Substance Use Disorder (SUD) Clinical Documentation and Authorization Training

February 6, 2019
LOCs OS/IOS/RES/RSS/WM
ACBH Quality Assurance (QA) Staff

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updated 2/19/19
# Quality Assurance ACBH Contacts

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</thead>
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</tr>
</tbody>
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# Agenda

## Today’s Topics of Discussion

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

<table>
<thead>
<tr>
<th>Approximate Time</th>
<th>Break Schedule</th>
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<tbody>
<tr>
<td>10:00 to 10:10 am</td>
<td>Break #1</td>
</tr>
<tr>
<td>11:00 to 11:10 am</td>
<td>Break #2</td>
</tr>
<tr>
<td>12:00 to 12:30 pm</td>
<td>Lunch</td>
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<tr>
<td>1:30 to 1:40 pm</td>
<td>Break #3</td>
</tr>
<tr>
<td>2:40 to 2:50 pm</td>
<td>Break #4</td>
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Introductions

What is one question you have about SUD documentation you would like answered today?
ACBH SUD SOC Audit

• Q1 2018 System of Care Audit Preliminary Results
  • Overall quality compliance was 69%
  • Out of 535 claims reviewed, 383 were not compliant (28% claims compliance rate)

• The top 5 reasons for disallowance were:
  • For residential programs, 20 hours of minimum services not documented
  • Information on client’s attendance not documented properly (ODF)
  • Medical Necessity not established (full chart disallowance)
  • Client Plans were not completed within allotted timeframes
  • Services at residential programs not documented accurately (weekly note)
    • A daily note is now required for residential programs to help reduce full week disallowances for non-compliant claiming

updated 2/19/19
Your Success is Our Success
Upcoming Audit Info & SUD Claims

• Non-compliance on some quality measures will result in claims disallowance.
• Next audit period January – March 2019; Expect charts to be requested in April

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What Levels of Care is this training for?

Note that Opioid (Narcotic) Treatment Programs (NTPs) will be covered in a different training

- All Alameda County subcontracted SUD providers:
  - Outpatient Services (OS)
  - Intensive Outpatient Services (IOS)
  - Residential Services (RES)
    - Perinatal and Non-Perinatal
    - Withdrawal Management (WM RES)
  - Recovery Support Services (RSS)

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Alameda County SUD System Overview
Outpatient Services (OS)  
(ASAM Level 1.0) – Outpatient contracts

• Adults = Up to 9 hours of medically necessary services
• Adolescents = Less than 6 hours of medically necessary services

• Not limited to DMC certified sites (e.g. special population contracts – older adults, youth prevention)

Services can be provided in-person, by telephone, by telehealth (except group), and in any appropriate setting in the community.
Intensive Outpatient Services (IOS)  
(ASAM Level 2.1) – IOS contracts

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

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

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

Allowable Services

- Intake/Assessment
- Treatment Planning
- Individual and Group Counseling
- Patient Education (Ind. or Group)
- Family Therapy (LPHAs only)
- Medication Services
  - (Medical Providers MD, DO, NP, PA ONLY)
  - More information available later in the presentation
- Case Management
- Physician Consultation
- Collateral Services
- Crisis intervention services
- Discharge planning and coordination
Withdrawal Management (Residential)  
(ASAM Level 3.2) – WM RES – Currently Cherry Hill

• Detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC-ODS beneficiaries.

• Individuals enter Withdrawal Management Services (Cherry Hill Detox) through the Sobering Center and may stay very briefly or as long as a few days.

• During the first 24-48 hours at Cherry Hill Detox, a 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. Clients tend to stay in withdrawal management for an average of 4 days.

• Upon discharge, individuals may be referred to additional SUD services based on the ALOC.
Components of Withdrawal Management
Currently Cherry Hill

- **Intake/Treatment Planning**: The process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

- **Observation/Monitoring**: The process of monitoring the beneficiary’s course of withdrawal. To be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary’s health status.

- **Medication Services**: The prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.

- **Case Management/Care Coordination**: See CM slides.

- **Physician Consultation**: Physician consultation between agency MD and ACBH approved addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. Must be claimed separately in order to be reimbursed.

- **Discharge/Transition Services**: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

updated 2/19/19
Recommended WM RES Workflow

- Referral to WM RES, perhaps from the Sobering Center or another referral source
- SUD Intake/Assessment
- Planned services may be claimed initially. Once the plan is due or complete, only service types in the plan can be claimed.
- Provision of WM Services in accordance with Client Plan
- If Screening ALOC (Portal) is incomplete or missing information due to beneficiary's level of functioning at intake, complete another at discharge
- Information gathered for Client Plan
  - Primary SUD Counselor/LPHA writes/revises the plan
  - LPHA reviews plan and either approves or provides feedback to plan author
- Beneficiary reviews and signs the plan
- If ALOC is not WM 3.2, then refer to the indicated or desired LOC
- Beneficiary Informing Materials, Consent to Treat, Additional ROIs, Privacy Practices
- Establish Medical Necessity
  - Complete Screening ALOC (Portal), LPHA reviews ALOC, makes SUD diagnosis...
- Episode Opening Information / Health Questionnaire & SUD Programs & ROI
- Referral to Other SUD Services
- Complete Discharge Plan or Discharge Summary
Case Management Services
LOCs: OS/IOS/RES/RSS/WM

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

Care Coordination

- Bringing together various providers and information systems to coordinate health services, client needs, and information to help better achieve the goals of treatment and care.

Service Coordination

- A service to assist clients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, and/or other community services. It is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost effective outcomes. In order to link client with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate service needed for the client to optimize care through effective, relevant networks of support.
Physician Consultation Services

LOCs: IOS/OS/RES/WM/RSS

- Physician Consultation Services consist of DMC Physicians’ consultation with ACBH approved external addiction medicine physicians, addiction psychiatrists, or clinical pharmacists.
- Designed to assist provider physicians by allowing them to seek expert advice when developing client plans for specific DMC-ODS beneficiaries.
- May address medication selection, dosing, side effect management, drug interactions, or level of care considerations.
- DMC physicians may only use ACBH specified consultants - TBD

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Medication Services and Medication Assisted Treatment (MAT)

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

Individual and group counseling, assessment, treatment planning, and:

- **Substance Abuse Assistance**: Peer-to-peer services and relapse prevention.
- **Education and Job Skills**: Linkages to life skills, employment services, job training, and education services.
- **Family Support**: Linkages to childcare, parent education, child development support services, family/marriage education.
- **Support Groups**: Linkages to self-help and support, spiritual and faith-based support.
- **Ancillary Services**: Linkages to housing assistance, transportation, case management, individual services coordination.

IA, III.T
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Recovery Support Services (RSS)

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

• Providers must attempt one (1) contact every 30 days unless LPHA clinically justifies reduced contact (in-person, telephone, or telehealth). Document this contact or attempt in the medical record.

• Medical Necessity shall be reassessed between 5-6 months from RSS episode opening date (EOD) or most recent Medical Necessity. The beneficiary must meet criteria for medical necessity to qualify for continuing services.

• Services may be delivered by an approved certified Peer Specialist (for substance abuse assistance services only) or SUD Counselor / LPHA

• Peers may not be concurrently receiving and providing SAA RSS

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Residential Treatment Services

ASAM Levels 3.1 to 3.5
Residential Services

- Open to all populations per contract
- Based on assessed ASAM Level of Care (ALOC)
- There are limitations on length of stay
- Prior authorization required
  - Referral from portal
  - UM must authorize within 5 days from admission
- 24-hour structure
- 7 days a week

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Residential Services, cont.

- Minimum of 20 hours of total structured therapeutic activities per week (AOD Standards)
  - For ASAM 3.1 at least five (5) of the 20 hours must be face-to-face clinical services
    - Each resident must have at least one (1) hour of structured therapeutic services per day
  - For ASAM 3.5 at least twelve (12) of the 20 hours must be face-to-face clinical services
    - Each resident must have at least one (1) hour of clinical service per day.
Residential Treatment Services

Counts towards weekly clinical hours requirement of: 3.1=5hrs and 3.5=12hrs

Counts towards overall 20 hours of structured therapeutic activities, but not the required clinical hours

Per DHCS reimbursable residential services are:

- Intake/Assessment
- Individual
- Group Counseling (2-12 participants)
- Family Therapy (LPHAs only)
- Collateral Services
- Crisis Intervention Services (relapse crisis)
- Treatment Planning
- Discharge Services

- Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment
- Patient Education (not considered a clinical intervention)

Counts towards weekly clinical hours requirement of: 3.1=5hrs and 3.5=12hrs

Counts towards overall 20 hours of structured therapeutic activities, but not the required clinical hours

updated 2/19/19
## Alameda County Residential ASAM LOCs

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<thead>
<tr>
<th>ASAM LOC</th>
<th>Service Name</th>
<th>Description of Care</th>
</tr>
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<tbody>
<tr>
<td>3.1</td>
<td>Clinically Managed Low-Intensity Residential Services</td>
<td>24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment.</td>
</tr>
<tr>
<td>3.3</td>
<td>Clinically Managed Population-Specific High-Intensity Residential Services</td>
<td>24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for outpatient treatment. (Note: This level is not designated for adolescents). (Currently in development)</td>
</tr>
<tr>
<td>3.5</td>
<td>Clinically Managed High-Intensity Residential Services</td>
<td>24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.</td>
</tr>
<tr>
<td>3.7 (referral)</td>
<td>Medically Monitored Intensive Inpatient Services</td>
<td>24-hour nursing care with physician availability for significant problems. 16 hour/day counselor availability. (N/A to this training)</td>
</tr>
<tr>
<td>4 (referral)</td>
<td>Medically Managed Intensive Inpatient Services</td>
<td>24-hour nursing care with daily physician care for severe, unstable problems. Counseling available to engage patient in treatment. (N/A to this training)</td>
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</table>
Referrals to Residential

Beneficiaries must be referred to a residential facility through one of the SUD portals

- CenterPoint aka Call Center ➔ (844) 682-7215
- CenterPoint AB109 Criminal Justice Case Management Program
- Cherry Hill
- Drug Court

The ASAM Level of Care (ALOC) screening is completed at one of the portals and referral information securely sent to the referred provider

Portals may also refer to other levels of care

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ACBH UM Pre-Authorization Process

For questions about SUD RES authorization process contact ACBH UM.
Preauthorization of Residential Services

• **At least 24 hours** prior to scheduled admission or within 24 hours of admission the RES provider submits to UM Prior Authorization Request form and ALOC (portal screening ALOC ok). This authorizes the first 5 days.

• Within 5 days from EOD complete the diagnosis (including written basis), Initial Medical Necessity form, and Initial ALOC. It is highly recommend that the ALOC and SUD Intake/Assessment are completed prior to making a diagnosis. This information is then used to develop the client plan.

• This information is securely sent to UM for authorization along with other referral information.

• Residential programs have 10 days from date of admission to complete the Intake Assessment, client plan, and other required admission documentation.
Length of Residential Services: Non-Perinatal Adults

- Adults are beneficiaries aged 21 and older
- Length of stay
  - 1 to 90 days, 90 day maximum *(continuous transitions between 3.1 and 3.5 are one stay)*
  - UM may authorize a one-time 30 day extension per 365-day period
  - Beneficiary may use a maximum of two (2) non-continuous 90-day regimens, in a one-year period
    - For example, a beneficiary who no longer meets criteria for perinatal residential but needs additional residential services may be closed to services on one day and reopened the next day for their second stay of non-perinatal residential

IA, III.Q
updated 2/19/19
Length of Residential Services

**Perinatal**

**Perinatal** beneficiaries are those who are pregnant and up to 2 months postpartum

- Perinatal eligibility begins on first day pregnancy is medically substantiated and ends on the last day of the calendar month in which the 60th day from the end of the pregnancy occurs
- For example, if a mother gives birth on 2/18 then they are eligible for perinatal services until 4/30

Beneficiary record must contain medical documentation that substantiates beneficiary’s pregnancy and last day of pregnancy

- **A birth certificate is not considered medical documentation per DHCS**
Length of Residential Services

Parenting Residential Programs

- Available for parenting non-pregnant mothers with children (0-17)
  - Children may reside at the residential program with their mother up to age 17, but this is not advised. ACBH highly recommends that children up to age 5 live at the residential facility with their mother, but school-aged children live off-site due to the significant coordination requirements needed for those youth.

- All DMC eligible residential services, including extensions, must be used before this additional SABG funded residential service

- Additionally, for the parenting residential services a 90 day maximum length of stay with an available extension of up to 90 additional days (6 months total) is allowed.

- Children are only allowed to live at women’s only residential facilities

- UM preauthorization is required for Parenting Residential

- No more than 12 children may receive care in one facility at the same time

- When a SUD treatment provider is unable to provide licensed on-site child care service, the SUD treatment program should partner with local, licensed child care facilities or offer on-site, license-exempt child care through a cooperative arrangement between parents for the care of their children

updated 2/19/19
Women’s Services Overview

Residential Treatment Service Lengths

• Perinatal RES → Eligible until the last day of the month in which the 60th day from date of birth occurred.

• Adult RES → 90 days, plus 90 days, plus one 30 day extension annually
  • Perinatal RES is considered one of the two 90 day treatment episodes regardless of length of stay at the perinatal program

• Parenting RES → 90 days, plus 90 days annually for mothers with children
  • Eligibility is in addition to DMC residential limits
  • Must continue to meet ACBH SUD documentation standards, even though non-DMC funded

updated 2/19/19
Additional Required Perinatal Services

APPLIES TO ALL LOCs

- Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792)
- Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment)
- Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant
- Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

updated 2/19/19
Residential Treatment: 
Adolescents

- Adolescents are beneficiaries aged 12 to under 21
- Length of stay
  - Adolescents, under the age of 21, can receive continuous residential services for a maximum of 30 days
  - UM can approve a 30-day extension if determined to be medically necessary; one extension per year.
  - Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment
  - Nothing in the DMC-ODS overrides any EPSDT requirements
  - Additional extensions allowed if medically necessary and authorized
- Adolescent beneficiaries 18 and older must reside in adult residential programs

updated 2/19/19
Recommended RES Workflow

- Individual contacts or is referred to one of the four portals
- Portal conducts ALOC Screening and refers client to assessed LOC
- UM Authorization
- Episode Opening Information/Health Questionnaire & SUD Programs ROI
- Planned services may be claimed initially. Once the plan is due or complete, only service types in the plan can be claimed.
- ASAM/ALOC - Initial
- Establishing Medical Necessity
- LPHA reviews ALOC, meets with intake LPHA/Counselor or client, Intake Assessment and determines SUD diagnosis...

Intake/Admission
- Beneficiary Informing Materials, Consent to Treat, Additional ROIs, Privacy Practices

Client Plan Workflow
- Information gathered for Client Plan
- Beneficiary reviews and signs the plan
- Primary SUD Counselor/LPHA writes/revises the plan
- LPHA reviews plan and either approves or provides feedback to plan author
- UM Authorization
- Provision of SUD services in accordance with Client Plan
- ALOC Review
- Complete Discharge Plan or Discharge Summary
- Referral to Outpatient SUD Services
- Continuing Services Justification/UM Re-Auth.
- Refer to the indicated or desired LOC

updated 2/19/19
Medical Record Requirements
Charting Requirements
Individual Client Record

• Each client must have an individual record that meets 42 CFR, Part 2 Final Rule, HIPAA, & HITECH requirements → whichever is stricter

• NO other client identifying information is allowed in another client’s record
  • In past audits, services were disallowed because they contained multiple client PHI information, often in the form of combined group notes or group sign-in sheets
  • As a result, the medical record was not considered unique
  • References to other clients should happen only when absolutely necessary and done anonymously (e.g. “another client”)
    • Never use other clients’ initials, names, nicknames, etc.
Individual Client Record

• Client record MUST include:
  • A unique identifier
    • Client’s InSyst number
  • Client’s DOB
  • Client’s sex at birth, gender identity/expression, sexual orientation, and other cultural factors
  • Client’s preferred name and preferred pronoun
  • Client’s race or ethnicity
  • Client’s address or indicate “homeless” for address
  • Client’s telephone number or again indicate “homeless” for no telephone
  • Client’s record and InSyst record must include emergency contact information with Release of Information (or reason why this was not provided)

Missing info (name, id #, etc.) in the chart will result in the entire chart being non-compliant
Individual Client Record

Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including but not limited to all of the following:

- Informing Materials signature page
- ROIs and ROI Log
- Intake and admission data, including, if applicable, a physical examination
- Client Plans
- Progress Notes
- Continuing Services Justifications
- Laboratory test orders and results
- Referrals
- Counseling notes
- Discharge Plan
- Discharge Summary
- Provider Authorizations for Residential Services
- Any other information relating to the treatment services rendered to the beneficiary
- CQRT and Authorization Forms

updated 2/19/19
Medical Record Retention Policy

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

For these reasons ACBH recommends providers maintain all records for at least 15 years from the last date of service, or the client’s 18th birthday, whichever is later.

Many hospitals and other medical services store records indefinitely.

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SUD Provider Personnel
Medical Director’s P&P

• The SUD Medical Director is required to develop program and/or agency policy and procedures
• These are common policies and procedures to guide on-site medical and related requirements. ➔ Must be updated as necessary
• Ultimately the content of this P&P is up to the MD, however here are some content suggestions from DHCS:
  • Medical concerns, seizures, OD, death, under the influence, TB, medical emergencies/emergency protocol, disease prevention, injury response, injury prevention, medication guidelines, medication storage, medication errors, dosing protocol, physical exam requirements
• Current Medical Director signature must be present on the P&P

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SUD Counselor/LPHA Responsibilities

All with appropriate training and experience

- Assessment (Intake and ongoing as medically necessary)
- ASAM/ALOC (LPHA and Certified Counselors only)
- Initial & Updated Client Plans
- Individual & Group Sessions
- Sign-In Sheets
- Crisis Intervention
- Collateral Services
- Progress Notes
- Case Management Services
- Continuing Services Justification (Counselors may complete recommendation only)
- Discharge Plan / Discharge Summary

LPHA and Certified Counselors may conduct these.

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

Also, see co-signature requirements for Intake/Assessment for all SUD Counselors.
Alameda County SUD Providers’ Admission/Pre-Admission Process
Informing Materials


- **ALL** SUD treatment providers are required to review ACBH Informing Materials (aka Consent to Services and Acknowledgments) packet with the beneficiary (client) prior to signing the signature page. Now also available in ALL Alameda County threshold languages.
  
  http://www.acbhcs.org/providers/QA/General/informing.htm

- Providers may add additional privacy notices, sliding scale, informing forms, etc., if necessary but may not remove or modify any components of the ACBH form

- Discussions around informed consent should begin at admission and clients must sign the Informing Materials by the SUD Intake/Assessment due date. Providers must retain the signature page in the beneficiary’s medical record. This must be completed initially and then reviewed annually.

- Having the Informing Materials’ signature page signed does not relieve the provider of their duties to have the Incidental Disclosure Acknowledgement, ROIs, Sliding Scale/Payment Provisions, etc. acknowledged (signed & dated) and in place as required by regulation.

updated 2/19/19
Components of Informing Materials

Must review all of these items and check these boxes indicating these items were reviewed.
Minor Consent for SUD Services

- Family Code § 6929 allows for minors aged 12 – 17 to consent for services related to the treatment of a drug or alcohol related disorder
- ACBH is checking to see the limitations of this regulation and if/how Medi-Cal claiming is allowed
Incidental Disclosures

42 CFR, Part 2 does not allow providers to unintentionally disclose PHI (called incidental disclosures) that may occur through conversations with their co-workers in such places as hallways or breakrooms.

Beneficiaries may unintentionally disclose personal information during casual conversations, “free talk,” with other beneficiaries (clients) outside of the treatment room or provider environment. 42 CFR, Part 2 does not regulate beneficiaries’ conversations. However, the Incidental Disclosure Information form reminds clients about the importance of privacy for others and promotes respect and confidentiality. The Incidental Disclosure form must be reviewed upon admission and be completed for each beneficiary.

These documents shall be in the beneficiary’s chart and ACBH will be auditing to this standard.
Incidental Disclosures Form

This additional disclosure is required by ACBH and must be maintained in client’s chart.
Releases of Information (ROIs)

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

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Releases of Information (ROIs), Cont.

- Required for any contact outside of your agency
- Required ACBH form has been approved by County Counsel
- ACBH currently has two (3) approved versions of this two (2) page form:
  - Emergency Contact ROI
  - SUD Programs ROI \(\leftarrow\) REQUIRED BY DAY ONE AND BEFORE ANY ENTRY INTO INSYST/CG
  - Criminal Justice ROI
SUD Programs ROI is required on day one before any beneficiary information may be inputted into Clinician's Gateway and InSyst.

### Clinical Justice ROI

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<th>Patient Information</th>
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<td>Last Name</td>
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<td>Client ID</td>
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### Emergency Contact ROI

<table>
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<tr>
<th>Patient Information</th>
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Updated 2/19/19
ACBH SUD Programs ROI

- Required ACBH SUD Programs ROI must be signed prior to releasing any information and prior to entering any information into Clinician’s Gateway/InSyst.
- Best practice remains to discuss and have client sign a specific ROI whenever releasing information outside of your agency.
- When the beneficiary signs the ACBH SUD Programs ROI, this allows communication between ACBH contracted SUD programs.
- Use the ACBH SUD Provider Directory to determine which agencies are covered by the ACBH SUD Programs release:

If the beneficiary declines to sign the required SUD Programs ROI, DO NOT OPEN EPISODE IN INSYST/CG. Indicate on ROI and consult with ACBH immediately.

updated 2/19/19
ROI Tracker Log Usage

- Upon Intake, each client must sign required Releases of Information (ROIs).
- File ROI Log in the client’s medical record
- All signed ROIs are maintained in the client file.
- Each time client information is released it must be logged.
The Tracker Log is a new standard. Who is doing IT?

Tracker log will be requested for audits

---

### Release of Information (ROI) Tracker Log

<table>
<thead>
<tr>
<th>DATE Request Received</th>
<th>WHO [Requester] Name of Organization Who Made the Request</th>
<th>WHO [disclosed to whom] Name &amp; Organization Who Requested the Information [Requestor]</th>
<th>WHO Verified that the ROI [here] Information is correct &amp; signed by the Beneficiary</th>
<th>DATE ROI SENT ROI must be sent within 15 days of request</th>
<th>EMPLOYEE COMPLETING THE REQUEST Employee Name &amp; Job Title</th>
<th>METHOD of Transmission 1) Mail 2) Fax 3) Secure Email 4) Other</th>
<th>BRIEF DESCRIPTION OF DISCLOSED INFORMATION</th>
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</table>

1. Upon intake, each client must sign required Releases of Information (ROIs).
2. Maintain the log in the client’s medical record.
3. All signed ROIs are maintained in the client file.
Physical Health and SUD Treatment
Health Screening / Questionnaire
DHCS Form 5103 highly recommended for all programs

• AOD Certified/Licensed programs are required to have a Health Questionnaire that MUST contain at minimum the information in the DHCS 5103 (06/16)
  • To be completed prior to intake
  • Client should complete on their own unless they require assistance
  • Must be reviewed and signed by staff

• Health Questionnaire requirement is intended to be a client self-report document that provides information for the treatment staff conducting the intake assessment. It does NOT substitute for medical history in screening/assessment

• Client self-report used to determine if client has immediate medical needs that would impact their ability to safely participate in SUD Treatment. Non-AOD DMC providers are recommended to have the client self-report their medical history using DHCS 5103 in addition to gathering required medical history.

updated 2/19/19
DHCS Form 5103: Health Screening Questionnaire

Meets requirements AOD Alcohol And Drug Certification Standards Section 12020

DHCS Form 5103, Version (06/16) this is a 10 page form:

Available in handout section!
Physical Examinations are an integral part of SUD Treatment

Scenario A
If the beneficiary has had a physical exam in the 12 months prior to the date of admission, then the physician, nurse practitioner, or physician assistant must review documentation of this exam within 30 days of admission. If these individuals are unable to obtain documentation of this exam, then their efforts to obtain should be documented.

Scenario B
If beneficiary has not had a physical exam in the 12 months before admission, a physician, registered nurse practitioner, or physician's assistant may perform a physical examination within 30 days of admission.

Scenario C
If a physical examination has not been completed within the last 12 months OR the physician, nurse practitioner, or physician assistant does not review the exam record AND/OR new exam is not completed, then the initial client plan MUST have a goal of obtaining a physical exam.

It is not acceptable to roll this (or any other) goal over from one Plan to the next, without revisiting the current obstacles and what modified action steps will allow for the goal to be met in the new Plan time period. (Reason for chart non-compliance from that Plan date and onward.)
Additional Physical Examination Info

• An agency’s Medical Policies and Procedures (as determined by the Medical Director), indicate the necessary components for a valid physical examination

• If the beneficiary's physical examination, which was performed during the prior twelve months, indicates a beneficiary has a significant medical illness, the client plan must include a goal that the beneficiary obtain appropriate treatment for the illness.

updated 2/19/19
Intake and Assessment of Substance Use Disorders

Part of the Golden Thread
Intake Assessment

At a minimum the SUD Intake/Assessment must include the following detailed information:

<table>
<thead>
<tr>
<th>Drug and Alcohol Use History-Cause of SUD</th>
<th>Medical History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family History</td>
<td>Psychiatric/Psychological History</td>
</tr>
<tr>
<td>Social/Recreational History</td>
<td>Financial Status/History</td>
</tr>
<tr>
<td>Educational History</td>
<td>Employment History</td>
</tr>
<tr>
<td>Criminal History / Legal Status (probation etc.)</td>
<td>Previous SUD Treatment History</td>
</tr>
</tbody>
</table>

Narrative evaluation or analysis of the cause or nature of the mental, emotional, psychological, behavioral, and SUD(s). Note: Medical Necessity includes the DSM Diagnosis and criteria specific to drug of choice.
SUD Intake Assessment

- The intake assessment must include an evaluation or analysis of the cause or nature of the mental, emotional, psychological, behavioral, and substance use disorders.
  - DSM diagnosis alone does not fully meet this requirement
  - The assessment must include a formulation of the beneficiary’s presentation, based on the information gathered during the intake process (Intake Assessment + ASAM + Health Screening/Physical)

Keep in mind that the problems/challenges/issues identified during the assessment are required to be addressed or deferred on the client plan.
Who may complete an Intake Assessment and ASAM, and Participate in ACBH CQRT?

- **ACBH highly recommends** that the Intake Assessment and ALOC are completed by LPHAs and Certified SUD Counselors ONLY
- When there is no other option, Registered SUD Counselors may do so with the minimum training and experience:
  - Required ASAM e-modules training
  - Registered SUD Counselors who have one year full time equivalent SUD treatment experience; **OR**
  - Registered SUD Counselors who have completed the following hours towards their certified credential (essentially the equivalent of half of CCAPP CADC-I requirement):
    - 158 hours of approved education
    - 127 practicum hours (internship experience)
    - 1500 hours of supervised work experience (includes practicum hours)
    - **AND** Supervisor must provide an attestation of experience and knowledge to conduct Intake Assessments, ALOC ← Maintain in employee's personnel file. This will be requested during an audit.

FYI

updated 2/19/19
The ACBH comprehensive Intake/Assessment form meets minimum requirements. The goal is to complete as much as possible during the first session(s), however some information won’t be available at intake.

This intake will likely take a few sessions to complete. If you attempted to gather information but the client declined to answer, or there was a clinical reason not to assess a certain section, you must indicate the why. When sections are left blank it is not known if the information was gathered or not assessed.
Additional Perinatal Assessment Items

Required for all LOCs

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

- If an assessment is completed in one session, both the gathering of assessment information and completion of the assessment form, one progress note may document the claim. In the progress note, make reference to the assessment form (“see assessment form dated xx/xx/xx”). It is not necessary to repeat all gathered information in both the note and form. The progress note documentation time includes both the time writing the Assessment form and completing the progress note.

- If an assessment is completed over multiple sessions, each progress note must clearly indicate what was done in each session. Information gathered in each session must be indicated in the progress note, or the progress note must link to specific sections of the assessment. Time spent completing the assessment form may be spread out over each session, or at the last assessment session.
  - An auditor or other individual reviewing the note/claim must be able to determine precisely what information was gathered for each claimed service

- Intake/Assessment may be claimed for face-to-face services plus documentation time OR only for documentation time when completing the assessment form

All activities (face-to-face, PN documentation, completing the form, etc.), require start and end times.
Intake / Assessment Due Dates

Required for all treatment levels

- For OS/IOS/RSS
  - Completed within 30 days of episode opening date (EOD)

- For RES
  - Completed within 10 days of EOD ➔ HIGHLY RECOMMENDED by day 5

- For WM RES (ASAM 3.2)
  - Due within 24-48 hours of EOD (24 hours highly recommended due to short length of stay)
Intake / Assessment Review Due Dates

If assessment/client-reported information was collected by a SUD Counselor, an LPHA must review and approve the assessment as part of the determination of medical necessity.

• An LPHA is required to review and approve the assessment → Now required in CG
• This LPHA review and approval must occur on or before the date medical necessity is completed as it is part of determination of medical necessity.
• If during the LPHA review, they determine that the assessment is incomplete or needs additional information then the assessment must be revised. The completion date on the assessment will be the date when all required signatures are present.
A few reminders about assessments…

- The assessment process can take several sessions to complete.
- The assessment process is a key part in the development of a trusting, helping relationship with the beneficiary,
- The problems or challenges identified during the assessment process are used to inform the client’s client plan.
  - This will be explored more extensively in the client plan section of this training
- Detailed comments are required for each assessed component.
- If comment sections and/or checkboxes are left blank, it cannot be determined if that section was assessed and no credit will be given. When it is not clinically appropriate to assess a particular component, indicate the reason why. As treatment progresses, update the assessment information as necessary.
Information from this section of the intake assessment is used in part by the LPHA to make the diagnosis and establish medical necessity. It is essential that the information gathered is individualized, specific, and with timeframes of the symptoms.

Specific information about each substance should be gathered. The LPHA then uses this (and other assessment information) to write the written basis for the included diagnosis(es). Information in this form will not be considered as symptoms of the diagnosis. This is information gathered for the diagnosis then the LPHA determines which symptoms are relevant to the diagnosis.
Establishing Medical Necessity

Part of the Golden Thread
Initial assessment documentation identifies problems to be addressed in SUD treatment. The LPHA establishes Medical Necessity by reviewing all information and making the diagnosis, and completes a **written basis** for the diagnosis (see exceptions for completing written basis).

Initial client plans are based on the Initial Assessment and must indicate all **identified problems** that were identified unless documented as deferred. These may be prioritized for work during the Tx Plan period.

Client Plan updates document the ongoing Medical Necessity and progress towards completion of the program.

Progress Notes must contain evidence that the services claimed for reimbursement are helping client achieve their client plan.
The essential parts of establishing Medical Necessity

Part 1 - ASAM

- Must meet the ASAM Criteria definition of **medical necessity** for services based on the ASAM Criteria.
- Providers must complete the ASAM Level of Care (ALOC) accurately to the client’s needs. We are finding that often the ALOC confirms the level of care of the provider (e.g. IOS providers determine client needs ASAM 2.1) and is not consistent with the individual’s documented presentation and assessment. ACBH will be monitoring ALOCs closely for accuracy.
ASAM Level of Care (ALOC)

• If the beneficiary is referred to SUD services through one of the portals, a brief ALOC screening will have been completed
  • Often the portals’ screening will have incomplete information
  • May have been a phone screening
  • Providers **must** complete the full ALOC within established medical necessity timelines
ASAM Level of Care (ALOC), Cont.

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

updated 2/19/19
REFLECTING A CONTINUUM OF CARE

Note:
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.
ASAM Dimensions

- Each of the six (6) ASAM dimensions require assessment
- For each dimension that is not *No Risk/Stable*, a written descriptive comment is required
- Depending on how the intake is completed, information from the Assessment is used to inform the ASAM and vice versa
- Regardless there must be a congruence between the intake assessment documents, medical necessity, and ASAM
AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1. **DIMENSION 1**
   - Acute Intoxication and/or Withdrawal Potential
     - Exploring an individual's past and current experiences of substance use and withdrawal

2. **DIMENSION 2**
   - Biomedical Conditions and Complications
     - Exploring an individual's health history and current physical condition

3. **DIMENSION 3**
   - Emotional, Behavioral, or Cognitive Conditions and Complications
     - Exploring an individual's thoughts, emotions, and mental health issues

4. **DIMENSION 4**
   - Readiness to Change
     - Exploring an individual's readiness and interest in changing

5. **DIMENSION 5**
   - Relapse, Continued Use, or Continued Problem Potential
     - Exploring an individual's unique relationship with relapse or continued use or problems

6. **DIMENSION 6**
   - Recovery/Living Environment
     - Exploring an individual's recovery or living situation, and the surrounding people, places, and things

Check the ACBH SUD page for information about upcoming ASAM trainings.

updated 2/19/19

Your Success is Our Success
ASAM Clinical Placement Scoring Summary

• Be mindful that only one Risk Rating is required for each dimension (score one row per column)

• A detailed narrative written description is required to explain the Key Findings Supporting the Placement Decision

• Refer to ASAM training materials and guidance to assist in determining the Level of Care accurately and consistently

updated 2/19/19
ASAM LOC

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

• OS/RSS – Due within 30 days from date of admission and then every 90 days from date of previous ALOC
• OTP – Due within 28 days from date of admission and then every 90 days from date of previous ALOC
• IOS – Due within 30 days from date of admission and then every 60 days from date of previous ALOC
• RES – Due within 5 days from date of admission and then every 30 days from date of previous ALOC
  • This is a required component of the ACBH UM authorization packet
• WM RES (ASAM 3.2) – Due within 24-48 hours (24 hours highly recommended due to short length of stay) from date of admission and then every 30 days from date of previous ALOC
• ALOCs are due prior to every plan or plan update and whenever clinically indicated
  • ALOCs completed within 45 days of plan date may be used to meet this requirement, if there are clinical changes then the ALOC must be redone.

updated 2/19/19
Transitioning between Levels of Care
OS/IOS/RSS - same agency

When an ALOC indicates that a beneficiary requires a transition between different levels of care you must close to the previous RU and open to the new RU with new EOD. Dates of service between RUs must be continuous.

Within the same agency, within 10 days from the new RU opening date, complete the following:

• ALOC Initial (if not done previously)
• Initial Medical Necessity Form (link to new EOD)
• Client Plan (or Recovery Plan for RSS) – Plan updates requires CQRT re-authorization
• The Intake/Assessment, Informing Materials, and ROIs, may be used from the previous episode if still valid
• A progress note must be completed, detailing this LOC change and that the intake documents were reviewed and updated as clinically necessary. Updated assessment info may be documented in a progress note or revised Intake/Assessment.

When a beneficiary transitions to a different level of care at a different program or a different agency, then services should be opened as if a new client

If a different medical record, any shared documents must be available in each medical record
Transitioning between Levels of Care Residential (3.1 & 3.5) – same agency

Once an ALOC indicates a different level of care than is currently being provided, RES providers have 10 days to assist in transitioning the beneficiary to the new LOC. Required authorization documents must be submitted to UM within 5 days of level of care determination.

Once authorized, close to the previous RU and open to the new RU. Dates of service between RUs must be continuous and the RU close and reopen dates must be the same. Length of stay timeframe is based off the original EOD.

Within 5 days from the new LOC determination complete the following and submit to UM:

- ALOC Initial (if not done previously)
- Initial Medical Necessity Form (link to new EOD)
- UM Authorization Form

Once authorized by UM and within 10 days from the new LOC determination complete the following:

- Client Plan
- The Intake/Assessment, Informing Materials, and ROIs, may be used from the previous episode if still valid
- A progress note must be completed, detailing this LOC change and that the intake documents were reviewed and updated as clinically necessary. Updated assessment info may be documented in a progress note or revised Intake/Assessment.

If a different medical record, any shared documents must be available in each medical record
Transitioning between Levels of Care
Residential ↔ OS/IOS/RSS

Once an ALOC indicates a different level of care than is currently being provided, providers have 10 days to assist in transitioning the beneficiary to the new LOC.

When transitioning between these residential and outpatient LOCs the client must be closed in the previous RU and opened in the new RU.

Client records must be opened as if a new client for this type of transition.
Essential parts of Medical Necessity
Part 2 (Dx, Sx, Impairments)

• An included DSM-5 SUD diagnosis

• A diagnosis must be given/established in order for treatment to be provided for that diagnosis. All diagnoses treated must be established medical necessity form.
  • For example, diagnosing someone with Alcohol Use Disorder does not allow treatment for impairments related to Cocaine addiction. The LPHA would need establish the Cocaine Use Disorder diagnosis. Once the additional diagnosis is made, the plan must also be updated.
  • To be given a diagnosis, the beneficiary must meet the criteria as specified in the DSM-5 for the each diagnosis given. ACBH does not determine criteria for diagnoses.
What does ‘establish a diagnosis’ mean?  

Option A or B is required

**Option A:** The LPHA may meet directly or via telehealth with the beneficiary and establish the diagnosis.

**Option B:** The LPHA may meet face-to-face or via telehealth with the SUD counselor who completed the assessment. For Cont. Justification of Services the LPHA must meet with the Primary SUD Counselor.

Regardless of the above options, the LPHA must complete the individualized written basis for the diagnosis:

- Note, that if the LPHA is not licensed, they must have the diagnosis and written basis reviewed and co-signed by a licensed LPHA
- The written basis for the diagnosis must include specific, individualized symptoms along with timeframes for each included SUD diagnosis to be treated. Not meeting this requirement is the most common reason for chart non-compliance.

A good rule of thumb is that an individual reviewing the diagnosis should be able to determine the diagnosis from the written narrative alone.
Included SUD Diagnoses

- Diagnoses that are treatable through DMC-ODS SUD treatment are indicated on the Alameda County SUD Diagnoses Included List
  - Must use the most recent list published by ACBH on 11/1/18
  - Only the DSM-5 diagnoses on this list may be treated through SUD services
- Include both the ICD-10 code and DSM-5 name (CG will provide both)
  - Select code with appropriate DSM-5 specifiers (e.g. In Early Remission, In Sustained Remission, In a Controlled Environment)

updated 2/19/19
ACBH SUD Included Diagnosis List

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

Alameda County SUD providers may only provide treatment for the DSM-5 diagnoses on this list.
Medical Necessity Criteria
Youth/Adolescents

- Youth under 21 may be assessed to be at-risk for developing a SUD, and if applicable, must meet the ASAM adolescent treatment criteria.
  - Youth with a DSM-5 SUD diagnosis → refer using ASAM
  - Youth at-risk for SUD (ASAM 0.5) → refer to early intervention, primary physician, or MH provider

- Youth under age 21 are eligible for EPSDT services, which includes SUD prevention treatment, if medically necessary
Initial Medical Necessity Form

• May only be completed by LPHA
  • If LPHA is unlicensed, then must have licensed LPHA review and co-signature within due date of medical necessity
• This form documents the basis for SUD diagnosis in the client’s individual medical record
• The IMN must include complete signatures (printed name, credentials, date, and signature) of the LPHA(s) required on the document
• Completing the IMN (or CSJ) inputs the diagnosis into CG, without this complete the diagnosis will not be auto populated on the client plan document

updated 2/19/19
Initial Medical Necessity Form

Due Dates

Required for all treatment modalities

- IOS/OS/RSS – Due within 30 days of date of admission
- RES – Due within 5 days of date of admission
  - Part of pre-authorization packet required by ACBH UM
  - WM RES (ASAM 3.2) – Due within 24-48 hours of admission (24 hours highly recommended due to short length of stay)

updated 2/19/19
LPHA must enter all ASAM levels of care here (up to 3).

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

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

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

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

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

Up to 9 diagnoses may be added to the beneficiary’s medical record.

Your Success is Our Success
Levels of Care on IMN

• As part of establishing medical necessity the LPHA must review and approve the ASAM
• The LPHA may require that the ALOC be redone if they feel it is not accurate or is missing elements
• The LOC information from the ALOC is included in the IMN and indicates the LPHA concurs with the ALOC findings.
• By signing the IMN, the LPHA is attesting that medical necessity is met and they have reviewed the required components of the intake to inform their decision.
A few review questions are coming up, we know the answers are in your handout, they’re right there on the next page. Please don’t look so we can all figure them out together.
Medical Necessity & Assessment Review

Questions

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

- A DHCS included SUD diagnosis which is the Primary Focus of Treatment
- Appropriate ASAM LOC (ALOC)
- Initial Medical Necessity Form

Who may establish a diagnosis?

- LPHA (with co-signatures if unlicensed LPHA)

Who may complete the ASAM?

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

Who MAY NOT formulate a diagnosis?

- Certified/Registered SUD Counselor

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

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

updated 2/19/19
Medical Necessity & Assessment Review Cont.

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

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

- OS/IOS within 30 days, Residential within 5 days of the date of admission, 24-48 hours for WM RES (Cherry Hill)
- Between 5 and 6 months (from the Initial Medical Necessity or Last Justification for Continuing Treatment) the Justification for Continuing Tx must be established by the LPHA with determination of Medical Necessity and with a written recommendation from the counselor/LPHA to continue treatment. Unlicensed LPHAs require licensed LPHA co-signature.

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

- If the LPHA completing the form was not licensed
Client Plans

Part of the Golden Thread
We are so in sync

Client Plans & Documentation
“We are so *NSync”
SUD Client Plan

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

Client Plan Challenges

- All problems identified during the intake and assessment are required to be on the plan (some may be deferred)
- On the ACBH plan template, we consider these challenges and not problems
- Indicate ASAM Dimension:
  1) Acute Intoxication and/or Withdrawal Potential
  2) Biomedical Conditions/Complications
  3) Emotional/Behavioral/Cognitive Conditions/Complications
  4) Readiness to Change
  5) Relapse/Continued Use/Continued Problem Potential
  6) Recovery Environment

updated 2/19/19
Required Parts of a SUD Client Plan, cont.

Client Plan Goals

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

Measurable and attainable goals create opportunity for success

updated 2/19/19
Required Parts of a SUD Client Plan, cont.

Deferring Client Plan Goals

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

Name a few reasons why a goal is deferred…
Required Parts of a SUD Client Plan, cont.

Action Steps

• Steps that will be taken by the provider and/or beneficiary to accomplish identified goals.

• During the plan development process providers assist the client in developing the short-term action steps related his/her identified goal(s)

• Instead of client will participate in groups or treatment, indicate what will be the expected benefit to client.
Required Parts of a SUD Client Plan, cont.

Action Steps Continued

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

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

Not This:
Client will attend Relapse Prevention Group

Client will participate in individual counseling every week.

updated 2/19/19
Required Parts of a SUD Client Plan, cont.

Action Steps Continued

• Provider’s Action Steps (aka Interventions)
  • Provider Action Steps must focus on helping the client achieve their treatment goals
  • Interventions for Collateral (see prior slides) should include listing significant others by their names and roles (professional relationships do not qualify for Collateral services) for whom contact is planned and indicating “others as needed”
  • Only approved ACBH abbreviations (acronyms) may be used in the Medical Record—see website for list
Required Parts of a SUD Client Plan, cont.

Frequency of Services

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

IA, III.PP.12 updated 2/19/19
Required Parts of a SUD Client Plan, cont.

Description of Services

• The following services types need to be in the plan:
  • Individual, group, collateral, case management, medication services, residential services, patient education, family therapy, family support (recovery support services only), Residential and Withdrawal Management Residential (if applicable).

• Best practice is to include a brief description of the type of services

• Intake, treatment planning, physician consultation, crisis, and discharge planning do not need to be in the plan.
Required Parts of a SUD Client Plan, cont.

• Plan must indicate the primary SUD Counselor/LPHA. If this changes, indicate the change in a progress note and update on the next plan.

• If a beneficiary has not had a physical examination within the twelve month period prior to beneficiary’s admission to treatment date, a goal that the beneficiary have a physical examination—if goal is carried over to the following Tx Plan, the current barriers and needed Action Steps must be indicated.

• If a beneficiary has a significant medical illness, the plan must contain a goal to obtain appropriate treatment for the illness

• DSM-5 SUD Diagnosis (both code and name with specifiers are required)
Signature Requirements Reminder

- All treatment staff signatures in SUD must have the printed name, credentials, legible signature, and date signed.

- In CG this should be done automatically when signatures are finalized. Non-finalized signatures are not considered complete. Also verify your name and credentials are correct in CG.

- When beneficiaries are required to sign documents, ask that they print their name, sign legibly, and include that day’s date. If they have difficulty with this, note this on the progress note documenting the service.

- One of the most common causes of non-compliance is due to incomplete signatures that did not contain all three above requirements – Will cause claims disallowances.
Client Plan Signatures
For Initial Plan

- The following signatures are due by the plan due date:
  - The SUD Counselor or LPHA who completes the plan
  - Beneficiary’s signature (see following slide for specific requirements)
- If required, the LPHA co-signature is due 15 days from the date the SUD Counselor or LPHA completes the plan
  - Note that CG does not allow the client signature to occur after the LPHA signature
Client Plan Signatures
For Plan Updates

• For plan updates only, providers have a few additional days to get all required signatures
  • The SUD Counselor or LPHA who completes the plan must still sign the plan by the due date
  • If a SUD Counselor completes the plan, the required LPHA co-signature is due within 15 days of the SUD Counselor’s signature.
  • The beneficiary signature on the plan update is 15 days from the date the SUD Counselor/LPHA completed the plan
    • Note that CG does not allow the client signature to occur after the LPHA signature
What if the beneficiary is unwilling or unable to sign the plan or plan update?

• The beneficiary’s signature is required on the plan and plan update. It is the formal indication that the beneficiary has participated in the plan development and their agreement to the specifics of treatment.

• If the beneficiary refuses to sign the plan, the provider must document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment – if not may cause multiple claims disallowances.

• A beneficiary not being available to sign the plan or the provider forgetting to have the beneficiary sign are not valid reasons for non-signature on the plan or plan update.
Client Plan: Using ACBH Template

updated 2/19/19
Client Plan Due Dates

Required for all service modalities

- **OS/IOS/RSS**
  - Due within 30 days from EOD
  - OTP plans due within 28 days of date of admission

- **RES**
  - Due within 10 days from EOD

- **WM RES**
  - Due within 24-48 hours from EOD (24 hours highly recommended due to short length of stay)

- **OS/IOS/RSS 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/functioning
  - OTP plans are due every 3 months from the date of admission, and every 3 months thereafter (always tied to the admission date—not the prior plan signature date).

FYI

updated 2/19/19
Client Plan Due Dates

Plans are required for all service modalities

- **OS/IOS/RSS**
  - Initial plan is due within 30 days from EOD
  - Plan updates are due at a minimum of 90 days from date of previous plan (date of primary counselor/LPHA's signature)

- **OTP**
  - Initial plan is due within 28 days of date of admission
  - OTP plans are due at least every 3 months from the date of admission, and every 3 months thereafter (always tied to the admission date-not the prior plan signature date).

- **RES**
  - Due within 10 days from EOD
  - Plan updates are due at a minimum of 90 days from date of previous plan (date of primary counselor/LPHA's signature)

- **WM RES**
  - Due within 24-48 hours from EOD (24 hours highly recommended due to short length of stay)

Plans may need to be updated more frequently based on beneficiary status/functioning
Services required to be listed in the Plan

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

- **What are planned services?**
  - Services that are required to be identified in the plan in order to be provided
  - Planned Services may be provided prior to the initial plan due date, if the initial plan has not yet been completed.
  - Once an initial plan is completed, regardless of the plan due date, only services identified in the plan may be provided
  - Residential programs (including WM RES) must indicate the LOC as the plan service modality
  - See next slide for planned services
# Planned Services by Provider Type

<table>
<thead>
<tr>
<th>OS/IOS/RES</th>
<th>Residential</th>
<th>Recovery Services</th>
<th>Withdrawal Management</th>
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<tr>
<td>Individual Counseling</td>
<td>3.1 Residential Day</td>
<td>Individual Counseling</td>
<td>3.2 Residential Withdrawal Management Day</td>
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<tr>
<td>Group Counseling</td>
<td>3.5 Residential Day</td>
<td>Group Counseling</td>
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</tr>
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<td>Case Management</td>
<td>Recovery Monitoring</td>
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<tr>
<td>Medication Services</td>
<td></td>
<td>Service Coordination</td>
<td></td>
</tr>
</tbody>
</table>

*Updated 2/19/19*
Potential Client Plan Issues

Non-Compliance

Services may be disallowed when:

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

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

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

updated 2/19/19

Your Success is Our Success
Perinatal Client Plans

Additional requirements for perinatal beneficiaries:

Prenatal exposure to substances harms developing fetuses. If this is identified as a need in the assessment there must be a goal to provide education to the mother, action steps, and target date must be included in the plan to address this problem.

• Does the mother need assistance in accessing ancillary services (dental, social, community, educational/vocational, and other services that are medically necessary to prevent risk to the fetus)?

• If yes, the plan must include a goal, action steps, and target date to accomplish this goal.
Perinatal Client Plans, cont.

• Was a need for mother/child habilitative services identified in the assessment?
  • If yes, the plan must include a goal, action steps, and target date to accomplish this goal

• Were sexual or physical abuse issues identified in the assessment?
  • If yes, the plan must include a goal, action steps, and target date to accomplish this goal

• Are there service access needs (i.e. transportation, financial, other barriers) identified in the assessment?
  • If yes, the plan must include a goal, action steps, and target date to accomplish this goal
How to claim for writing the Client Plan
OS/IOS/RSS

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

Example

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

OS/IOS/RSS

If the development of the plan took place over several sessions, document each session separately.

• For the treatment planning sessions, indicate the sections of plan template that were completed in the progress note or write data in the note.

• After the last session, on the same day that the note is written for that service, also write the plan. Include the time (including date, start and end times) spent doing each activity: Session time, PN documentation, plan writing, travel time, etc.
A few review questions are coming up, we know the answers are in your handout, they’re right there on the next page. Please don’t look so we can all figure them out together.
Client Plan Review Questions

• If a service type or modality is not listed in the plan can those services be claimed?
  • Unplanned services (intake/assessment, treatment planning, crisis, physician consultation, discharge) may be provided at anytime, and do not need to be listed in the plan.
  • Planned services (group, individual, case management, medication, collateral, patient education, etc) may only be provided when included in the plan and after the initial plan due date. Planned services may be provided prior to the plan due date.

• When is a plan update due for a person receiving perinatal services?
  • 90 days from the date the counselor or LPHA signed the previous plan

• What part of the diagnosis needs to be listed on the plan?
  • The ICD-10 code and DSM-5 name
Client Plan Review Questions

• When does the plan need to be updated?
  • Within 90 days from the date the counselor or LPHA signed the previous plan and whenever there is a clinical need (change in functioning or a new service type needs to be added), or if a beneficiary is moving between service types at the same agency (say from IOS to OS).

• Can the time I spent writing the plan be claimed?
  • Yes. This should be claimed as treatment planning. It must be connected to a treatment planning session but may be claimed separately.
Continuing SUD Services

Beyond 6 months from date of admission
Continuing Services Justification Counselor Recommendation

• The Primary SUD Counselor/LPHA must review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

• This recommendation must be completed by the Primary SUD Counselor/LPHA prior to the LPHA completing the Continuing Services Justification

• It must be completed within the same time frames as the CSJ
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 complete this recommendation form before completing the Continuing Services Justification Form.
Continuing Services Justification (CSJ)

Required for all SUD 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
  • Example: EOD is 1/15. Complete no sooner than 6/16 and no later than 7/14
• 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
The LPHA completing the CSJ MUST include documentation that they have considered the following:

- Each client’s personal, medical, and substance abuse history
- Documentation of the most recent physical examination
- The beneficiary’s progress notes and client plan goals
- The primary SUD Counselor/LPHA’s recommendation
- The beneficiary’s progress
- Most recent ASAM Level of Care (ALOC)

Signing of Client Plan Update by the LPHA does NOT meet requirement of Justification for Continuing Services. The CSJ Recommendation and CSJ Form are always required.
The LPHA must complete the components of this form. Must list and indicate written basis for each treated diagnosis.

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

If any are determined to be ‘No’, medical necessity is not met.

The LPHA must initial one of these statements.

updated 2/19/19
Progress Notes

Part of the Golden Thread
Claiming using ACBH 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 client plan, the SUD Counselor might meet with the beneficiary to discuss plan goals, then later that day or the next day the SUD Counselor sits down to write the plan. The SUD Counselor would document that this way:
    • Possible to write one note
      • Document the face-to-face session with dates and times of service
      • Include documentation date/time for writing the progress note and writing the plan
IOS/OS/RSS 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
• Must be completed by the staff that provided the service within 7 calendar days of the service (the date of service is day 1)
• Providers must enter the actual time and minutes on the service note, InSyst will calculate correct claiming
IOS/OS/RSS Group Claiming

When a client attends more than one group per day, then separate notes for each group must be completed.

In CG first write a note for the whole group, then go back and individualize it for each group member.

Groups are reimbursed for staff time, with that time divided between all group members.

Group members can be prepopulated and will be displayed here.

Add additional clinicians here, along with group time.

Documentation time is the time for all group members, CG will divide by the number of group members to calculate service time.

updated 2/19/19
OS/IOS/RSS Single Service Note

• For all other OS/IOS/RSS claiming other than groups, a single service note for each activity must be documented

• Use ACBH single service OS/IOS/RSS progress note to document these services, including case management and physician consultation (if allowed)
For each claimed individual and group counseling session, the LPHA or counselor must record a progress note, “for each beneficiary who participated in the counseling session or treatment service.”

- Progress notes are, “individual narrative summaries”
- Group counseling notes must be completed for each session and specific to the individual client
  - No other client information is allowed in another client’s chart/record
- Notes must be completed and signed within seven (7) calendar days from the date of service (day one is date of service)
  - A signature date is required
Progress Notes - required components continued
For OS, IOS, RSS

REQUIRED COMPONENTS:
• The topic of the session or purpose of the service
• Date and Start and End time for each component of the session or service
  • Date and start/end time of service
  • Travel time start and end time
    • If traveling to multiple locations do not double claim travel time
    • e.g. for the first session claim travel time from the office to the community location only, for the second session claim travel time from the first session to the next session only, and for the last session claim travel time from the previous session to the last session AND from the last session to back to the office.
  • Date and start/end time of documentation

All are reasons for non-compliance
Progress Notes - required components continued

For OS, IOS, RSS

• The location of the service: in-person, telephone, telehealth, community.
• If services were provided in the community, include the location and a description how the provider ensured confidentiality.
• The topic of the session (e.g. Relapse Prevention, Relationships, etc.)
• A description of the beneficiary's progress on the client plan problems, goals, action steps, objectives, and/or referrals.
• The legibly printed name, credentials, signature, and date signed of the LPHA or counselor who provided the session/service.

All are reasons for non-compliance.

updated 2/19/19
Reimbursement of Documentation Time
OS, IOS, RSS, RES

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

Although RES services and WM documentation time is included in the day rate and is not separately reimbursable a record of time, location, provider etc. is required for each service.
WM Residential Service Requirements

• Program shall closely observe and physically check each client receiving withdrawal management services at least every 30 minutes during the first 72 hours.
• These checks must occur face-to-face by a trained staff member and documented in the medical record.
• After 24 hours, close observations and physical checks may be discontinued or reduced based upon a determination by a staff member trained in providing withdrawal management services.
• If observations and physical checks drop below daily, one of the following services must be documented at least daily: Medication Services, Coordination of Care, or Discharge/Transition Planning
  • Additional individual and group services may be provided and documented but will not meet this requirement.
WM RES Progress Notes

- Daily Note required with documentation of WM services within 7 days of the date of service (date of service is day one)
- Daily Notes that include Medication Services have their own template and must be co-signed by the Medical Provider as an addendum
- Additional and separate PNs required for Case Management and Physician Consultation services

updated 2/19/19
Progress Notes – RES

• RES providers are to complete a daily progress note for each beneficiary receiving these services
  
  • Each daily progress notes must include all of the following:
    
    • A record of the beneficiary’s attendance at each claimable structured therapeutic activity (clinical and non-clinical) throughout the day
    
    • Must include the date, start and end times, and topic of each session
    
    • Location of each service activity
    
    • Indicate if services were provided in-person, by telephone, or by telehealth
    
    • Doc. time and travel time for each service activity
    
    • The legibly printed name, credentials, signature, and signature date of the provider completing the note

All are reasons for non-compliance

updated 2/19/19
Progress Notes – RES, cont.

- The individual completing the daily and weekly note must be an individual who provided one of the structured therapeutic activities during on that day.
- A daily progress note is required due to CG configuration.
- Only include reimbursable activities in this progress note.
- Daily notes must be completed, dated and signed within seven (7) calendar days from the date of service.
- The weekly note must be completed within the next calendar week of the service week being documented.
- Services are claimed by the day unit, both in the note and InSyst.
Progress Notes – RES, cont.

*Documentation time for RES services*

- Recording and documenting the time spent writing progress notes and completing required forms is required.
- Time spent completing documentation does not count towards the required face-to-face time (min. 20 hours of structured therapeutic activities) as it is included in the Residential Day rate.
- Must include documentation date/time and start/end times for each documentation service.
- We require this in order to track the time RES providers are completing documentation related activities.

updated 2/19/19
Progress Notes – RES, cont.

Narrative Summary Requirements

• A narrative summary is available for each daily progress note
• The narrative summary is optional if the weekly note is being completed
• In order to be considered compliant, both the daily or weekly narrative summary must include a description of the client’s progress towards client plan challenges, goals, action steps, objectives, and/or referrals for day or week.
• The narrative summary must be a comprehensive summary of the clinically relevant day or week’s events related to the beneficiary’s treatment.
The Case for a Daily Progress Note with Summary

• The daily note (when completed with the optional summary) exceeds DHCS requirements and a weekly note is not required.
• A daily progress note is required due to CG configuration regardless
• The weekly narrative summary must be detailed, comprehensive and include all important events that took place over the week being documented. It is very possible that significant events will go undocumented.
• Documenting the weekly note may take even longer total staff time, due to the need to keep a daily record regardless to incorporate those into the weekly narrative
Each of the contracted residential services occurring that day must be documented in the daily progress note.

The contracted residential services are:

| Intake/assessment, group/individual counseling, family therapy, crisis, treatment planning, discharge planning, patient education, and transportation services. |
| Comments for each services may be entered here as well. |
| The daily narrative summary goes here. This is optional if a weekly summary is being completed. |

Total face-to-face time is calculated here, do not include documentation time as this is used to track service time requirements.

Record time spent on documentation activities here, such as writing the assessment, client plan, and this progress note.

updated 2/19/19

Your Success is Our Success
RES Daily Note and Weekly Note

When opting to write a weekly note this box must be checked.
Documenting Case Management and Physician Consultation

- FOR ALL SUD PROVIDERS: Case Management and Physician Consultation are separate services and need to be claimed and documented separately.
- For residential programs these services must be documented separately from the daily required progress note.
- The time spent providing Case Management and Physician Consultation services do not count towards minimum or maximum service requirements as they are separate services.
  - For example, at Residential programs providing say 2 hours of Case Management services does not count towards clinical hour or structured therapeutic activity requirement-the 20 hour minimum.
- Providers must use the single service progress note to separately document these services.
- Transportation time is part of the Residential Day rate and not claimable as case management.

Updated 2/19/19
Requirements for Physician Consultation Notes

- Physician Consultation notes must include all of the following:
  - Beneficiary’s name
  - The purpose of the service
  - Date, start and end times of each service
  - Identify if services were provided face-to-face, by telephone or by telehealth
  - ACBH Consultants name and discipline. e.g. Charles, Smith, PharmD
  - The physician completing the note must sign their name and include their printed name, credentials, and date signed
  - The progress note must be completed within seven (7) calendar days of the service

updated 2/19/19
Requirements for Case Management Notes

- Case Management progress notes must include all of the following:
  - Beneficiary’s name
  - The purpose of the service
  - A description of how the service relates to the beneficiary’s client plan problems, goals, action steps, objectives, and/or referrals
  - Date, start and end times of each service
  - Identify if services were provided in-person, by telephone, or by telehealth
  - If services were provided in the community, identify the location and how the provider ensured confidentiality.
  - The SUD Counselor or LPHA completing the note must sign their name and include their printed name, credentials, and date signed
  - The progress note must be completed within seven (7) calendar days of the service

updated 2/19/19
Clinicin’s Gateway Screenshot: SUD Information Only Note

Use this note for recording information that is not billable but needs to be documented in the client’s medical record.
Transportation vs. Travel Time

- **Transportation** is when a staff transports a beneficiary to an off-site location. It may be to an appointment, a community resource, to pick up their medications, or any number of other off-site activities. Time transporting clients is not reimbursable, except at SUD RES programs (where it counts towards the required 20 hours of structured therapeutic activities per week).

- A staff providing counseling or other treatment interventions while going 1:1 off-site with a beneficiary may claim only the actual time providing the treatment service. This must be documented clearly and be a medically necessary service.

- **Travel Time** is the time a treatment staff spends traveling (one-way or round trip) to meet the beneficiary at their home and in the community. The beneficiary is not with the staff during time claimed as Travel Time.
SUD Group Treatment Requirements
SUD Groups

• SUD groups may only be between 2 and 12 participants regardless of staffing — reason for non-compliance
  • Groups larger than 12 participants must be divided into separate groups with different group facilitators (counselors/LPHAs)
  • Multi-family Therapy Groups—members present = # of clients represented
  • Groups with more than 12 participants may not be claimed for any of the participants. Instead, a non-billable note would be completed for each group participant.
  • Residential Patient Education groups may have more than 12 participants (Group Education is the only exception to the group limit)
• A client that is 17 years of age or younger may not participate in group counseling with any participants who are 18 years of age or older — reason for non-compliance for all group members.
• However, a client who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's Medi-Cal certified school site.

updated 2/19/19
Group Sign-In Sheets

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

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

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

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

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

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

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

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<thead>
<tr>
<th>Participant</th>
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Group Sign-In Sheets

Updated 2/19/19
Transcribing and Validation Requirements for Residential Daily Notes

• Residential providers have the option to have an individual other than the final signer of the RES Daily Note to enter data into the note. In these cases the staff may only input the data, i.e., date, time-in/out, topic facilitator/co-facilitator that is documented elsewhere, such as on group sign-in sheets. Data entry staff may not interpret data or make assumptions about the information. Appropriate policies and procedures must be developed before this type of documentation can be implemented.

• Entering individual service also requires the data entry staff to transcribe data from a similar sign-in sheet or log. All transcribed data must be on the form with initials for data entry clerk and counselor for validation purposes.

• The treatment staff who signs the note must review and validate the accuracy of the note and they are ultimately responsible for the accuracy for its content.

• For example, the two ADMIN USE columns on the group-sign in sheet are one way this data can be tracked and its entry validated. Providers will need to develop other mechanisms to document client attendance that the data entry staff may easily reference to input into the daily note.

• No other type of SUD services are allowed to be documented this way

• If your agency would like to explore this option, contact ACBH SUD TA for guidance on developing the required validation checks.

updated 2/19/19
Clinicin’s Gateway Instructions
For transcribing RES Daily Notes

1. From the Enter New Service screen, the data entry staff uses Edit Primary Clinician List to add additional staff to their dropdown.

2. Once back at the Enter New Service screen, choose the appropriate treatment staff from the dropdown, Service Note Daily RES, and click Start Indiv Service.

3. When finished inputting the information, the data entry staff chooses Saves as Pending. The note will be added to the treatment staff’s CG home page under Pending Services queue. The treatment staff is then responsible for the note and the data entry staff will not be able to alter it any longer.
Service Types

Including InSyst Procedure Codes
Intake/Assessment
Allowed for all SUD providers

- The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted 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.
- Assessment services are required at intake, but also may occur anytime they are medically necessary.
- Intake/Assessment does not need to be in the plan in order to be provided.
- May be provided by SUD Counselors and LPHAs.
- May be face-to-face, or separate if claiming for completing other non-face-to-face assessment activities such as writing the assessment.

updated 2/19/19
Intake/Assessment

InSyst Procedure Codes

- OS ➔ 611
- OS Recovery Services ➔ 677 (use RSS Individual Counseling code)
- IOS ➔ 211
- IOS Recovery Services ➔ 278 (use RSS Individual Counseling code)

For Residential Programs, including Withdrawal Management Residential, Intake/Assessment is included in the day rate code
Treatment Planning
Allowed for all SUD providers

• For each beneficiary the provider must prepare an individualized written client plan, based upon information obtained in the intake and assessment process. The plan will be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new plan.

• May be provided by SUD Counselors and LPHAs. When completed by a SUD Counselor it must be co-signed by a LPHA by the plan due date.
Treatment Planning

InSyst Procedure Codes

- OS Treatment Planning → 644
- OS RSS Treatment Planning → 677 (use RSS Individual Counseling code)
- IOS Treatment Planning → 244
- IOS RSS Treatment Planning → 278 (use RSS Individual Counseling code)

For Residential Programs, including Withdrawal Management Residential, Treatment Planning is included in the day rate code

updated 2/19/19
Individual Counseling

- Contact between a beneficiary and a LPHA or SUD counselor
- Individual Counseling must be indicated in Client Plan with frequency (e.g. 1x/week)
- Services are provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.
- May be provided by SUD Counselors and LPHAs
- For WM RES Individual Counseling may be provided but does not count towards the required daily components of treatment

(updated 2/19/19)
Individual Counseling

InSyst Procedure Codes

- OS Individual Counseling → 601
- OS Recovery Services Individual Counseling → 677
- IOS Individual Counseling → 201
- IOS Recovery Services Individual Counseling → 278

For Residential Programs Individual Counseling is included in the day rate code
Group Counseling

- Contacts in which one or two LPHAs or counselors treat two (2) or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served.
- **Group Counseling must be indicated in Client Plan with frequency (e.g. 3x/week)**
- A beneficiary that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.
- May be provided by SUD Counselors and LPHAs.
- For WM RES Group Counseling may be provided but does not count towards the required daily components of treatment.

IA, IV.42
Group Counseling

InSyst Procedure Codes

- OS Group Counseling \( \rightarrow \) 654
- OS Recovery Services Group Counseling \( \rightarrow \) 680
- IOS Group Counseling \( \rightarrow \) 215
- IOS Recovery Services Group Counseling \( \rightarrow \) 281

For Residential Programs Group Counseling is included in the day rate code
Collateral
Allowed for OS, IOS, RES

- Sessions with LPHAs or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals.

- Significant persons are individuals that have a personal relationship (family member, non-paid advocate, sponsor, etc.), AND not an official or professional relationship (CWW, Probation Office, Teacher, etc.) with the beneficiary.
  - Teachers, outside therapists, probation workers, CWWs, etc. are considered professional relationships and cannot be claimed as collateral. Case Management may apply.

- Releases of Information are required for collateral contacts

- Collateral must be indicated in Client Plan with frequency (e.g. 2x/month)

- May be provided by SUD Counselors and LPHAs

updated 2/19/19
Collateral

InSyst Procedure Codes

- OS Collateral → 621
- IOS Collateral → 221

For Residential Programs, except Withdrawal Management Residential, Collateral Services are included in the day rate code

updated 2/19/19
Crisis Intervention

Allowed for OS, IOS, RES

• “Crisis intervention” is a face-to-face contact between a beneficiary who is at risk for imminent threat of relapse and a LPHA or counselor

• “Crisis” for SUD means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.

• Services shall focus on alleviating crisis problems

• Not required to be in the plan as crises by definition are unplanned events

• As crises can happen anytime, and by definition are unexpected, it’s good practice to have signed ROIs in place in case of emergency

• May be provided by SUD Counselors and LPHAs
Crisis Intervention

InSyst Procedure Codes

- OS Crisis Intervention → 639
- IOS Crisis Intervention → 239
- OTP/NTP Crisis Intervention → 491

For Residential Programs, except Withdrawal Management Residential, Crisis Intervention services are included in the day rate code

updated 2/19/19
Patient Education

Allowed at OS, IOS, RES

- Means providing research based education on addiction, treatment, recovery and associated health risks
- May be provided as an individual or group service (use correct codes)
- When documenting group patient education (a non-clinical service), at a minimum, the service note for group patient education must always relate back to the individualized client plan.
- Patient Education must be indicated in Client Plan with frequency (e.g. 2x/month)
- Patient Education groups may only have 2-12 participants per group (no limit for RES)
- May be provided by SUD Counselors and LPHAs

updated 2/19/19
Patient Education

InSyst Procedure Codes

• OS Individual Patient Education → 631
• OS Group Patient Education → 659
• IOS Individual Patient Education → 231
• IOS Group Patient Education → 231

For Residential Programs Patient Education is included in the day rate code

updated 2/19/19
Physician Consultation

Allowed for all SUD service types by
DMC physicians only (consultee)

- Physician Consultation Services include DMC physicians’ consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing client plans for specific DMC-ODS beneficiaries.
  - Designed to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations
  - Physician consultation services can only be billed by and reimbursed to DMC providers
  - DMC physicians may only use ACBH specified consultant → TBD
  - Physician Consultation is not required to be in the plan in order to be claimed as it is an assessment/treatment planning function (unplanned service)
Physician Consultation

InSyst Procedure Codes

- OS Physician Consultation → 670
- IOS Physician Consultation → 270
- 3.1 Residential → 116
- 3.2 WM Residential → 397
- 3.3 Residential → 146
- 3.5 Residential → 176

updated 2/19/19
Medication Services
Allowed for OS, IOS, RES, WM RES

• Definition: The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication

• May only be conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice, licensure, training, and experience

• OS/IOS/RES providers may prescribe if within their scope of practice and training. The prescribed medication needs to be picked up by the client at a local pharmacy
  • Prescribed medication currently may not be any medication for opioid treatment
  • RES requires IMS Certification

• Prescription and administration of medications may occur at the following locations:
  • NTP/OTPs (only certain medications)
  • Fee-for-service primary care physicians
  • Medication Services must be indicated in Client Plan with frequency (e.g. 2x/month)
Medication Services

InSyst Procedure Codes

- OS Medication Services → 634
- IOS Medication Services → 234

For Residential Programs, including Withdrawal Management Residential, Medication services are included in the day rate code
Case Management Services

InSyst Procedure Codes

- OS Case Mgmt-Care Coord → 665
- OS Case Mgmt-Serv Coord → 666
- IOS Case Mgmt-Care Coord → 254
- IOS Case Mgmt-Serv Coord → 255
- OS Rec Srv – Case MgmtCareCoord → 684
- OS Rec Srv – Case Mgmt Serv Coord → 685
- IOS Rec Srv – Case MgmtCareCoord → 284
- IOS Rec Srv – Case MgmtServCoord → 285
- 3.1 RES Case Mgmt-Care Coord → 112
- 3.1 RES Case Mgmt-Serv Coord → 113
- 3.2 WM RES Case Mgmt-Care Coord → 392
- 3.2 WM RES Case Mgmt-Serv Coord → 393
- 3.3 RES Case Mgmt-Care Coord → 142
- 3.3 RES Case Mgmt-Serv Coord → 143
- 3.5 RES Case Mgmt-Care Coord → 172
- 3.5 RES Case Mgmt-Serv Coord → 173

For all services allowed to provide case management services, the time providing case management does not count towards minimum or maximum service hours. It is a separate service.
Family Therapy
Allowed for RES, IOS/OS Only

- Family Therapy may only be provided by LPHAs
- The effects of addiction are far-reaching and patient’s family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient’s recovery as well as their own recovery can be conveyed.
- Family members can provide social support to the client, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
- Family Therapy must be indicated in Client Plan with frequency (e.g. 1x/week)
Family Therapy

InSyst Procedure Codes

- OS Family Therapy → 626
- IOS Family Therapy → 226

- For Residential Programs, except Withdrawal Management Residential, Family Therapy services are included in the day rate code

Remember that Family Therapy is a therapy service and may only be provided by LPHAs working within their scope of practice

updated 2/19/19
Monitoring and Substance Abuse Assistance

Recovery Support Services Only

- OS Recovery Srv Monitoring SAA → 689
- IOS Recovery Srv Monitoring SAA → 289

Peers who have completed the ACBH peer certification program may provide Substance Abuse Assistance services. All other RSS services must be provided either by a SUD Counselor or LPHA.

updated 2/19/19
Discharge Planning
Allowed for OS, IOS, RES, WM RES

• Process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services

• Discharge Services are not required to be in the plan in order to be claimed
Discharge Planning

InSyst Procedure Codes

- OS Discharge Planning: 649
- IOS Discharge Planning: 249

For Residential Programs, including Withdrawal Management Residential, Discharge Planning services are included in the day rate code.
OS Collateral Family Contact (622)

Adolescent programs only

- May be provided by LPHAs and SUD Counselors
- Sessions that include family and/or caretaker in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary’s treatment goals. Significant persons are individuals that have a personal, not official or professional relationship with the beneficiary.
- If in the best interest of the beneficiary, parents/caregivers should participate in all phases of the beneficiary’s treatment.
- Frequency and service type must be indicate in the client plan

updated 2/19/19
OS Group Multi-Family Counseling (664)

Adolescent programs only

• May be provided by LPHAs and SUD Counselors
• A group process in which several families are together to obtain information on substance use disorder(s). The group can be topic focused with a set curriculum, or can be process focused using an EBP. By including family members in the treatment process, education about factors that are important to the patient’s recovery as well as their own recovery can be conveyed. Family members can provide social support to the client, help motivate their loved one to remain in treatment, and receive help and support for their own family. Session are considered as therapeutic counseling sessions which require a minimum of 2 and maximum of 12 in a group with a focus on group process.
• Frequency must be clinically justified and service type noted in the client plan
• Services may be provided in-person and in any appropriate setting in the community
  • Group counseling services may not be conducted through telehealth
• The group count is the # of clients and/or client’s represented. Not the # of group participants. Min. 2 and max 12.
OS Screening Engagement (673)  
Adolescent programs only

- Utilizes county specific screening tools.
- May be provided by SUD counselors and LPHAs.
- Beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905 (a) Medicaid authority.
  - The adolescent shall be screened / assessed to be at risk for developing SUD
- Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

updated 2/19/19
Tracking Codes

Exist for each program type

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

**Substance Use Disorder - InSyst Procedure Codes effective 7-1-18**

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## Alameda County Behavioral Health Care Services
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### Clinically Managed Population Specific 3. BDS High Intensity Residential Services

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<td>113</td>
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### Clinically Managed Residential Withdrawal Management

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<td>3. BDSM</td>
<td>DD</td>
<td>B0607</td>
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<td>X</td>
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</tr>
</tbody>
</table>

### Note
- Y: Yes
- X: No
- DO: Determined on a case-by-case basis
- AA: Authorized by an appropriate health care professional
- DD: Determined on a case-by-case basis
- DD: Determined on a case-by-case basis

### Updated Information
- Updated: 2/19/19
- Provider Resources: [June 28, 2019](#)
Discharges from SUD Treatment
Discharge: Summary v. Plan

• A discharge plan is a plan to support client’s discharge from the program
  • A plan is developed in conjunction with the client and is intended to transition client from treatment services
  • Can be claimed when completed face-to-face with client
  • In order to be claimed, discharge plans must be prepared (discussed and signed with client) within 30 days prior to the last face-to-face treatment

• A discharge summary is a summary of treatment services, progress, and prognosis—this is required when contact is lost with the client.
  • Must be completed within 30 days of last face-to-face service
Discharge Plan

- Previous SUD Audits indicate that client discharges are not being documented or completed according to requirements.
- When provider has lost contact with client, a discharge plan is not required, but the circumstances should be documented in a non-billable note & Discharge Summary.
- Must document that client was provided (or offered and reason for refusal) a copy of their discharge plan at the last face-to-face.
- When a beneficiary is transitioning to RSS after completing treatment, the discharge plan can be used as the basis for the RSS support plan.

“Client discharged from the program” Is not a discharge plan!
Discharge Plan

• Discharge Plans MUST include:
  • Description of each client’s triggers and a plan to assist the client to avoid relapse when confronted with triggers
  • A support plan
  • Complete signature of LPHA or counselor
  • Client’s legibly printed name, date, and signature
Discharge Plan

DISCHARGE/SUPPORT PLAN

The discharge plan must be completed with the client and the counselor or therapist within 15 days prior to the completion of treatment services.

The following is my personalized Continuing Care Plan for my ongoing 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, family or spiritual advisor and review feedback, suggestions, and comments about my plan.

Discharge Date: [Date]

This treatment program has my permission to contact me during the next 12 months as a follow-up to my treatment and recovery.

Client Initial: [Initial]

Address Support Services (Other): [Address]

I will attend Recovery Support Services:

Day, Time, Location:

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

<table>
<thead>
<tr>
<th>Day(s)</th>
<th>Location</th>
<th>Time</th>
<th>Description or Program Name</th>
</tr>
</thead>
</table>

SPONSOR, MENTOR, SPIRITUAL ADVISOR OR OTHER SUPPORT PERSON:

Name of Support Person: [Name]

I will meet with [PERSON] [Daily] [Weekly] [Monthly] [Other]

Description of this commitment: [Description]

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

Describe this commitment: [Description]

ADDITIONAL SUPPORT (Individual therapy, medical/physical health needs, outside groups, social activities):

[Description]
Discharge Summary

Required when client contact is lost

• The discharge summary must be completed within 30 calendar days of the last face-to-face contact with the beneficiary

• Discharge Summary MUST include:
  • Duration of treatment (admission date to date of last service)
  • Reason for discharge and if discharge was involuntary or successful completion of SUD services
  • A narrative summary of the treatment episode
  • Client’s prognosis

• A Discharge Summary is required (whenever contact is lost with a beneficiary) but it is not a claimable activity.
Discharge Codes
California Outcome Measurements (CaOMS)

For the CA Department of Behavioral Health Services (DBHS) California Outcome Measurements (CaOMS) discharge information must be collected for all service recipients regardless of the discharge status.

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

OVERVIEW
A standard discharge shall be reported when the client is available to be reassessed for the CaOMS treatment discharge criteria via phone or in person. The client has 31 completed first treatment 2 attended a single treatment session at least satisfactory or unsatisfactory progress in treatment and will be referred to another program.

Providers shall use Standard Discharge Codes Table A and B to select the discharge code based on the ratio of achieved goals to the client’s total goals. For table A, 4, 6, 8, and 9. For table B, 4, 6, 8, and 9.

In deciding which Discharge Status Code to use, providers must consider the client’s status of success or failure, and also evaluate the client’s progress based on a composite score of the performance for all treatment plan goals associated with the episode of service. This score includes any objectives and action steps associated with the treatment plan goals. If a goal is decomposed of multiple objectives or action steps, the goal shall be considered “unachieved” if at least 10% of the objectives and or action steps associated with the goal are completed.

Definitive treatment plans goals are not included when considering the ratio of total treatment plan goals to the number of achieved goals.

Standard Discharge Codes Table A

<table>
<thead>
<tr>
<th>Percent (%) of Total Goals Achieved</th>
<th>Discharge Status Code and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-95%</td>
<td>Completed Treatment Plan Goals – Satisfied</td>
</tr>
<tr>
<td>90-94%</td>
<td>Completed Treatment Plan Goals – Not Satisfied</td>
</tr>
<tr>
<td>80-89%</td>
<td>Referred to Another Program with Unsatisfactory Progress – Not Satisfied</td>
</tr>
<tr>
<td>70-79%</td>
<td>Left Before Completion with Unsatisfactory Progress – Not Satisfied</td>
</tr>
</tbody>
</table>

Example Administrative Discharge Codes (CALM) may be entered on the Administration Educational Coding Sheet.

Example:
- Scenarios:
  - Scenario 1: Of the 9 goals, the client completed 4 goals consisting of 9 objectives and action steps.
    - Answer: 1. 4/9 = 44%, Use “1. Left Before Completion with Unsatisfactory Progress – Not Satisfied”
  - Scenario 2: Of the 9 goals, the client partially completed 2 goals including 10% of the six objectives associated with those 2 goals and fully completed 3.
    - Answer: 2. 3/9 = 10%, Use “2. Completed Treatment Plan Goals – Satisfied”
  - Scenario 3: Of the 9 goals, the client completed 6 goals including less than 10% of the 7 objectives associated with those 6 goals and 1 completely.
    - Answer: 3. 6/9 = 66%, Use “3. Left Before Completion with Unsatisfactory Progress – Not Satisfied”
  - Scenario 4: Of the 9 goals, the client completed 5 goals including less than 10% of the 7 objectives associated with those 5 goals and 1 completely.
    - Answer: 4. Left Before Completion with Unsatisfactory Progress – Not Satisfied

Your Success is Our Success
## Discharge Codes
California Outcome Measurements (CalOMS)

### Standard Discharge Codes-table A

<table>
<thead>
<tr>
<th>Percent (%) of Tx Plan Goals Achieved</th>
<th>Discharge Status Code and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-75%</td>
<td>1. Completed Tx/Recovery Plan Goals - Referred</td>
</tr>
<tr>
<td>100-75%</td>
<td>2. Completed Treatment/Recovery Plan Goals – Not Referred</td>
</tr>
<tr>
<td>75-50%</td>
<td>3. Left Before Completion with Satisfactory Progress - Referred</td>
</tr>
<tr>
<td>&lt;50%</td>
<td>4. Left Before Completion with Unsatisfactory Progress – Referred</td>
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</table>

### Administrative Discharge Codes-table B

<table>
<thead>
<tr>
<th>Proposed % of Tx Plan Goals Achieved</th>
<th>Discharge Status Code</th>
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</thead>
<tbody>
<tr>
<td>75-50%</td>
<td>4. Left Before Completion with Satisfactory Progress – Not Referred</td>
</tr>
<tr>
<td>&lt;50%</td>
<td>6. Left Before Completion with Unsatisfactory Progress – Not Referred</td>
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<tr>
<td>Death</td>
<td>7. Death</td>
</tr>
<tr>
<td>Incarceration</td>
<td>8. Incarceration</td>
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</tbody>
</table>

updated 2/19/19
Miscellaneous Items
SUD Lockouts

- Beneficiaries with Medi-Cal and Medicare (Medi-Medi) are not eligible to receive SUD services. Refer the individual to their Medicare or primary care provider.
- If a Medi-Cal beneficiary is incarcerated, claiming is not allowed on the days of incarceration
  - Services are allowed for adjudicated adolescents
- Claiming is locked out after 60 days from EOD if out-of-county Medi-Cal has not transferred to Alameda County
- SUD services additionally may not be allowed, due to duplication of service and same day billing considerations
- SUD services are not locked out if the beneficiary is receiving mental health services, as long as there is not a duplication of services and the services provided remain medically necessary
DMC-OS
Same Day Billing Matrix
(updated 5/25/2017)
Drug Medi-Cal Eligibility

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

ACBH Requirement
updated 2/19/19
Other Insurance or Private Pay

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

- Providers may claim for time spent collecting urine samples when deemed “medically indicated” and it is part of the intake or individual session.
  - The provider must establish procedures which protect against falsification and/or contamination of the sample.
  - Document the results in the file and if part of an individual session, may claim documentation time for this.
- UA lab fees are not reimbursable by Drug Medi-Cal. Medi-Cal (physical health) may be an option for coverage of lab services.
- Rates for RES include intake and the service body specimen screening is billed as part of the bundled day rate.
Drug Test Reporting Form

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

If the urine sample collection and completing of this form is part of an individual/intake session, the time spent may be claimed as documentation time as part of the individual counseling/intake note.
Backing out Claims in CG/InSyst

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