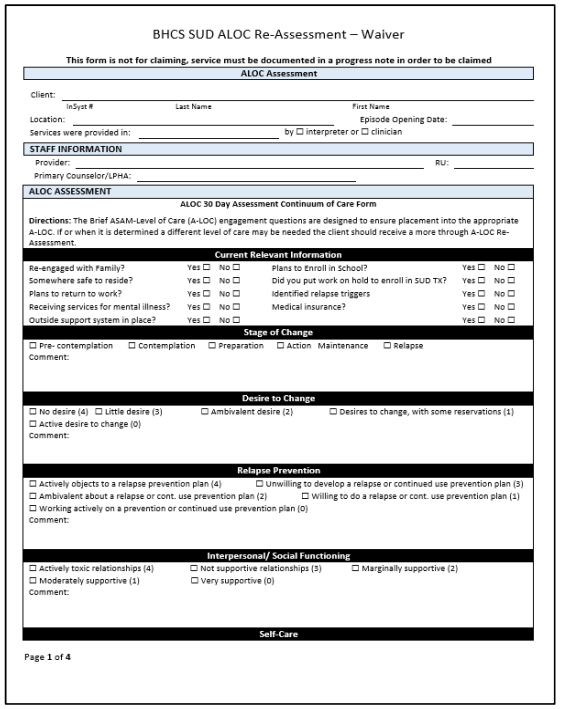
Interpersonal/ Social Functioning

☐ Actively toxic relationships (4) ☐ Not supportive relationships (3) ☐ Marginally supportive (2)
☐ Moderately supportive (1) ☐ Very supportive (0)

Comment:

Self-Care

Page 1 of 4



BHCS SUD ALOC Re-Assessment – Waiver

This form is not for claiming, service must be documented in a progress note in order to be claimed

ALOC Assessment

Client: _____
InSyst # Last Name First Name

Location: _____ Episode Opening Date: _____

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

STAFF INFORMATION

Provider: _____ RU: _____

Primary Counselor/LPHA: _____

ALOC ASSESSMENT

ALOC 30 Day Assessment Continuum of Care Form

Directions: The Brief ASAM-Level of Care (A-LOC) engagement questions are designed to ensure placement into the appropriate A-LOC. If or when it is determined a different level of care may be needed the client should receive a more through A-LOC Re-Assessment.

Current Relevant Information

Re-engaged with Family?	Yes ☐ No ☐	Plans to Enroll in School?	Yes ☐ No ☐
Somewhere safe to reside?	Yes ☐ No ☐	Did you put work on hold to enroll in SUD TX?	Yes ☐ No ☐
Plans to return to work?	Yes ☐ No ☐	Identified relapse triggers	Yes ☐ No ☐
Receiving services for mental illness?	Yes ☐ No ☐	Medical insurance?	Yes ☐ No ☐
Outside support system in place?	Yes ☐ No ☐		Yes ☐ No ☐

Stage of Change

☐ Pre- contemplation ☐ Contemplation ☐ Preparation ☐ Action Maintenance ☐ Relapse

Comment:

Desire to Change

☐ No desire (4) ☐ Little desire (3) ☐ Ambivalent desire (2) ☐ Desires to change, with some reservations (1)
☐ Active desire to change (0)

Comment:

Relapse Prevention

☐ Actively objects to a relapse prevention plan (4) ☐ Unwilling to develop a relapse or continued use prevention plan (3)
☐ Ambivalent about a relapse or cont. use prevention plan (2) ☐ Willing to do a relapse or cont. use prevention plan (1)
☐ Working actively on a prevention or continued use prevention plan (0)

Comment:

Interpersonal/ Social Functioning

☐ Actively toxic relationships (4) ☐ Not supportive relationships (3) ☐ Marginally supportive (2)
☐ Moderately supportive (1) ☐ Very supportive (0)

Comment:

Self-Care

Page 1 of 4

INFORMING MATERIALS

- BHCS Informing Materials are required for all SUD beneficiaries
- Providers may add additional privacy notices, informing forms, etc, if necessary but may not remove or modify any components of the BHCS form
- Providers must review and have signed the informing materials by the treatment plan due date
  - This does not relieve you of your duties to have agreement to consent of treatment, ROIs, etc. in place as required by regulation
    - BHCS required ROIs must be signed prior to releasing any information and prior to entering any information into Clinician's Gateway/InSyst
    - BHCS recommends these documents are signed on the day of admission
- Providers must retain the signature page in the beneficiary's medical record

COMPONENTS OF INFORMING MATERIALS

Informing Materials -- Your Rights & Responsibilities

Welcome to Alameda County Behavioral Health Plan

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

PROVIDER NAME:

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

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

Consent for Services

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

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

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

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

Must review <u>all</u> of these items and check these boxes indicating these items were reviewed

Beneficiary signs here

Alameda County Behavioral Health Care Services

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

Informing Materials -- Your Rights & Responsibilities
Acknowledgement of Receipt

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

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

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

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

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

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

COMPONENTS OF INFORMING MATERIALS

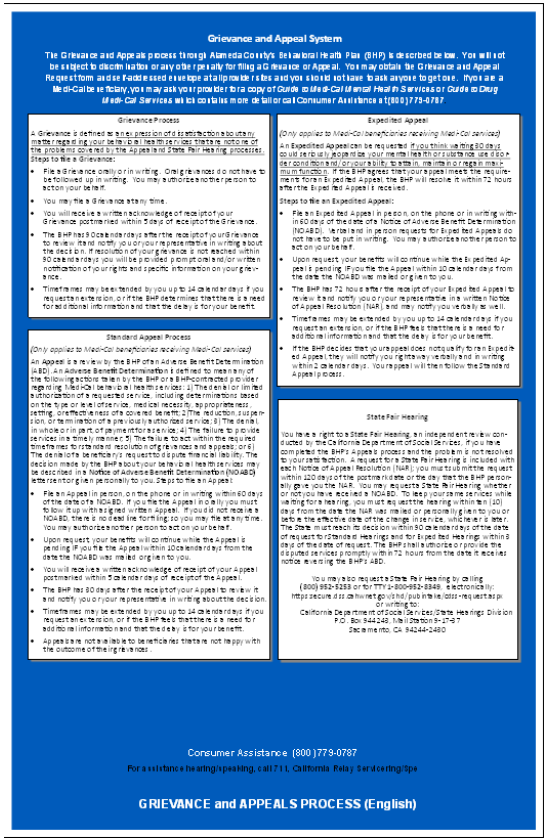
- Consent for Services
- Freedom of Choice
- Confidentiality & Privacy
- Maintaining a Welcoming & Safe Place (not a State-required informing material)
- "Guide to Medi-Cal Mental Health Services" OR "Guide to Drug Medi-Cal Services"
- Provider Directory for Alameda County Behavioral Health Plan
- Beneficiary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

GRIEVANCES

- All of the following BHCS Grievance materials must be posted and available in the lobby:
  - Poster
  - Forms
  - Envelopes

- Beneficiaries with Grievances & Complaints of any type must be referred to the ACBHCS Grievance Line, see poster for more information

BHCS GRIEVANCE POSTER



Grievance and Appeal System

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

Grievance Process

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

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

Standard Appeal Process

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

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

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

Expedited Appeal

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

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

Steps to file an Expedited Appeal:

- File an Expedited Appeal in person, on the phone or in writing within 60 days of the date of the Notice of Adverse Benefit Determination (NOABD). Actions and in person requests for Expedited Appeals do not have to be put in writing. You may authorize another person to act on your behalf.
- Upon request, your benefits will continue while the Expedited Appeal is pending. If you file the Appeal within 10 calendar days from the date the NOABD was mailed or given to you.
- The BHP has 72 hours after the receipt of your Expedited Appeal to review it and notify you or your representative in a written Notice of Appeal Resolution (NAR), and may notify you verbally as well.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the BHP feels that there is a need for additional information and that the delay is for your benefit.
- If the BHP decides that your appeal does not qualify for an Expedited Appeal, they will notify you right away verbally and in writing within 2 calendar days. Your appeal will then follow the Standard Appeal process.

State Fair Hearing

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

You may also request a State Fair Hearing by calling (800) 952-5253 or for TTY (800) 952-8349, electronically: https://secure.dss.ca.gov/CDSS/Forms/public/cdss-request.aspx or writing to:

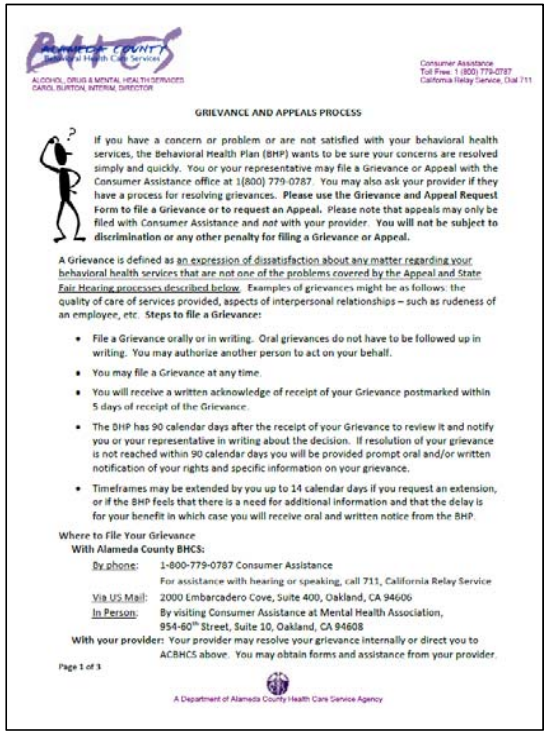
California Department of Social Services, State Hearings Division
P.O. Box 944243, Mail Station 9-17-7
Sacramento, CA 94244-2430

Consumer Assistance (800) 779-0787

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

GRIEVANCE and APPEALS PROCESS (English)

GRIEVANCE & APPEAL PROCESS



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

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

GRIEVANCE AND APPEALS PROCESS

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

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

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

Where to File Your Grievance

With Alameda County BHCS:

By phone: 1-800-779-0787 Consumer Assistance
For assistance with hearing or speaking, call 711, California Relay Service

Via US Mail: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606

In Person: By visiting Consumer Assistance at Mental Health Association, 954-60th Street, Suite 10, Oakland, CA 94608

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

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A Department of Alameda County Health Care Service Agency

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

Steps to file an Appeal:

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

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

Steps to file an Expedited Appeal:

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

Page 2 of 3 QA: Grievance & Appeal Information 6-25-2018

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

Where to File Your Appeal

With Alameda County BHCS:

By phone: 1-800-779-0787 Consumer Assistance
For assistance with hearing or speaking, call 711, California Relay Service

Via US Mail: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606

In Person: By visiting Consumer Assistance at Mental Health Association, 954-60th Street, Suite 10, Oakland, CA 94608

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

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

Consumer Assistance: 1(800) 779-0787

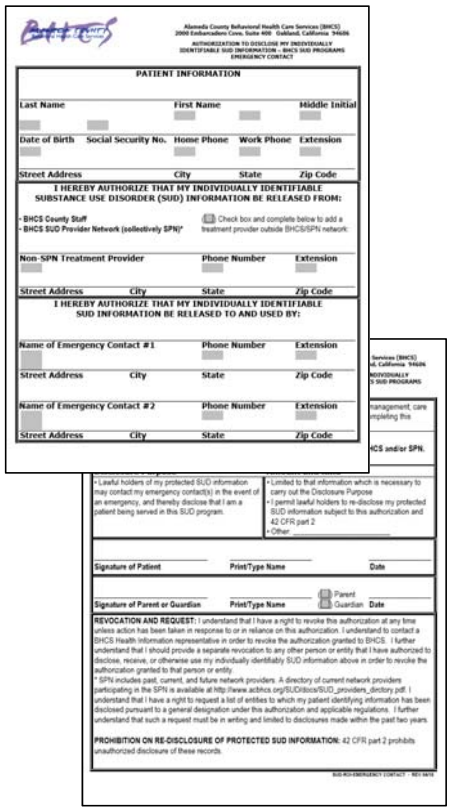
Page 3 of 3 QA: Grievance & Appeal Information 6-25-2018

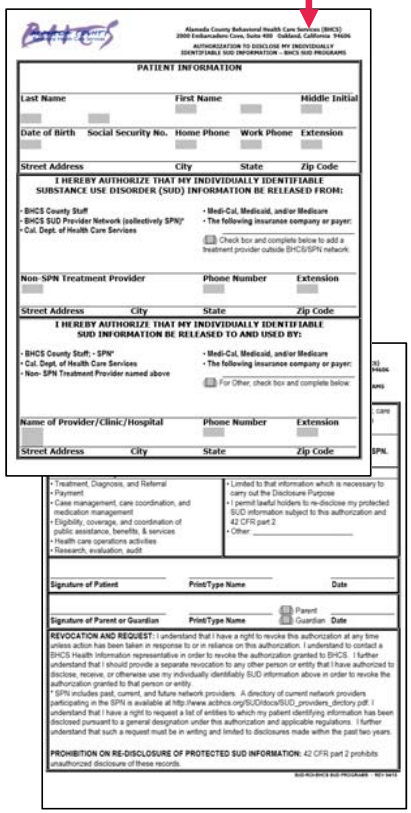
RELEASES OF INFORMATION (ROI)

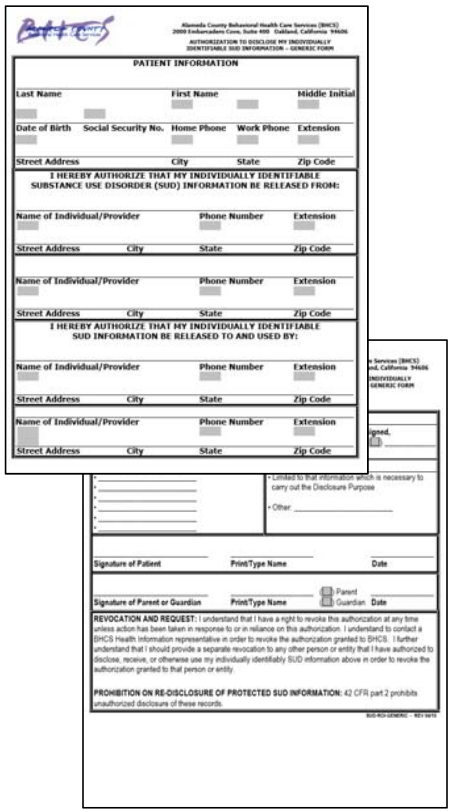
- Required for any contact outside of your agency
- Required BHCS form has been approved by County Counsel
- BHCS has four (4) versions of this two (2) page form:
  - Generic
  - Emergency Contact
  - SUD Programs ← REQUIRED BY DAY ONE AND BEFORE ANY ENTRY INTO INSYST/CG
  - Criminal Justice

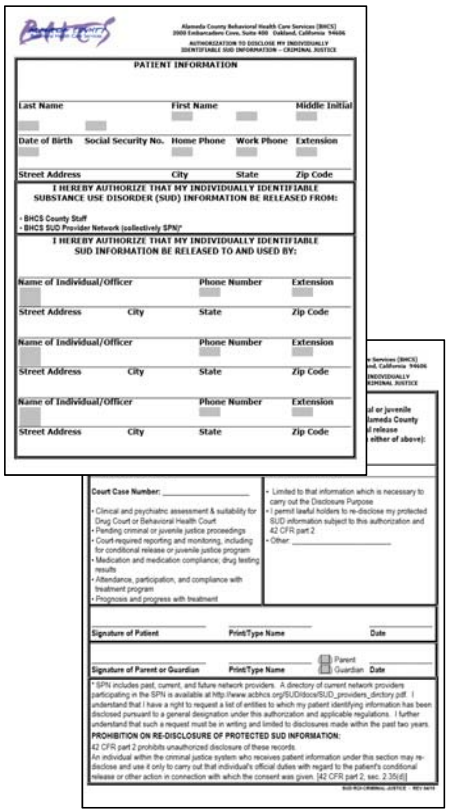
This ROI is required day one for ALL beneficiaries

BHCS ROI SCREENSHOTS









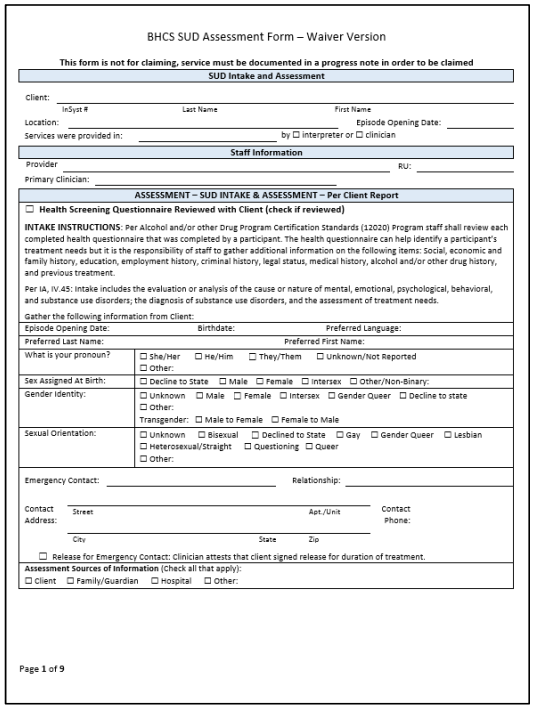
SUD INTAKE ASSESSMENT

Required for all treatment levels

- For OS/IOS/RS
  - Due within 30 days of episode opening date (EOD)
- For RES
  - Due within 10 days of EOD
- For WM RES
  - Due within 24 hours of EOD

- LPHA must review the assessment as part of the determination of medical necessity if assessment client-reported information was collected by a SUD Counselor
  - BHCS form has two signature lines to document completion and LPHA review

SUD INTAKE ASSESSMENT



BHCS SUD Assessment Form – Waiver Version

This form is not for claiming, service must be documented in a progress note in order to be claimed

SUD Intake and Assessment

Client: _____
InSyst # Last Name First Name

Location: _____ Episode Opening Date: _____

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

Staff Information

Provider _____ RU: _____

Primary Clinician: _____

ASSESSMENT – SUD INTAKE & ASSESSMENT – Per Client Report

☐ **Health Screening Questionnaire Reviewed with Client (check if reviewed)**

INTAKE INSTRUCTIONS: Per Alcohol and/or other Drug Program Certification Standards (12020) Program staff shall review each completed health questionnaire that was completed by a participant. The health questionnaire can help identify a participant's treatment needs but it is the responsibility of staff to gather additional information on the following items: Social, economic and family history, education, employment history, criminal history, legal status, medical history, alcohol and/or other drug history, and previous treatment.

Per IA, IV.45: Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; the diagnosis of substance use disorders, and the assessment of treatment needs.

Gather the following information from Client:

Episode Opening Date:	Birthdate: Preferred Language:
Preferred Last Name:	Preferred First Name:
What is your pronoun?	☐ She/Her ☐ He/Him ☐ They/Them ☐ Unknown/Not Reported ☐ Other:
Sex Assigned At Birth:	☐ Decline to State ☐ Male ☐ Female ☐ Intersex ☐ Other/Non-Binary:
Gender Identity:	☐ Unknown ☐ Male ☐ Female ☐ Intersex ☐ Gender Queer ☐ Decline to state ☐ Other: Transgender: ☐ Male to Female ☐ Female to Male
Sexual Orientation:	☐ Unknown ☐ Bisexual ☐ Declined to State ☐ Gay ☐ Gender Queer ☐ Lesbian ☐ Heterosexual/Straight ☐ Questioning ☐ Queer ☐ Other:

Emergency Contact: _____ Relationship: _____

Contact Address: _____ Street Apt./Unit
_____ City State Zip
Contact Phone:

☐ Release for Emergency Contact: Clinician attests that client signed release for duration of treatment.

Assessment Sources of Information (Check all that apply):
☐ Client ☐ Family/Guardian ☐ Hospital ☐ Other:

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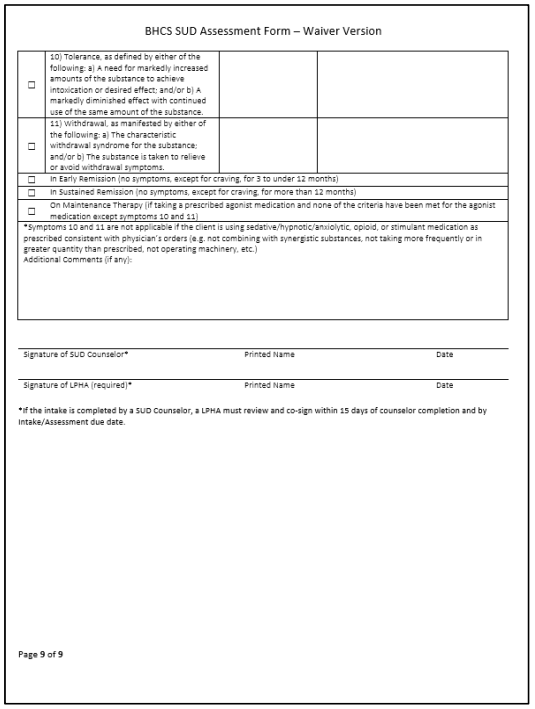
Nine (9) page assessment form



BHCS SUD Assessment Form – Waiver Version

☐	10) Tolerance, as defined by either of the following: a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect; and/or b) A markedly diminished effect with continued use of the same amount of the substance.		
☐	11) Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for the substance; and/or b) The substance is taken to relieve or avoid withdrawal symptoms.		
☐	In Early Remission (no symptoms, except for craving, for 3 to under 12 months)		
☐	In Sustained Remission (no symptoms, except for craving, for more than 12 months)		
☐	On Maintenance Therapy (if taking a prescribed agonist medication and none of the criteria have been met for the agonist medication except symptoms 10 and 11)		

*Symptoms 10 and 11 are not applicable if the client is using sedative/hypnotic/anxiolytic, opioid, or stimulant medication as prescribed consistent with physician's orders (e.g. not combining with synergistic substances, not taking more frequently or in greater quantity than prescribed, not operating machinery, etc.)

Additional Comments (if any):

Signature of SUD Counselor* Printed Name Date

Signature of LPHA (required)* Printed Name Date

*If the intake is completed by a SUD Counselor, a LPHA must review and co-sign within 15 days of counselor completion and by Intake/Assessment due date.

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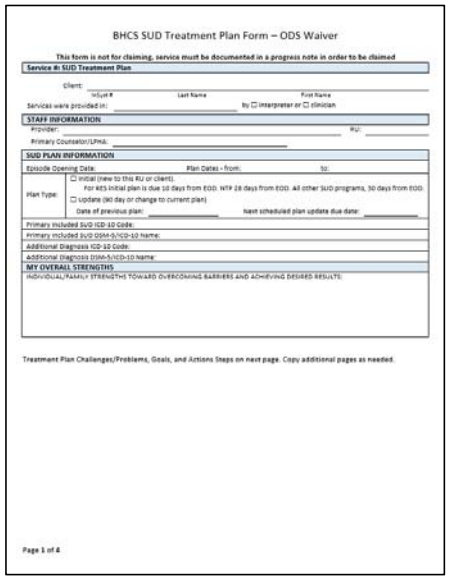
TREATMENT PLAN TEMPLATE

ASI models are currently integrated with this plan, ASAM dimensions coming soon to CG version



BHCS SUD Treatment Plan Form – ODS Waiver

This form is not for claiming, service must be documented in a progress note in order to be claimed

Service #: SUD Treatment Plan

Client: _____ (MSyst # / Last Name / First Name)

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

STAFF INFORMATION

Provider: _____ RU: _____

Primary Counselor/LPHA: _____

SUD PLAN INFORMATION

Episode Opening Date: _____ Plan Dates - from: _____ to: _____

Plan Type: ☐ Initial (new to this RU or client); For KES initial plan is due 10 days from EOD. NTP 28 days from EOD. All other SUD programs, 30 days from EOD. ☐ Update (90 day or change to current plan)

Date of previous plan: _____ Next scheduled plan update due date: _____

Primary included SUD ICD-10 Code:

Primary included SUD DSM-5/ICD-10 Name:

Additional Diagnosis ICD-10 Code:

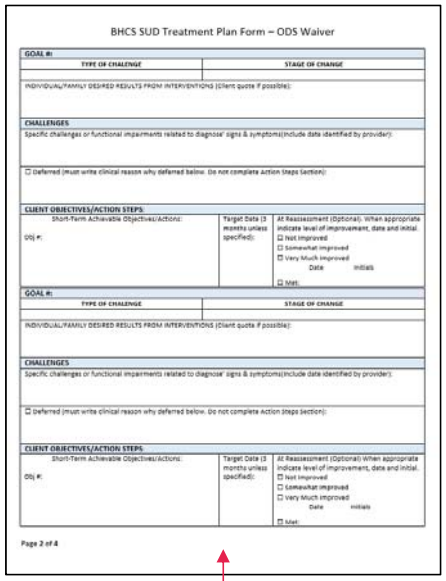
Additional Diagnosis DSM-5/ICD-10 Name:

MY OVERALL STRENGTHS

INDIVIDUAL/FAMILY STRENGTHS TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED RESULTS:

Treatment Plan Challenges/Problems, Goals, and Actions Steps on next page. Copy additional pages as needed.

Page 1 of 4



BHCS SUD Treatment Plan Form – ODS Waiver

GOAL #:

TYPE OF CHALLENGE	STAGE OF CHANGE

INDIVIDUAL/FAMILY DESIRED RESULTS FROM INTERVENTIONS (Client quote if possible):

CHALLENGES

Specific challenges or functional impairments related to diagnosis' signs & symptoms(include date identified by provider):

☐ Deferred (must write clinical reason why deferred below. Do not complete Action Steps section):

CLIENT OBJECTIVES/ACTION STEPS

Short-Term Achievable Objectives/Actions:	Target Date (3 months unless specified):	At Reassessment (Optional): When appropriate indicate level of improvement, date and initial.
Obj #:		☐ Not Improved ☐ Somewhat Improved ☐ Very Much Improved Date Initials ☐ Met:

GOAL #:

TYPE OF CHALLENGE	STAGE OF CHANGE

INDIVIDUAL/FAMILY DESIRED RESULTS FROM INTERVENTIONS (Client quote if possible):

CHALLENGES

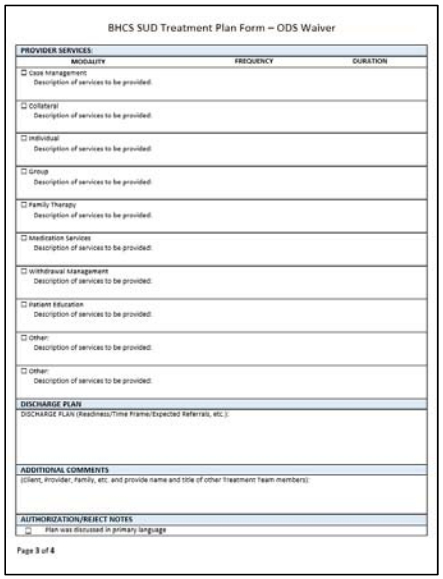
Specific challenges or functional impairments related to diagnosis' signs & symptoms(include date identified by provider):

☐ Deferred (must write clinical reason why deferred below. Do not complete Action Steps section):

CLIENT OBJECTIVES/ACTION STEPS

Short-Term Achievable Objectives/Actions:	Target Date (3 months unless specified):	At Reassessment (Optional) When appropriate indicate level of improvement, date and initial.
Obj #:		☐ Not Improved ☐ Somewhat Improved ☐ Very Much Improved Date Initials ☐ Met:

Page 2 of 4



BHCS SUD Treatment Plan Form – ODS Waiver

PROVIDER SERVICES

MODALITY	FREQUENCY	DURATION
☐ Case Management Description of services to be provided:		
☐ Collateral Description of services to be provided:		
☐ Individual Description of services to be provided:		
☐ Group Description of services to be provided:		
☐ Family Therapy Description of services to be provided:		
☐ Medication Services Description of services to be provided:		
☐ Withdrawal Management Description of services to be provided:		
☐ Patient Education Description of services to be provided:		
☐ Other: Description of services to be provided:		
☐ Other: Description of services to be provided:		

DISCHARGE PLAN

DISCHARGE PLAN (Readiness/Time Frame/Expected Referrals, etc.):

ADDITIONAL COMMENTS

(client, provider, family, etc. and provide name and title of other treatment team members):

AUTHORIZATION/REJECT NOTES

☐ Plan was discussed in primary language

Page 3 of 4

BHCS SUD Treatment Plan Form – ODS Waiver

☐ Individual/Family was offered a copy of this plan

☐ Individual/Family participated in the development of, and agreed to, this plan.

☐ Treatment team member participated in the development of the plan

☐ Provider attests that individual signed the plan on this date:

☐ Provider attests that legal representative (Parent, Legal Guardian, Conservator, etc.) signed or verbally accepted this Plan on this date due to individual inability to sign.

☐ Individual/Family verbally accepts this plan but not able to sign on this date (explain below).

☐ Individual/Family was offered a copy of this plan

☐ Individual/Family declines to sign (explain below).

☐ See progress note describing development of the plan with individual/Family, dated:

TREATMENT TEAM

☐ LPHA

☐ Physician

☐ Psychiatrist ☐ Client is being treated by a non-BHCS psychiatrist

☐ Program Supervisor

☐ Medical Director

☐ Other

This plan also sent to:

AUTHORIZATION/REJECT NOTES

Client Signature / Printed Name / Date

Counselor Signature / Printed Name / Date (plan date)

MD/LPHA Signature* / Printed Name / Date

*MD/LPHA co-signature required when signed by SUD counselor. Co-signature is required within 15 days of counselor signing the plan and within plan due date requirements.

Page 4 of 4

Copy page 2 as needed to add additional goals, problems, or action steps

TREATMENT PLAN DUE DATES

Required for all service modalities

- OS/IOS/RS
  - Due within 30 days from EOD
- RES
  - Due within 10 days from EOD
- WM RES
  - Due within 24 hours from EOD

- Treatment plan updates are due at a minimum of 90 days from date of previous plan (date of primary counselor/LPHA's signature)
  - Plan may need to be updated more frequently based on beneficiary status

TREATMENT PLAN SIGNATURES

- If the SUD Counselor completes the plan, a LPHA must review and co-sign the plan
- LPHA must co-sign the plan within 15 days of the SUD counselor signature and within plan due date
- Beneficiary must sign the initial plan within plan due date
- For plan updates, the beneficiary must sign the updated plan within plan due date
- For all notes, forms, etc., including the treatment plan, all signatures must include legibly printed name, credentials, signature, and date signed

IOS/OS/RS PROGRESS NOTES

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

MINIMUM TIME REQUIREMENTS FOR IOS AND OS

IOS

- Minimum of 9 hours to 19 hours per week of allowable services (adults 21+)
- Minimum of 6 hours to 19 hours per week of allowable services (adolescents aged 12-20)
- Excludes as needed: physician consultation and case management services

OS

- Up to 9 hours per week for adults
- Up to 6 hours per week for adolescents
- Excludes as needed: physician consultation and case management services

Time is recorded in actual minutes – input start/end time accurately on notes

OS/IOS/RS ALLOWABLE SERVICES

OS and IOS :

Assessment, treatment planning; individual and group counseling; patient education; family therapy; medication services; collateral services; crisis intervention services; and discharge planning and coordination.

RS:

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

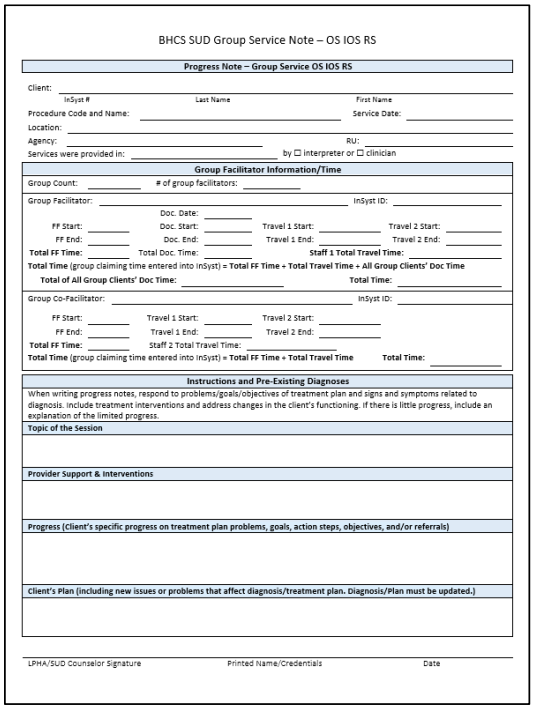
WHY CAN'T IOS PROVIDERS WRITE DAILY NOTES?

- Currently IOS claiming requirements are not met with daily service notes

IOS/OS/RS GROUP CLAIMING

Use this note only for group claims, for all other claims use the single service note

Complete all fields and staff must sign.



BHCS SUD Group Service Note – OS IOS RS

Progress Note – Group Service OS IOS RS

Client: _____
InSyst # Last Name First Name

Procedure Code and Name: _____ Service Date: _____

Location: _____

Agency: _____ RU: _____

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

Group Facilitator Information/Time

Group Count: _____ # of group facilitators: _____

Group Facilitator: _____ InSyst ID: _____

Doc. Date: _____

FF Start: _____ Doc. Start: _____ Travel 1 Start: _____ Travel 2 Start: _____

FF End: _____ Doc. End: _____ Travel 1 End: _____ Travel 2 End: _____

Total FF Time: _____ Total Doc. Time: _____ **Staff 1 Total Travel Time:** _____

Total Time (group claiming time entered into InSyst) = **Total FF Time + Total Travel Time + All Group Clients' Doc Time**

Total of All Group Clients' Doc Time: _____ **Total Time:** _____

Group Co-Facilitator: _____ InSyst ID: _____

FF Start: _____ Travel 1 Start: _____ Travel 2 Start: _____

FF End: _____ Travel 1 End: _____ Travel 2 End: _____

Total FF Time: _____ Staff 2 Total Travel Time: _____

Total Time (group claiming time entered into InSyst) = **Total FF Time + Total Travel Time** **Total Time:** _____

Instructions and Pre-Existing Diagnoses

When writing progress notes, respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Topic of the Session

Provider Support & Interventions

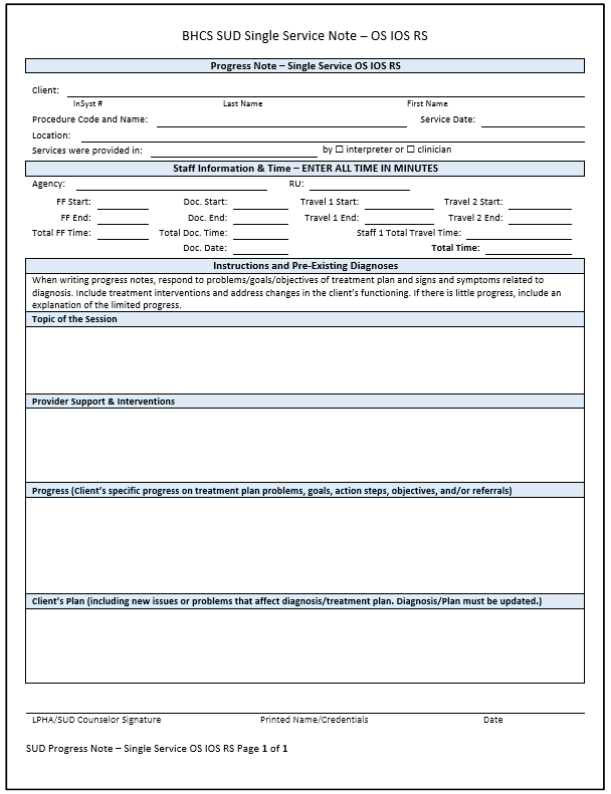
Progress (Client's specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals)

Client's Plan (including new issues or problems that affect diagnosis/treatment plan. Diagnosis/Plan must be updated.)

LPHA/SUD Counselor Signature Printed Name/Credentials Date

OS/IOS/RS SINGLE SERVICE NOTE

- For all other OS/IOS/RS claiming other than groups, a single service note for each activity must be documented
- Use BHCS single service OS/IOS/RS progress note to document these services, including case management and physician consultation (if allowed)



BHCS SUD Single Service Note – OS IOS RS

Progress Note – Single Service OS IOS RS

Client: _____
InSyst # Last Name First Name

Procedure Code and Name: _____ Service Date: _____

Location: _____

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

Staff Information & Time – ENTER ALL TIME IN MINUTES

Agency: _____ RU: _____

FF Start: _____ Doc. Start: _____ Travel 1 Start: _____ Travel 2 Start: _____

FF End: _____ Doc. End: _____ Travel 1 End: _____ Travel 2 End: _____

Total FF Time: _____ Total Doc. Time: _____ Staff 1 Total Travel Time: _____

Doc. Date: _____ **Total Time:** _____

Instructions and Pre-Existing Diagnoses

When writing progress notes, respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Topic of the Session

Provider Support & Interventions

Progress (Client's specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals)

Client's Plan (including new issues or problems that affect diagnosis/treatment plan. Diagnosis/Plan must be updated.)

LPHA/SUD Counselor Signature Printed Name/Credentials Date

SUD Progress Note – Single Service OS IOS RS Page **1** of **1**

RES / WM RES PROGRESS NOTES

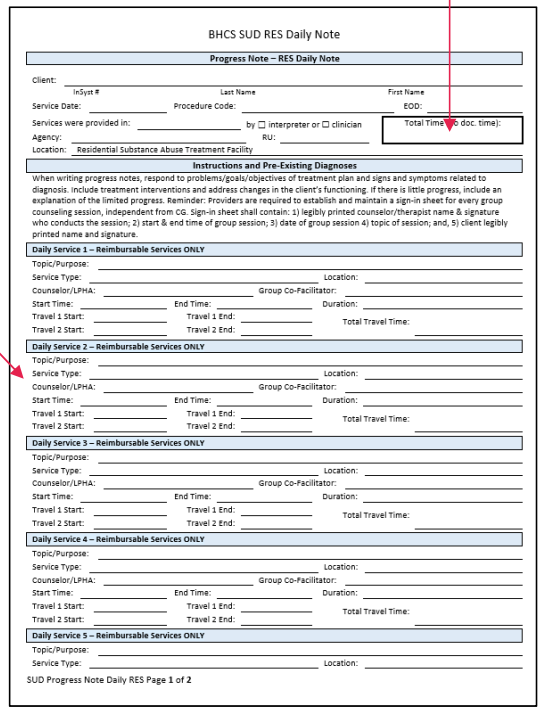
- A daily progress note is required
  - Must be completed within 7 calendar days of the service
- Only include reimbursable activities in this progress note
- Only a staff that has provided a reimbursable service to a beneficiary that day may write that day's progress note
- Services are claimed by the day unit, both in the note and InSyst
- A minimum of 20 hours of residential treatment service components per week are required, These include:
  - Individual and/or group counseling sessions and/or structured therapeutic activities shall be provided for each client in accordance with the client's treatment plan or recovery plan.
  - Of these 20 hours, for:
    - ASAM Level 3.1 – 5 clinical hours required per week
    - ASAM Level 3.3 & 3.5 – 12 clinical hours required per week
  - At least one (1) hour of clinical services must be provided daily

RES DAILY NOTE

Calculate total time and enter here, do not include documentation time as this is used to track service time requirements

Daily services logged separately in these areas

Include intake/assessment, group/individual counseling, family therapy, crisis, treatment planning, discharge planning, patient education, and transportation



BHCS SUD RES Daily Note

Progress Note – RES Daily Note

Client:
InSyst # Last Name First Name

Service Date: Procedure Code: EOD:

Services were provided in: by ☐ interpreter or ☐ clinician Total Time (& doc. time):

Agency: RU:

Location: Residential Substance Abuse Treatment Facility

Instructions and Pre-Existing Diagnoses

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

Daily Service 1 – Reimbursable Services ONLY

Topic/Purpose:
Service Type: Location:
Counselor/LPHA: Group Co-Facilitator:
Start Time: End Time: Duration:
Travel 1 Start: Travel 1 End: Total Travel Time:
Travel 2 Start: Travel 2 End:

Daily Service 2 – Reimbursable Services ONLY

Topic/Purpose:
Service Type: Location:
Counselor/LPHA: Group Co-Facilitator:
Start Time: End Time: Duration:
Travel 1 Start: Travel 1 End: Total Travel Time:
Travel 2 Start: Travel 2 End:

Daily Service 3 – Reimbursable Services ONLY

Topic/Purpose:
Service Type: Location:
Counselor/LPHA: Group Co-Facilitator:
Start Time: End Time: Duration:
Travel 1 Start: Travel 1 End: Total Travel Time:
Travel 2 Start: Travel 2 End:

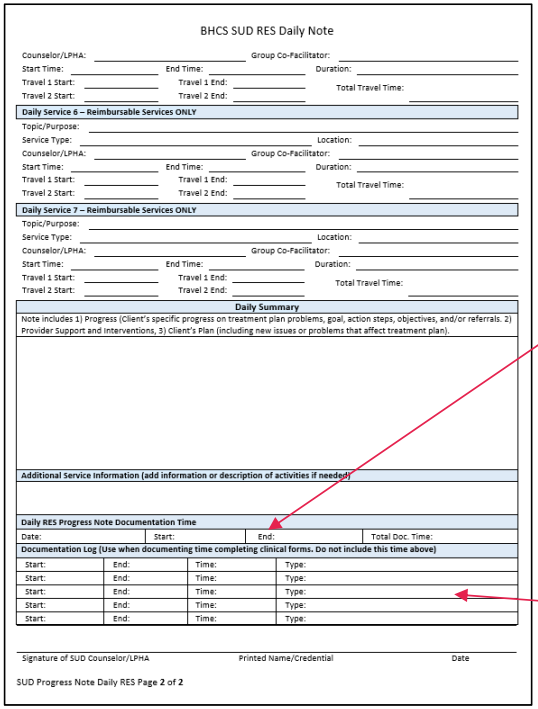
Daily Service 4 – Reimbursable Services ONLY

Topic/Purpose:
Service Type: Location:
Counselor/LPHA: Group Co-Facilitator:
Start Time: End Time: Duration:
Travel 1 Start: Travel 1 End: Total Travel Time:
Travel 2 Start: Travel 2 End:

Daily Service 5 – Reimbursable Services ONLY

Topic/Purpose:
Service Type: Location:

SUD Progress Note Daily RES Page **1 of 2**



BHCS SUD RES Daily Note

Counselor/LPHA: Group Co-Facilitator:
Start Time: End Time: Duration:
Travel 1 Start: Travel 1 End: Total Travel Time:
Travel 2 Start: Travel 2 End:

Daily Service 6 – Reimbursable Services ONLY

Topic/Purpose:
Service Type: Location:
Counselor/LPHA: Group Co-Facilitator:
Start Time: End Time: Duration:
Travel 1 Start: Travel 1 End: Total Travel Time:
Travel 2 Start: Travel 2 End:

Daily Service 7 – Reimbursable Services ONLY

Topic/Purpose:
Service Type: Location:
Counselor/LPHA: Group Co-Facilitator:
Start Time: End Time: Duration:
Travel 1 Start: Travel 1 End: Total Travel Time:
Travel 2 Start: Travel 2 End:

Daily Summary

Note includes 1) Progress (Client's specific progress on treatment plan problems, goal, action steps, objectives, and/or referrals. 2) Provider Support and Interventions, 3) Client's Plan (including new issues or problems that affect treatment plan).

Additional Service Information (add information or description of activities if needed)

Daily RES Progress Note Documentation Time

Date:	Start:	End:	Total Doc. Time:

Documentation Log (Use when documenting time completing clinical forms. Do not include this time above)

Start:	End:	Time:	Type:
Start:	End:	Time:	Type:
Start:	End:	Time:	Type:
Start:	End:	Time:	Type:
Start:	End:	Time:	Type:

Signature of SUD Counselor/LPHA Printed Name/Credential Date

SUD Progress Note Daily RES Page **2 of 2**

Log time spent documenting the daily note here

Log time spent on other documentation activities here, such as writing the assessment or treatment plan

RESIDENTIAL TREATMENT SERVICE COMPONENTS

- Intake/Assessment*
- Individual Counseling*
- Group Counseling*
- Family Therapy*
- Collateral Services*
- Crisis Intervention Services*
- Treatment Planning*
- Discharge Planning*

A total of 20 hours of these services are required per week for residential treatment

- Patient Education – Individual or Group (non-clinical hours)
- Transportation Services: Provision of needed transportation to and from medically necessary treatment (non-clinical hours)

*Counts towards 5 clinical hours per week

PHYSICIAN CONSULTATION AND CASE MANAGEMENT

- For all service levels, including residential, these services must be documented in separate single service progress notes

AND

- The time spent providing these services does not count towards minimum or maximum hours of treatment services as these are different service types

DISCHARGE PLAN

- Discharge planning is a vital component of SUD treatment and every attempt should be made to complete a discharge plan with a beneficiary
- Even with beneficiaries who abruptly terminate treatment, there are often in-person opportunities to quickly develop a supportive discharge plan
- The Discharge Plan must be developed within 30 days prior to the last scheduled face-to-face

- Claim for service using Discharge Planning procedure code
- This service may take place over multiple sessions and must be documented accordingly in progress notes

DISCHARGE PLAN FORM

- A progress note is required for claiming for this service, this three (3) page form is not a claimable document

SUD DISCHARGE PLAN FORM - WAIVER

This form is not for claiming, service must be documented in a progress note in order to be claimed

Discharge Plan

Client:

InSyst # | Last Name | First Name

Location: | Episode Opening Date:

Services were provided in: | By ☐ Interpreter or ☐ clinician

Plan

DISCHARGE/SUPPORT PLAN

The discharge plan must be completed with the client and the counselor or therapist within 30 days prior to completion of treatment services.

The following is my personalized Continuing Care Plan for my on-going recovery and support. Before completing treatment for my addiction I will present this Continuing Care Plan to someone within my support network such as my sponsor, other peers, mentor or spiritual advisor and receive thoughtful feedback, suggestions and comments about my Plan.

Episode Opening Date:	Episode Closing Date:	Date of Last Face-To-Face:

This treatment program has my permission to contact me during the next 12 months as a follow-up to my treatment and recovery: ☐ Yes ☐ No

Client Initial: | Best Contact/Email: | Phone:

I will attend Recovery Support Services: Day: | Time: | Counselor:

12 STEP AND/OR OTHER SUPPORT NETWORK: I plan to attend the following weekly meetings:

Day(s)	Location	Time	Description or Program Name

SPONSOR, MENTOR, SPIRITUAL ADVISOR OR OTHER SUPPORT PERSON:

Name of Support Person:

I WILL MEET WITH THEM: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

Description of this commitment:

SUPPORT GROUP COMMITMENTS (e.g. Community or Other Volunteer Services-Hospitals & Institutions, Coffee Maker, Religious/Spiritual). Describe:

ADDITIONAL SUPPORT (individual therapy, medical/physical health needs, outside groups, social activities):
I have identified the following activities as an important part of my recovery. Describe:

RELAPSE PREVENTION AND WARNING SIGNS (e.g. isolation, missed meetings, missed medications, failure, success, anxiety, anger, depression, people, places or things that jeopardize my recovery):

Page 1 of 3

SUD DISCHARGE PLAN FORM - WAIVER

Relapse Triggers/Warning Signs Are:	My Action Plan Is:

ADDITIONAL NEEDS FOR MY RELAPSE PREVENTION PLAN: (I have identified the following goals or issues as I continue to participate in my recovery (housing, employment, sponsorship, child care, transportation):

Name of Person	Telephone #

MY VISION FOR RECOVERY:

As a person in recovery I understand that neglecting my recovery plan will jeopardize my ability to maintain my recovery. I know that addiction is a chronic condition. I know how important it is that I maintain a recovery plan that includes a strong support system with people who care for me.

Time in Recovery as of this date: | Recovery Date:

My comments regarding treatment, such as: emotional highpoints, low points, & pivotal insights as a result of treatment:

Instructions: Based on the my most recent treatment plan Goals & Objectives, I will continue to work on the following:

Index #	Stage	My Continuing Goals

Was I advised of CCR 22 Sec 51341.1 Fair Hearing Rights if the discharge was due to loss of Medi-Cal benefits? ☐ Yes ☐ No

Page 2 of 3

SUD DISCHARGE PLAN FORM - WAIVER

Providers must inform each beneficiary in writing, at least ten (10) calendar days prior to the effective date of the intended action to terminate or reduce services, of the right to a fair hearing related to denial, involuntary discharge, or reduction in DMC substance use disorder services as it relates to their loss of eligibility or reduction of benefits, pursuant to Section 50953.

To request a hearing contact:

Department of Social Services: State Hearing Division P.O. Box 944243,M.S. 9-17-37 Sacramento, CA 94244-2430

Oral Requests by Telephone: 1-800-952-5253 TDD – 1-800-952-8349

Counselor/Therapist Summary of the Treatment Episode:

Prognosis (select one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Unstable

Describe prognosis and further treatment recommendations):

Discharge Summary Codes - Administrative - Table A

Percent (%) of Tx Plan Goals Achieved	Discharge Status Code and Description
☐ 100 - 76%	1. Completed Tx/Recovery Plan Goals - Referred
☐ 100 – 76%	2. Completed Treatment/Recovery Plan Goals - Not Referred
☐ 75 – 50%	3. Left Before Completion with Satisfactory Progress - Referred
☐ < 50%	5. Left Before Completion with Unsatisfactory Progress - Referred

Client Received a Copy: ☐ Yes ☐ No If no, must explain why:

Provider attests that the individual signed on this date:

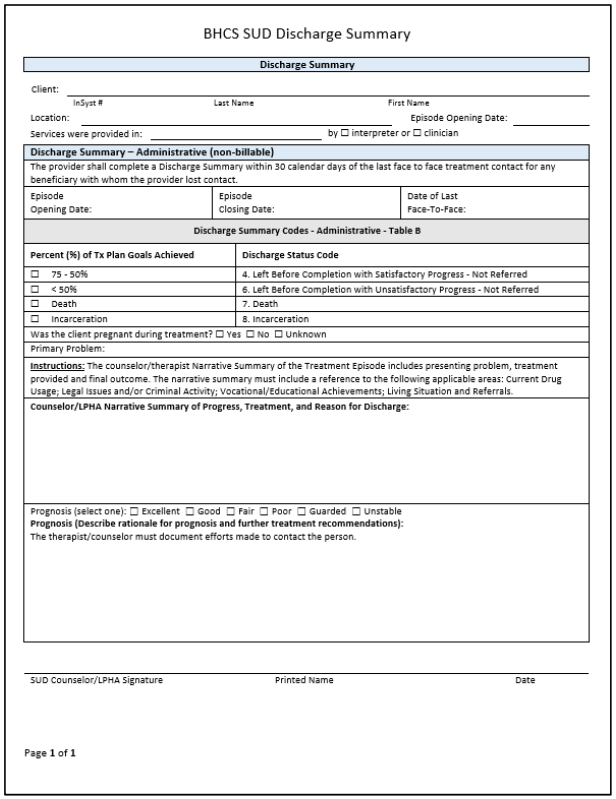
Client Signature (required) | Printed Name | Date

SUD Counselor/LPHA (required) | Printed Name | Date

Page 3 of 3

DISCHARGE SUMMARY

- Whenever a provider loses contact with a beneficiary a discharge summary must be completed within 30 days of last
- Completing the discharge summary is a non-billable service.
- Document completion of the discharge summary in a progress note as a non-billable service



BHCS SUD Discharge Summary

Discharge Summary

Client: _____
InSyst # Last Name First Name

Location: _____ Episode Opening Date: _____

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

Discharge Summary – Administrative (non-billable)		
The provider shall complete a Discharge Summary within 30 calendar days of the last face to face treatment contact for any beneficiary with whom the provider lost contact.		
Episode Opening Date:	Episode Closing Date:	Date of Last Face-To-Face:

Discharge Summary Codes - Administrative - Table B	
Percent (%) of Tx Plan Goals Achieved	**Discharge Status Code**
☐ 75 - 50%	4. Left Before Completion with Satisfactory Progress - Not Referred
☐ < 50%	6. Left Before Completion with Unsatisfactory Progress - Not Referred
☐ Death	7. Death
☐ Incarceration	8. Incarceration
Was the client pregnant during treatment? ☐ Yes ☐ No ☐ Unknown	
Primary Problem:	
Instructions: The counselor/therapist Narrative Summary of the Treatment Episode includes presenting problem, treatment provided and final outcome. The narrative summary must include a reference to the following applicable areas: Current Drug Usage; Legal Issues and/or Criminal Activity; Vocational/Educational Achievements; Living Situation and Referrals.	
Counselor/LPHA Narrative Summary of Progress, Treatment, and Reason for Discharge:	
Prognosis (select one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Unstable **Prognosis (Describe rationale for prognosis and further treatment recommendations):** The therapist/counselor must document efforts made to contact the person.	

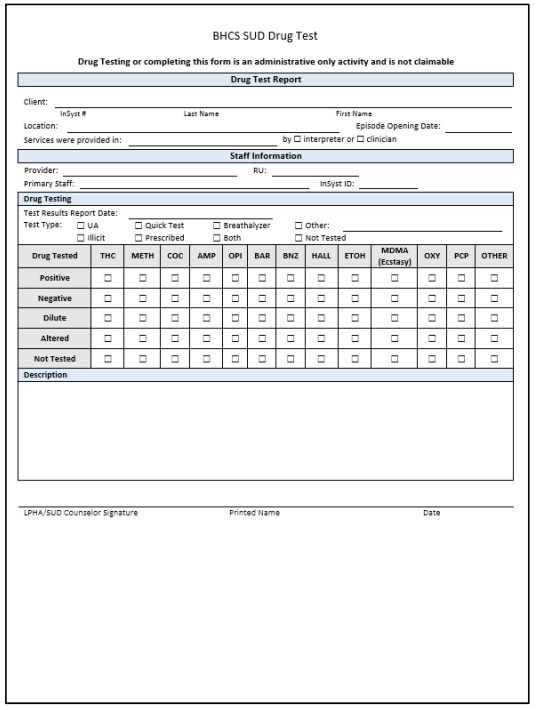
SUD Counselor/LPHA Signature Printed Name Date

Page 1 of 1

DRUG TEST REPORTING FORM

Form to be used to report Drug Test results, say to the court, and provide a record in CG

Completing the form or associated drug testing activities is not claimable as it is an administrative activity.



BHCS SUD Drug Test

Drug Testing or completing this form is an administrative only activity and is not claimable

Drug Test Report

Client: _____
InSyst # Last Name First Name

Location: _____ Episode Opening Date: _____

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

Staff Information

Provider: _____ RU: _____

Primary Staff: _____ InSyst ID: _____

Drug Testing

Test Results Report Date: _____

Test Type: ☐ UA ☐ Quick Test ☐ Breathalyzer ☐ Other: _____
☐ Illicit ☐ Prescribed ☐ Both ☐ Not Tested

Drug Tested	THC	METH	COC	AMP	OPI	BAR	BNZ	HALL	ETOH	MDMA (Ecstasy)	OXY	PCP	OTHER
Positive	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Negative	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dilute	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Altered	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Not Tested	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

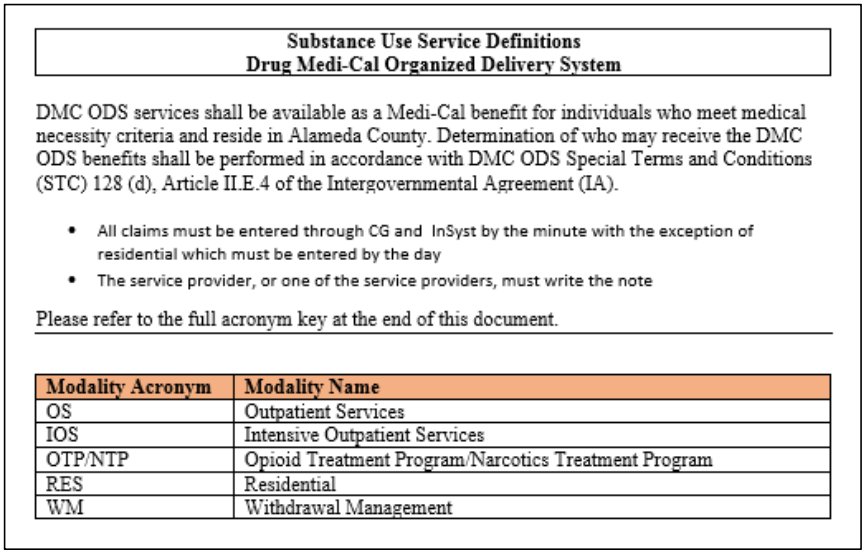
Description

LPHA/SUD Counselor Signature Printed Name Date

DESCRIPTION OF SERVICES

- Refer to SUD Service Definitions document, this is a 16 page document. This document includes a description of all billable DMC SUD services.

- For each Service Type, there is a modality, HCPC Code, Authorized Service Provider, Frequency, and Provision of Service (POS).



Substance Use Service Definitions
Drug Medi-Cal Organized Delivery System

DMC ODS services shall be available as a Medi-Cal benefit for individuals who meet medical necessity criteria and reside in Alameda County. Determination of who may receive the DMC ODS benefits shall be performed in accordance with DMC ODS Special Terms and Conditions (STC) 128 (d), Article II.E.4 of the Intergovernmental Agreement (IA).

- All claims must be entered through CG and InSyst by the minute with the exception of residential which must be entered by the day
- The service provider, or one of the service providers, must write the note

Please refer to the full acronym key at the end of this document.

Modality Acronym	Modality Name
OS	Outpatient Services
IOS	Intensive Outpatient Services
OTP/NTP	Opioid Treatment Program/Narcotics Treatment Program
RES	Residential
WM	Withdrawal Management


KEEP
CALM
AND
ASK
QUESTIONS