

**Outpatient Drug
Medi-Cal and Drug
Medi-Cal Organized
Delivery System Services**

Clinical Staff

CLINICAL DOCUMENTATION MANUAL

2022

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INTRODUCTION TO THIS MANUAL

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

The intent of this documentation manual is to support the implementation of updated DHCS requirements for clinical documentation and claims reimbursement for substance use disorder (SUD) treatment services. Additionally, policy changes that impact beneficiary care coordination efforts between the Mental Health Plan (MHP) and Managed Care Plan (MCP) services delivery systems (e. g., screening, transition of care, service referrals and “No Wrong Door”) as well as between the MHP and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery Systems (DMC-ODS) – notably “co-occurring treatment” are highlighted. Specifically, this manual provides guidance to Licensed Practitioner of the Healing Arts (LPHA)¹ staff in a setting that delivers and claims outpatient DMC or DMC-ODS services. This documentation manual will cover many relevant topics and concepts that support your work with youth and adults. The audience for this manual includes both those licensed, registered and waived practitioners who are new to documentation of services, as well as those practitioners who have experience with pre-CalAIM documentation standards. Aligned with CalAIM, readers will note the use of person-centered language, the focus on clinical treatment and a trauma-informed lens as key elements of the manual. For example, individuals receiving treatment will be referred to as “people” or “people in care”, rather than “clients”, “patients”, or “beneficiaries”.

HEALTH CARE SYSTEMS

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

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

- 1 “Licensed Practitioner of the Healing Arts” in this context means licensed, registered or waived psychologists, clinical social workers, marriage and family therapists or professional clinical counselors. Psychiatrists and nurses are also LPHAs; however, they have different scopes of practice.
- 2 Social Determinants of Health | CDC; Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [May 2022], from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

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

SDOH contribute to health disparities and inequities simply by limiting access to fundamental resources aimed at supporting health and wellness. For example, if behavioral health services are offered in one part of town that is difficult to get to, those who live far away or have transportation challenges may not receive the services they need in a timely fashion. Or perhaps the same clinic does not employ direct service staff who speak the language or understand the culture of the person seeking care. This again impacts a person's ability to access care that meets their individualized needs. Lastly, we have witnessed the harsh realities of inequities revealed by the COVID-19 pandemic, with stark differences in outcomes including mortality seen along racial/ethnic lines, socioeconomic status, and educational attainment³.

Although there are efforts aimed at addressing health disparities, there is still a lot of work to be done. As practitioners, we have a responsibility to look within our organizations and advocate for changes that help reduce or eliminate disparities within health systems. Through this diligent attention, systems can transform to best meet the needs of the people they are intended to serve. One of the monumental ways that CalAIM supports our systems in addressing health disparities is in the acknowledgment of the impact of trauma on health and wellness. We are able to streamline access to service, especially for youth, when an SUD is suspected but not yet diagnosed, or due to trauma. Details on this access criteria will be addressed later in this manual, as it cues practitioners in the way that treatment services can be initiated while assessment is occurring concurrently.

Social Determinants of Health



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

MEDI-CAL PROGRAMS

In California, the Department of Health Care Services (DHCS) is the state agency responsible for the administration of the state’s Medicaid program. In California, we refer to Medicaid as “Medi-Cal.” The Medi-Cal program is a mix of federal and state regulations serving over 13 million people, or 1/3 of all Californians. Medi-Cal covers 40% of children and youth and 43% of individuals with disabilities in California.⁴

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

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

County				State
MCP	MCP	MHP	DMC-ODS/DMC	Dental
Physical Healthcare	Non-Specialty Mental Health	Specialty Mental Health	Substance Use Treatment Services	Dental

Mental Health Plans

Specialty Mental Health Services (SMHS) are managed locally by county Mental Health Plans (MHPs). Fifty-six county MHPs are contracted with DHCS to administer the Medi-Cal SMHS benefit. In addition to managing the benefit, MHPs directly deliver and/or contract with Community-Based Organizations (CBOs) or groups/individual providers to deliver an array of services designed to meet the needs of individuals with Medi-Cal who have significant and/or complex care needs. This array includes highly intensive services and programs, including therapy, community-based services, wraparound, and intensive case management programs. (See [Appendix II](#) for a list of covered services.)

SMHS are provided to persons with mental health conditions that require intervention to support the person’s ability to safely participate in their communities and achieve wellbeing. The Medi-Cal populations served by county MHPs include elderly, disabled, adults, youth and foster or probation youth near or below federal poverty levels with mental health conditions or trauma significantly impairing their ability to successfully participate in their communities. In short, MHPs serve some of the most vulnerable populations.

DMC and the DMC-ODS

Within the broader Medi-Cal program, DHCS administers the DMC Program. DMC reimbursement is issued to counties and direct providers that have a contract with DHCS for approved DMC services provided to Medi-Cal beneficiaries. Persons in care who are eligible for DMC services include individuals eligible for federal Medicaid, for whom services are reimbursed

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

from federal, state, and/or county realignment funds. Such services include Narcotic Treatment Program (NTP), Outpatient Drug Free (ODF) individual and group, Intensive Outpatient (IOP), Perinatal Residential and Naltrexone Treatment. In order for DMC to pay for covered services, eligible Medi-Cal members must receive SUD services at a DMC certified program.

DMC-ODS is a program for the organized delivery of SUD treatment services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS program.⁵ Counties participating in the DMC-ODS program provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the DMC program. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria[®] for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care. To receive services through the DMC-ODS, a beneficiary must be enrolled in Medi-Cal, reside in a participating county, and meet the criteria for DMC-ODS services. (See [Appendix II](#) for a list of covered services.)

Managed Care Plans

Managed Care Plans (MCPs) are responsible for the majority of medical (physical health care) benefits and NSMHS for individuals. The MCPs provide mental health services to those with less significant or complex care needs, so may provide lower frequency/intensity of mental health services. MCPs cover medication evaluation and treatment, group and individual therapy, psychological testing, and long-term skilled nursing services as well as prescription medications, including psychotropic medications (See [Appendix II](#) for a list of covered services.) There are 24 MCPs across 58 counties delivering services across a managed network of providers (individual professionals or agencies.) Some counties may have multiple MCPs in one county and individuals with Medi-Cal can choose which MCP they would like to belong to. In other counties, there may be a single MCP providing coverage to all individuals with Medi-Cal. DHCS maintains a list of MCPs by county⁶ that is available to the public.

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

DEFINITION OF MEDICAL NECESSITY

All Medi-Cal services provided to persons in care need to meet the standard of being “medically necessary”. The definitions of medical necessity are somewhat different, based upon the age of the person in care. For individuals aged 21 and older, an SUD service is considered “medically necessary” when it is “reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.” For individuals under age 21, the definition of whether an SUD service is considered “medically necessary” falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT) Services language under Section

⁵ 42 CFR 438.2 <https://www.law.cornell.edu/cfr/text/42/438.2> or 42 CFR 438.14 <https://www.law.cornell.edu/cfr/text/42/438.14>, respectively

⁶ <https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx>

1396d(r) of Title 42 of the United States Code.⁷ This section requires provision of all Medicaid (Medi-Cal) coverable services necessary to correct or ameliorate substance misuse and SUDs discovered by a screening service, whether or not the service is covered under the State Plan. These services need not be curative or completely restorative, and can be delivered to sustain, support, improve or make more tolerable substance misuse or an SUD condition.

ASAM CRITERIA

Providers of DMC and DMC-ODS services are required to use the American Society of Addiction Medicine (ASAM) Criteria®, formerly known as the ASAM patient placement criteria, for all service types. The ASAM Criteria® is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcomes-oriented and results-based care in the treatment of substance use disorders (SUDs). The ASAM Criteria® relies on a comprehensive set of guidelines for level of care placement, continued stay, and transfer/discharge of patients with addiction, including those with co-occurring conditions. The ASAM Criteria® uses a multidimensional patient assessment to direct medical management and the structure, safety, security, and intensity of treatment services. Detailed information about The ASAM Criteria® is available on the ASAM website.⁸

ACCESS TO THE DMC/DMC-ODS SYSTEM

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

The criteria we will discuss in this section are for two distinct age cohorts: individuals aged 21 years and older⁹ and individuals under 21 years of age¹⁰. Each of these cohorts have distinct criteria due to their developmental needs. It is important to point out early that a person may begin to receive clinically appropriate services, so long as the person would benefit from the SUD services, even before a diagnosis has been fully articulated and a full ASAM assessment has been completed.

Criteria for persons aged 21 years and older, following completion of the ASAM assessment

- At least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
- OR at least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

⁷ Section 1396d(r) of Title 42 of the United States Code.

⁸ <https://www.asam.org/asam-criteria/about-the-asam-criteria>

⁹ W&I Section 14059.5(a)

¹⁰ Section 1396d(r) of Title 42 of the United States Code.

Criteria for persons under 21 years of age, following completion of the ASAM assessment

- **Appropriate and medically necessary services needed to correct and ameliorate health conditions. Services need not be curative or completely restorative to ameliorate a condition. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and thus covered as EPSDT**

Individuals can receive necessary SUD treatment aligned with their needs, no matter what health system they initially come to for support. This includes when:

1. The person in care has a co-occurring mental health condition and substance use disorder, even when the mental health diagnosis is later determined to be the primary diagnosis
2. OR services are provided concurrently with other delivery systems services when coordinated and non-duplicative.

In instances when a person is receiving or requires services from another delivery system – MCP or MHP delivery systems – the person may receive services from multiple delivery systems so long as the services are coordinated and not duplicative. In short, a person may receive or continue to receive services from multiple delivery systems but only through thoughtful care coordination amongst providers and for services covered by each of the delivery systems. For example, if a person accesses SUD treatment through the DMC-ODS system and it is determined the person would also benefit from care through the MHP SMHS system to treat a mental health condition, the systems and providers would be expected to coordinate with each other to ensure services are not duplicative. In keeping with this example, if the person was already receiving therapy services through the MCP and did not wish for a change in therapist, the person may continue to receive therapy through the MCP, while receiving other coordinated services through MHP and DMC/DMC-ODS systems, so long as they are not duplicative. Again, in this scenario, where persons in care are receiving needed services from multiple delivery systems, coordination of care is absolutely critical.

Access to medically necessary services, including all Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder, cannot be denied to persons in care if they meet criteria for substance use services as per the ASAM criteria. DHCS has also alerted counties that individuals seeking substance use treatment cannot be placed on wait lists¹¹.

¹¹ BHIN 21-075

SCREENING TOOLS

The aim of screening is to get the person the right care. While DMC and DMC-ODS systems are not required to use a new standard screening tool across programs, it is important as practitioners to understand how people you are treating access care in other systems. Individuals with Medi-Cal can access mental health treatment either from MHPs or MCPs (or both if appropriate) based upon the complexity of their care needs. To determine which system is best to provide mental health services, MHPs and MCPs are required to use the same screening tools to identify which system is likely to meet the person's needs best. Persons needing care may access care in several different ways including self-referral, receiving a referral from another behavioral health practitioner, including an SUD provider, from a primary health care provider, etc. No matter how a person initiates care, the person can expect to receive timely mental health services whether from an MHP or through the MCP. If we keep the person's care needs at the forefront of treatment decisions, there is no wrong door by which the person may enter. The goal is to ensure that individuals seeking care have access to the right care in the right place at the right time, regardless of what door they come to initially.

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

Clinically appropriate services include prevention, screening, assessment, and treatment services (e.g., individual, group, recovery services) and are covered and reimbursable under Medi-Cal even when¹²:

1. Services are provided prior to determination of a diagnosis
 - While a person may access necessary services prior to determining a diagnosis, a provisional diagnostic impression and corresponding ICD-10¹³ code must be assigned to submit a service claim for reimbursement. There are ICD-10 codes LPHAs may use prior to the determination of a diagnosis – if there is a suspected disorder within the LPHA's scope, "Other Specified" or Unspecified" ICD-10 codes

¹² Welfare & Institutions Code 14184.402(f)

¹³ <https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf> and <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

are available. Additionally, the code Z03.89 “Encounter for observation for other suspected diseases and conditions ruled out” may be used.

- As appropriate, LPHAs and non-LPHAs alike may use ICD-10 codes Z55–Z65 “Persons with potential health hazards related to socioeconomic and psychosocial circumstances”¹⁴.
2. The person in care has a co-occurring mental health condition and SUD, even when the mental health diagnosis is later determined to be the primary diagnosis; or
 3. Services are provided concurrently with other delivery systems when coordinated and non-duplicative.
 - In instances when a person is receiving or requires services from another delivery system, MCP or DMC/DMC-ODS delivery systems, the person may receive services from multiple delivery systems so long as the services are coordinated and not duplicative. In short, a person may receive or continue to receive services from multiple delivery systems but only through thoughtful care coordination amongst providers and for services covered by each of the delivery systems.

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

Screening

Assessment

Problem List

Care
Coordination

Treatment

Care
Transitions

Discharge

MULTI-DIMENSIONAL ASSESSMENT

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

¹⁴ <https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf> and <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

completes assessment activities by gathering background information that impacts the primary concerns of the person in care.

- DHCS requires practitioners to complete an assessment using ASAM Criteria® for persons of all ages for the determination of level of care placement. The exception is the delivery of prevention and early intervention services (ASAM Level 0.5) for persons under 21; a brief screening ASAM Criteria® tool is sufficient for these services. Assessments must include a typed or legibly printed name, and include the signature of the service provider, as well as the date of the signature¹⁵.
- For all levels of care except narcotic treatment programs (under both DMC or DMC-ODS), the assessment may be completed face to face (in an office, community location or at the person in care's home), by phone or by telehealth. A full ASAM assessment should be repeated when a person in care's condition changes.
- Narcotic Treatment Programs (NTP), also referred to as Opioid Treatment Programs (OTP) is considered an outpatient program. NPT/OTP programs shall conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to an NTP qualifies for the purpose of determining medical necessity.

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

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

The assessment using ASAM Criteria® serves to identify the level of care needs and outline recommendations for service provision. For both DMC and DMC-ODS providers¹⁶, the assessment can be completed by an LPHA or a registered/certified Alcohol and Other Drug (AOD) counselor when that counselor consults with an LPHA. In these scenarios, the LPHA is responsible for evaluating the assessment in consultation with the counselor. Consultation can occur in person, via live telephone or via live telehealth video chat and documentation of the consultation should be included in the assessment documentation. LPHAs are responsible for determining and documenting initial diagnoses, as this is outside the scope of practice for an AOD counselor. For narcotics treatment programs (under both DMC or DMC-ODS), the history and physical exams completed by an LPHA can justify medical necessity for people in care at that level of care.

¹⁵ BHIN 22-019

¹⁶ BHIN 21-075, BHIN 21-071

Multi-Dimensional Assessment Requirements

Assessment periods for non-residential DMC and DMC-ODS services are as follows, with the first date of service counting as “day 1”¹⁷:

- Up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established OR
- Up to 60 days if the person in care is under age 21 OR
- Up to 60 days if a provider documents that the person in care is experiencing homelessness and therefore requires additional time to complete the assessment

The assessment should be updated throughout treatment when there is significant information impacting the person’s clinical presentation. If a person in care withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over.

Assessment Dimensions

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

Below are the dimension categories¹⁸, key elements, and guidance on information to consider under each dimension. The information in the outline below is not meant to be an exhaustive list. The practitioner should always consider the person within the context of their developmental growth and their larger community, including cultural norms or expectations when completing and documenting an assessment. Information within the assessment should come from the person seeking care, in their own words whenever possible. Particularly for youth and those with disabling impairments, this may also include information from collateral sources.

¹⁷ BHIN 22-019, BHIN 21-075, BHIN 21-071

¹⁸ Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013. Copyright 2013 by the American Society of Addiction Medicine.

Acute
Intoxication
and/or
Withdrawal
Potential



Biomedical
Conditions and
Complications



Emotional,
Behavioral
or Cognitive
Conditions and
Complications



Readiness to
Change



Relapse,
Continued Use
or Continued
Problem
Potential



Recovery/
Living
Environment



Acute Intoxication and/or Withdrawal Potential (Dimension 1)

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

- **Substance Use (past and current)** – Explore the person in care's past and current experiences of substance use and withdrawal.
- **Risk related to Substance Use** – Identify risks associated with the person's current level of acute intoxication and what intoxication management services are needed.
- **Withdrawal** – Include current signs of withdrawal and/or significant risk of severe withdrawal symptoms, seizures or other medical complications (based on history and amount/frequency/chronicity and recency of discontinuation), including scoring of any standardized withdrawal rating scales used. Identify if there are sufficient supports available for ambulatory withdrawal management, if that would be safe.



Biomedical Conditions and Complications (Dimension 2)

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

- **Health Factors** – Explore individual's health history, chronic conditions, communicable diseases, current illnesses and current physical condition.
- **Medical Stabilization** – Review ongoing disease management or medical treatment needs for chronic conditions.
- **Pregnancy** – For female individuals, identify pregnancy status and pregnancy history, particularly if she has an opioid use disorder.



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

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

- **Mental Health** – Explore the person in care’s thoughts, emotions and mental health issues, including current or chronic psychiatric illnesses or psychological, behavioral, emotional or cognitive conditions, and how they create risk or interfere with/complicate treatment.
- **Connection to Substance Use** – Identify if any emotional, behavioral or cognitive symptoms appear to be part of SUD or if they appear autonomous and, even if connected to the substance use disorder, do the symptoms require specific mental health treatment. Include how course of illness and how mental health recovery efforts may be complicated by addiction challenges.
- **Coping and Social Functioning** – Explore how the person in care copes with any emotional, behavioral or cognitive conditions and the degree to which the individual’s relationships are impacted by substance use and/or mental health challenges.
- **Activities of Daily Living** – Review individual’s ability to manage activities of daily living.
- **Risk** – Exploration of risk for suicide, homicide or other forms of self-harm, including impulsivity, ideation, plans and behaviors.



Readiness to Change (Dimension 4)

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

- **Change Interest** – Explore individual readiness, willingness and interest in changing behaviors, as well as their feelings about their ability to change.
- **Awareness** – Review individual’s awareness of the relationship between substance use/ behaviors, reward/relief and negative life consequences.
- **Control** – Explore how much the individuals feels (or doesn’t feel) in control of their treatment services.



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

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

- **Relapse Relationship** – Explore the individual’s unique relationship with relapse or continued use or problems with substances, including the individual’s recognition, understanding and ability to cope with challenges to prevent relapse or cope with protracted withdrawal, cravings or impulses.
- **Relapse Risk** – Determine if the individual is in immediate danger of continued substance use and/or mental health distress.

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

Recovery/Living Environment (Dimension 6)

Dimension 6 supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

- **Living Situation** – Explore the person in care’s recovery or living situation and the surrounding people, places and things.
- **Support and Risk** – Identify if any family members, significant others, school, work or other settings/situations pose a threat to the individual’s safety or treatment engagement and, conversely, if the individual has resources that increase the likelihood of recovery including supportive friendships, financial resources, educational or vocational resources.
- **Mandates** – Explore legal, vocational, regulatory, criminal justice or social service mandates that may enhance motivation for treatment.
- **Environmental Factors** – Identify transportation, childcare, housing, employment or other environmental factors that may need to be addressed to increase recovery likelihood.

Diagnosis

While there is no longer a limited set of diagnosis codes that are allowable in relation to the provision of SUD treatment, the responsibility to provide a diagnosis has not changed. Information for the determination of a diagnosis is obtained through a clinical assessment. Information may come directly from the person in care or through other means, such as collateral information or health records. A diagnosis captures clinical information about the person's behavioral health needs and other conditions based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). Diagnoses are determined by an LPHA commensurate with their scope of practice. (See [Appendix IV: DMC-ODS Staff Service Categories](#)) Diagnoses are used to communicate with other team members about the person's substance use disorders, mental health symptoms, and other conditions and may inform level of distress/impairment. Moreover, and most importantly, diagnoses may help practitioners advise the person in care about treatment options.

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

Providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established¹⁹:

- ICD-10 codes Z55–Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.
- In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMHP in the CMS approved ICD-10 diagnosis code list 1, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code²⁰. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

19 <https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf>

20 <https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf> and <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

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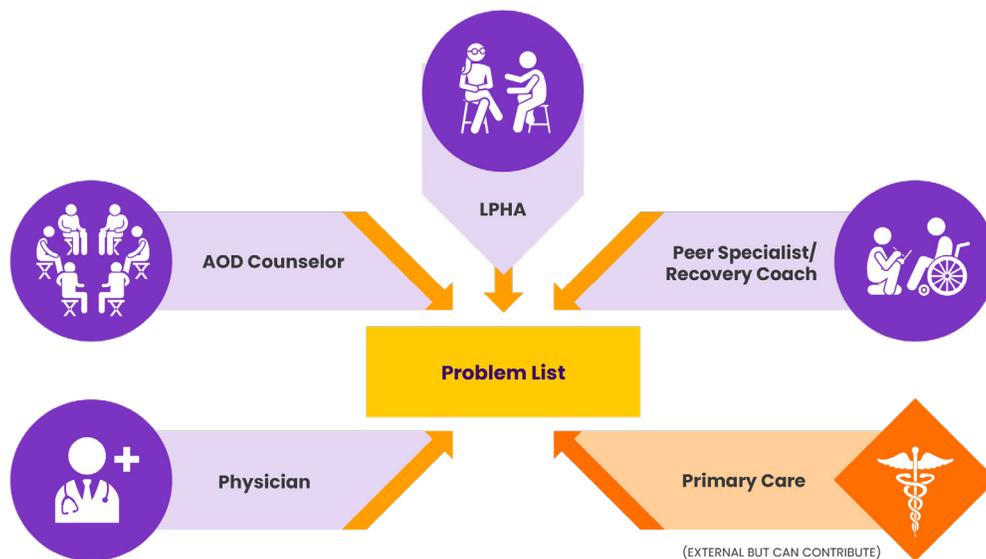
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THE PROBLEM LIST

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

The use of a Problem List has largely replaced the use of treatment plans²¹, except where federal requirements mandate a treatment plan be maintained (i.e., NTP treatment programs.) The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the problem list. The providers responsible for the beneficiary's care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by non-LPHA staff. The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person's care needs, including current diagnoses and key health and social issues.



When used as intended, treatment teams can use the problem list to quickly gain necessary information about a person's concerns, how long the issue has been present, the name of the practitioner who recorded the concern, and track the issue over time, including its resolution. The problem list is a key tool for treatment teams and should be kept up to date to accurately communicate a person's needs and to support care coordination.

Problem lists will have DSM diagnosis codes, including Z codes, as well as the DHCS Priority SDOH codes²². See [Appendix VI](#) for a list of DHCS SDOH Priority Codes.

21 Treatment or Care Plans remain in place for some specialty programs, per BHIN 22-019, Attachment 1 <https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf>

22 <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2021/APL21-009.pdf>

Problem List Requirements

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

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

Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.

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

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

Treatment Plan Requirements

In the past, treatment plans (sometimes called "care plans") were static and complicated documents with strict start and end dates. If services were provided that were not documented on the treatment plan, they could not be claimed for reimbursement. Persons in care had to sign the treatment plans or services were not considered reimbursable. Over time it has become clear that effective treatment planning involves a more dynamic process since the needs of the person in care are dynamic and can change rapidly or over time. As part of CalAIM, treatment plans are no longer required for many types of services. For services that require a treatment plan, the requirements are moving from treatment plans being standalone documents to being embedded in progress notes. Exceptions to these changes can be found in Attachment 1 of BHIN 22-019²³.

Peer Support Services

Peer support services must be based on an approved care plan²⁴. The care plan shall be documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services. (See [Appendix III](#) for a sample care plan progress note.)

Additional Treatment/Care Planning Requirements

Requirements for treatment/care planning for additional service types are found in Attachment 1 of BHIN 22-019²⁵.

²³ <https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf>

²⁴ <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf>; <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Att-3-1-A-Supp-3.pdf>

²⁵ <https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf>

Example of a Person in Care's Problem List:

Number	Code	Description	Begin Date	End Date	Identified by	Provider Type
1	Z65.9	Problem related to unspecified psychosocial circumstances	07/01/2022	07/19/2022	Name	AOD Counselor
2	Z59.02	Unsheltered homelessness	07/01/2022	Current	Name	Peer Support Specialist
3	Z59.41	Food insecurity	07/01/2022	Current	Name	Peer Support Specialist
4	Z59.7	Insufficient social insurance and welfare support	07/01/2022	Current	Name	Peer Support Specialist
5	F33.3	Major Depressive Disorder recurrent, severe with psychotic features	07/19/2022	Current	Name	Psychiatrist
6	F10.99	Alcohol Use Disorder, unspecified	07/19/2022	Current	Name	Clinical Social Worker
7	I10.	Hypertension	07/25/2022	Current	Name	Primary Care Physician
8	Z62.819	Personal history of unspecified abuse in childhood	08/16/2022	Current	Name	Clinical Social Worker

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CARE COORDINATION

In the previous sections, we explored social determinants of health and their contribution to quality of life based on access to resources. Access to health care requires services to be available and accessible at the time the person needs the services. It also requires practitioners to work alongside the person in care throughout their health care journey and to take a stance of curiosity and ask meaningful questions aimed at understanding the person within the context of their culture, community, and help seeking behaviors. By doing so, we are in better

alignment with developing treatment recommendations that support a person-centered approach. However, as practitioners, we must further support the access to other necessary resources through coordination efforts across systems and providers, while keeping the person in care as the central and most important voice on the team.

Care coordination is necessary, requiring the practitioner to be intentional and informed about coordinating activities or services with other providers to best meet the person in care's needs. We know far too well that accessing and navigating healthcare systems can be a challenge for anyone. This may be especially true in behavioral health because care coordination involves treatment providers across multiple disciplines and organizations. A person may receive care by multiple providers within and across systems, all at the same time. To ensure smooth coordination of care, practitioners should request authorization to share information (also known as releases of information) for all others involved in the care of the person in treatment during the intake process and throughout the course of treatment.

Care coordination benefits from a point person who is accountable for coordination, bringing the person in care, natural supports/family, all service providers and system partners to the table. The Care Coordinator may be you, a treatment team member from your organization, or a treatment provider from another organization or delivery system. This role may have different names within various organizations, such as case manager, care manager, team facilitator, or the function of care coordination may be incorporated into the role of a clinician or other staff. The main goal of the Care Coordinator is to meet the person's care needs by using care information in a deliberate way and sharing necessary information (with a release of information) with providers and the person in care, to guide the delivery of appropriate and effective care. Care coordinators work to build teams and facilitate partnerships, creating formal and informal networks of support that enhance treatment for persons in care and allow for sustainable support long after treatment ends. Care coordination serves as a key element of service planning, ensuring that treatment across the team is meeting the needs of the person in care, that plans are updated as needed and that barriers to success are overcome. Within the team, communication is a key element of success, along with empowering the person in care to guide the team to meet their own needs. When referring or transitioning a person in care, the practitioner should discuss the reason for referral or transition and ensure the person understands, not only the reason for referral or transition, but also the expected outcome of the referral or transition. In January 2023, DHCS will launch a universal tool for transitioning between MHPs and MCPs to assist with care coordination and communication during transitions.

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TREATMENT

Stages of Change

While the assessment, diagnosis, and problem list are necessary to understanding the person's overall care needs, equally as important is the consideration of the stage in which the person is in their recovery. The Stages of Change²⁶ framework supports practitioners in meeting the

²⁶ Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19, 276-287.

person where they are. Their readiness for change offers empowerment to the person. This framework lends itself to the identification of evidence-based interventions compatible with each stage of change and supports the conceptualization of change as a continuum. Change is not considered a linear process and should be evaluated throughout the course of care.

Moreover, a person may be in different stages of change relative to each issue. Movement from stage to stage may vary per person and may, at times, move backwards in addition to forwards through the stages. Some persons may move faster than others, while others may plateau in one stage for a longer period. A practitioner may take this opportunity to engage the person in understanding the situation.

We should note, relapse or reversion in symptoms, behaviors and/or functioning is a normal part of the change process. When relapse occurs, practitioners should take time to evaluate the situation alongside the person in care and continue to encourage and explore pros and cons of changes. Next, let us explore the framework.

Stage	Description	Potential Behaviors
Precontemplation	This is the period prior to any action towards change. The person has not yet begun to think about change. Person is not aware they have a problem.	Seeking services due to pressure of others (i.e., parent, partner, employer, courts). Place responsibility of problems on other factors or persons.
Contemplation	Person is aware they have a problem. During this period, the person begins to consider the possibility of change and begins to evaluate the benefits of making change. Not fully dedicated to taking action.	Considerations of the pros and cons of change are weighed. Action may take place if pros outweigh cons. Planning may take place the next few months.
Preparation	Person begins planning to make changes to what they are most committed to. Adjustments begin toward making change.	Person is future thinking and focused on their commitment.
Action	Specific changes to aspects of life that are contributing to undesired situation or problem. Changes may be behavioral or environmental. Changes may include decreasing unhealthy behaviors or increasing health ones.	Person is actively modifying their behaviors and is committed to change.
Maintenance	Actively working to sustain previously changed behaviors.	Person is committed to maintaining changes. Requires strong commitment of the person to avoid reverting to previous behaviors. Person has strong supports, including community connectedness.

Evidence-Based Practices

Providers working within the DMC-ODS system are required to implement at least two of the following evidenced-based treatment practices (EBPs) based on their county's implementation plan²⁷. The two EBPs are per provider and per service modality and fidelity is monitored by the county to ensure practices are well implemented within programs. Please check in with your county SUD administrator or program director to confirm which modalities are currently being used. The evidenced-based practices approved for use are:

- **Motivational Interviewing** – A person in care-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on the past successes of people in care.
- **Cognitive-Behavioral Therapy** – Based on the theory that most emotional reactions, thought processes and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
- **Relapse Prevention** – A behavioral self-control program that teaches individuals with SUD how to anticipate and cope with triggers and/or the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial SUD treatment.
- **Trauma-Informed Treatment** – Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
- **Psycho-Education** – Psycho-educational groups are designed to educate people in care about substance abuse and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to the lives of people in care; to instill self-awareness, suggest options for growth and change, identify community resources that can assist people in care with recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

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

Motivational Interviewing

Built on the Stages of Change model, service providers tend to find that principles of Motivational Interviewing (MI)²⁸ align closely with the person in care's treatment needs, is applicable in a broad range of settings and works well in combination with other common clinical practices. MI is an approach that addresses the comprehensive needs of people in care, views the person in care as an equal partner in the therapeutic process and integrates a focus on moving through the stages of change to support building motivation. People in care develop insight and skills through the use of focused MI interventions when service providers meet the individual where they are in their thinking about change and believe that people are the experts in their own lives.

²⁷ BHIN 21-075

²⁸ <https://motivationalinterviewing.org/understanding-motivational-interviewing>

Service providers use MI styles of communication to demonstrate respect and curiosity in ways that empower people in care to move through the recovery process. People in care experience incremental success and, through each step towards goal attainment, develop confidence in their ability to recover from their mental health and/or substance use challenges. In the MI model, the person in care, rather than the service provider, should present the arguments for change. This happens through a variety of strategic responses focused on enhancing the individual's understanding of change and building intention towards change. Individuals are invited to new perspectives, but these perspectives are not imposed on the person in care.

Service providers support individuals in moving through the Stages of Change through four widely applicable processes:

1. Engaging
<ul style="list-style-type: none"> • Accepting people as they are in order to free them to change • Employing acceptance and respect, normalize ambivalence and affirm strengths
2. Focusing
<ul style="list-style-type: none"> • Development of shared purpose • Assessing how important the person in care thinks change is in their life – life goal analysis, values exploration, discrepancy development.
3. Evoking
<ul style="list-style-type: none"> • Building the case for change – developing a “why” • Exploration of ambivalence and change talk
4. Planning
<ul style="list-style-type: none"> • Development of plans for change – exploration of the “how” • Supporting self-efficacy and exploring previous successes the person in care has experience to increase their confidence in their ability to change.

MI is especially useful when a person in care is in the pre-contemplation and contemplation stages of change. As is true with other EBPs, it is vital that a person is not only well-trained in MI, but also continues to receive supervision, consultation, or mentorship to ensure that it is performed with fidelity to the model.

LEVEL OF CARE DETERMINATION AND TREATMENT SERVICES

Placement and level of care determination must be provided in the least restrictive level of care that is clinically appropriate to treat the person's condition, based on the results of the ASAM-based multidimensional assessment²⁹. Covered services are based on recommendations by an LPHA, within their scope of practice, and must be provided by DMC-certified practitioners. Services shall be "medically necessary," as justified by the assessment, diagnosis and problem list. More information on the below services can be found in the ASAM manual, as well as in [BHIN 21-075](#). See [Appendix V](#) for the ASAM Level of Care Crosswalk.

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

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

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

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

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

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

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

²⁹ W&I Code 14184.402(e)

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

ASAM Level 2.1 – Intensive Outpatient Treatment Services

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

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

ASAM Level 2.5 – Partial Hospitalization Services

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

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

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

ASAM Levels 3.1, 3.3, & 3.5 – Residential Treatment

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

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

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

Residential treatment is designed to address functional challenges related to substance use disorders and to restore, maintain and practice interpersonal and independent living skills, along with access to community support systems. Services support people in care to develop practice and demonstrate recovery skills needed to avoid immediate relapse and/or high-risk behaviors. Self-help groups are often brought on site and integrated within the treatment schedule at this level of care.

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

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

- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

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

Medically Monitored and Medically Managed Inpatient Services are designed to provide inpatient residential treatment to people in care who require support to restore, improve or maintain interpersonal and independent living skills in order to thrive in the community. Such programs are typically provided in a hospital setting and include the direction from a medical professional for direct evaluation, observation and medical monitoring. Medically Monitored and Medically Managed programs are intended to meet the needs of people in care with significant functional challenges in Dimensions 1, 2 and/or 3 of the ASAM assessment. Individuals in Medically Managed programs require primary medical and nursing care where treatment is medically directed by a physician and in locations where the full resources of a general acute care or psychiatric hospital are available. Programs require additional licensure beyond DMC certification

Per DHCS³⁰, these levels of care are optional for counties participating in the DMC-ODS system, though the counties who do not opt to provide this level of treatment must have a clearly defined referral mechanism and care coordination for these levels of care.

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

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

30 [DHCS All-Plan Letter 1801](#)

Narcotic Treatment Program

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

- Methadone
- Buprenorphine (transmucosal and long-acting injectable)
- Naltrexone (oral and long-acting injectable)
- Disulfiram
- Naloxone

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

In addition, NTPs provide a variety of psychosocial services in order to support the use of pharmacotherapy to treat SUDs. Counseling (individual or group) must be offered to the person in care for at least 50 minutes per calendar month either in person, by telephone or by telehealth. Medical evaluation must be conducted in-person³². Service components include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medical Psychotherapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Medical evaluation for methadone treatment, including medical history, laboratory tests, physical exam

Withdrawal Management Services

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

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

³² BHIN 21-075, page 14

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

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Observation
- Recovery Services

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

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

Medications for Addiction Treatment

Medications for Addiction Treatment (previously also known as Medication-Assisted Treatment or MAT) is a service that provides people in care with medications that treat substance use conditions. The required MAT medications were expanded to include all medications and biological products Food and Drug Administration (FDA)-approved to treat opioid use disorders (OUD) and Alcohol Use Disorders (AUD)³³. Medications to be provided include:

- Methadone
- Buprenorphine (transmucosal and long-acting injectable)
- Naltrexone (oral and long-acting injectable)
- Disulfiram
- Naloxone

³³ On December 29, 2020, DHCS obtained a one-year extension for DMC-ODS 115 waiver.

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

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

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

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

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

DMC-ODS counties who do not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, DMC-ODS counties are still required to cover the drug product costs

for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a stand-alone service.

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

Peer Support Services

Peer Support services are a new service implemented as a County Option effective July 1, 2022. Services are provided by Certified Peer Support Specialists³⁴, who are individuals in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification. Peer Support Specialists must meet all other applicable California state requirements, including ongoing education requirements³⁵.

Peer Support services must be provided under the direction³⁶ of a Behavioral Health Professional^{37,38}. An individual directing a service is not required to be physically present at the service site to provide direction. The licensed professional directing a service assumes ultimate responsibility for the service provided. Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements³⁹.

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

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

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

34 [Behavioral Health Information Notice 21-041](#)

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

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

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

38 [Supplement 3 to Attachment 3.1-A](#) of the California State Plan. DMC-ODS services are described in the “Expanded SUD Treatment Services” section

39 Requirements outlined in [BHIN 22-018](#)

- **Engagement services** – activities and coaching led by Peer Support Specialists to encourage and support people in care to participate in behavioral health treatment. Engagement may include supporting people in care in their transitions between levels of care and supporting people in care in developing their own recovery goals and processes.
- **Therapeutic Activity** – a structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the person in care's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the person in care; promotion of self-advocacy; resource navigation; and collaboration with the people in care and others providing care or support to the person in care, family members, or significant support persons.

Peer Support Services are billable services that must be based on a care plan approved by a Behavioral Health Professional (see definition of Behavioral Health Professional above; this term is specific to the administration of Peer Support Services).

Recovery Services

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

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

Care Coordination

Care coordination consists of activities, previously referred to as case management, to provide coordination of SUD care, mental health care, and medical care, and to support the person in care with linkages to services and supports designed to restore the person in care to their best possible functional level. Care coordination must be provided in conjunction with *all* levels of treatment. Care Coordination may also be delivered and claimed as a standalone service in a DMC-ODS County.

Care coordination occurs in person, by telephone and via telehealth in a variety of clinical and non-clinical settings, including in the community. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness⁴⁰. Service components include one or more of the following:

- Coordination between medical and behavioral health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

Clinician Consultation

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

Treatment Team

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

⁴⁰ DMC-ODS counties shall have an executed memoranda of understanding to support care coordination

CO-OCCURRING TREATMENT

A substantial number of people experience co-occurring mental health and substance use disorders. These conditions can be treated via “co-occurring treatment”, with clinically appropriate services for substance use disorders in the presence of a co-occurring mental health condition, covered in all delivery systems. Likewise, clinically appropriate services for mental health disorders in the presence of a co-occurring SUD are also covered in all delivery systems.

This means that a person in care may receive clinically appropriate, covered services by the delivery system they sought care under that may be coordinated and co-treated. A person’s behavioral health condition may be addressed for problems identified on a person’s problem list. All services shall be delivered within the practitioner’s scope of competence.

PROGRESS NOTES

In previous sections, we explored the use of the screening tools, assessment, diagnosis, and problem lists to best identify the person’s care needs and treatment options. Now, we will explore the use of progress notes for documenting services as practitioners work with individuals to address their needs.

Progress notes have multiple functions. First and foremost, progress notes are used as a basis for planning care and treatment among practitioners and across programs. Progress notes are communication tools; therefore, each progress note should be understandable when read independent of other progress notes. This means, documentation should provide an accurate picture of the person’s condition, treatment provided, and response to care at the time the service was provided.

Secondly, progress notes are considered a legal record describing treatment provided for reimbursement purposes. The progress note is used for verification of billed services for reimbursement. As such, there must be sufficient documentation of the intervention, what was provided to or with the person, to justify payment. See Appendix VI for sample note narratives that provide sufficient documentation of the intervention.

Lastly, as noted earlier, progress notes are also used to communicate with other care providers. For these reasons, abbreviations should be avoided, unless universally recognized, to facilitate clear and accurate communication across providers and for when notes are used for legal or other reasons. Keep in mind that the person in care has legal privilege to their medical record and may review the medical record documentation. They should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

The following list are characteristics of a progress note that supports quality documentation. Consider the following characteristics when documenting⁴¹:

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Clear | <input type="checkbox"/> Reliable |
| <input type="checkbox"/> Consistent | <input type="checkbox"/> Accurate/Precise |
| <input type="checkbox"/> Descriptive | <input type="checkbox"/> Timely |

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

Required Progress Note Service Information

- The type of service rendered
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
- The date that the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time.
- Location of the beneficiary at the time of receiving the service.
- A typed or legibly printed name, signature of the service provider and date of signature.
- ICD 10 code (required for the claim but not needed on the progress note itself).⁴²
- Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

Group Progress Notes

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

- For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners shall be used to document the group service provided. Progress notes shall contain the information as noted above and modifications and additional information as noted below:
- Information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity, including time spent traveling to/from the service and documenting the service.
- A list of group participant names shall be maintained. Please note, due to confidentiality standards, the full list of group participants must **not** be kept in any single participant's personal health records, instead the MHP or practitioner must maintain the full participant list outside of any participant's health records.

Progress Notes Timeliness

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

- **Routine outpatient services:** Documentation should be completed within three business days. If a note is submitted outside of the three business days, it is good practice to document the reason the note is delayed. Late notes should not be withheld from the claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations⁴³), stricter note completion timelines may be required by state regulation.
- **Crisis services:** Documentation should be completed within 24 hours.

⁴² <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

⁴³ <https://www.dhcs.ca.gov/Documents/STRTP-Regulations-version-II.pdf>

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

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and abuse⁴⁴ within the service provision and claiming system. Disallowances in audits will only occur when there is evidence of fraud, waste, and abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this manual are necessary steps to promote compliance.

Screening

Assessment

Problem List

Care
Coordination

Treatment

Care
Transitions

Discharge

CARE TRANSITIONS

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

As noted earlier in this manual, there are multiple service delivery systems that cover distinct Medi-Cal services, with some not covered under the DMC/DMC-ODS program or best provided by another delivery system. Although a person may receive care from more than one delivery system or provider, the practitioner or Care Coordinator must ensure this is done without duplication. To avoid duplication of care and to facilitate the transitions between healthcare systems, DHCS is developing child and adult transition of care tools. Let us explore these tools with an understanding that additional information will be provided by DHCS regarding the transition of care tools in the future.

Screening

Assessment

Problem List

Care
Coordination

Treatment

Care
Transitions

Discharge

DISCHARGE PLANNING

Behavioral health treatment should always commence with the understanding that recovery is possible. Appropriate treatment and supports benefit people with a wide variety of conditions; lessening disability and improving the ability to live full and fulfilling lives. For this reason, the

⁴⁴ Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual.

discussion about discharge planning begins at the time of initial assessment (as clinically appropriate) and continues throughout the course of treatment. Routinely asking yourself and the person in care how you will know when they are ready to discontinue treatment and what they imagine their life will look like after treatment is a valuable discussion that enhances engagement and instills hope for the future.

Discharge planning must include the person in care and their social supports as full partners in the planning process and should be done as far in advance as practical. Additionally, including other treatment providers, when applicable, paves the ways to successful transitions from one care setting to another. Detailed information on discharge planning should be clear, concise, and accurately communicated and documented.

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

Claiming for Services

Code Sets for Claiming Services

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

- **DSM Diagnosis:** Captures clinical information about the person's behavioral health needs and other conditions (clusters of symptoms) based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). Treatment intervention is based on diagnosis, assessed need and problem list.
- **International Classification of Diseases – Clinical Modification (ICD-10-CM) Codes:** Captures detailed information about the disorder (granular information) and is used in claiming. The ICD is a standard transaction code set for diagnostic purposes under the Health Insurance Portability and Accountability Act (HIPAA).
- **Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes:** These codes are used to capture uniform information for billing medical services and procedure. County Behavioral Health currently uses primarily HCPCS codes to bill Medi-Cal. Starting in July 2023, a subset of services will be claimed using CPT codes. More information to follow.

These code sets are used throughout healthcare settings and offer standardization and uniformity for data collection, claims processing, and evaluation of disease prevalence and service provision. Now, let us take a brief look at the interplay of how interventions and code sets are used to claim for reimbursement of services.

Diagnosis and ICD-10 Codes

While a substance use diagnosis is **not** a prerequisite for access to covered services and a person may receive services prior to a final diagnosis, a diagnosis and corresponding ICD-10⁴⁵ code must be present on the claim for processing. Annually, the Centers for Medicare and Medicaid Services (CMS) publishes the approved lists of ICD codes to be used for Medicaid (Medi-Cal) reimbursement⁴⁶. The CMS-approved ICD-10 code set includes options for use when services were rendered prior to establishing a diagnosis or when access criteria is met by means other than by diagnosis, such as due to trauma. In these instances, for example, the ICD-10 list includes codes for “other specified” and “unspecified disorders” or “factors influencing health status and contact with health services” (i.e., Z Codes). Each of these codes are allowable for Medi-Cal billing and can be used to claim for services.

Commonly Used Codes

Several elements are required for the successful submission of service claims for processing, including a diagnosis (preliminary, provisional or otherwise), a corresponding ICD-10 code, and either a CPT code or a HCPCS code. DHCS has issued guidance on the most commonly utilized codes.⁴⁷

CONCLUSION

We hope that this manual has given you useful tools to implement the service delivery system transformation and documentation redesign concepts foundational to CalAIM. Achieving the goals of CalAIM requires transformation across our system, including in the practice and documentation of services provided by LPHAs. Through coordination of care and strong engagement with the person in care, LPHAs can streamline documentation and provide higher-quality care and further the goals of improving access for all Californians.

45 32 BHIN 22-013 (ca.gov)

46 33 2022 ICD-10-CM | CMS

47 34 BHIN 22-013 (ca.gov)

APPENDICES

Appendix I: Acronym List

- **ASAM:** American Society of Addiction Medicine
- **BHIN:** Behavioral Health Information Notice
- **BIPOC:** Black, Indigenous and People of Color
- **CalAIM:** California Advancing and Innovating Medi-Cal
- **CMS:** Centers for Medicare & Medicaid Services
- **CPT:** Current Procedural Terminology
- **DHCS:** Department of Health Care Services
- **DMC:** Drug Medi-Cal
- **DMC-ODS:** Drug Medi-Cal Organized Delivery Services
- **DSM-5:** Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
- **EPSDT:** Early Periodic Screening, Diagnosis and Treatment
- **FFS:** Fee-for-Service
- **HCPCS:** Healthcare Common Procedure Code System
- **HIPAA:** Health Insurance Portability and Accountability Act
- **ICD-10:** International Classification of Diseases, Tenth Revision
- **LGBTQ+:** Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and others
- **LOC:** Level of Care
- **LPHA:** Licensed Practitioner of the Healing Arts
- **MAT:** Medication-Assisted Treatment
- **MCO:** Managed Care Organization
- **MCP:** Managed Care Plan
- **MHP:** Mental Health Plan
- **NSMHS:** Non-specialty Mental Health Services
- **NTP:** Narcotics Treatment Program
- **SMHS:** Specialty Mental Health Services
- **SUD:** Substance Use Disorder
- **TCM:** Targeted Case Management

Appendix II: Medi-Cal Plans by Type

Medi-Cal Benefits			
System	Operated by	Services	Service Definition
Mental Health Plan (MHP)	County Behavioral Health Departments	Specialty Mental Health Services (SMHS) – Carved out of overall Medi-Cal benefit within 1915b Waiver ⁴⁸	<p>SMHS includes the following⁴⁹:</p> <ul style="list-style-type: none"> • Inpatient psychiatric services • Outpatient services, including intensive and community-based services, such as individual, family and group therapy, collateral, plan development and assessment. • Rehabilitative skill building services in individual and/or group settings • Targeted Case Management • Medication Support Services • Day Treatment Intensive or Rehabilitation • Crisis Intervention and Stabilization • Adult and Crisis Residential Treatment • Psychiatric health facilities • Population specific services such as Intensive Care Coordination, Therapeutic Foster Care, Intensive • Home-Based Services and Therapeutic Behavioral Services
Managed Care Plan (MCP)	Private insurance companies contracted with Department of Health Care Services ⁵⁰	Non-Specialty Mental Health Services (NSMHS) and Physical Healthcare	<p>NSMHS include the following:</p> <ul style="list-style-type: none"> • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies and supplements

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

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

50 Managed Care Plans by county

Medi-Cal Benefits (cont.)			
System	Operated by	Services	Service Definition
Fee For Service (FFS) Providers	Department of Health Care Services	Non-Specialty Mental Health Services (NSMHS) and Physical Healthcare	Same as available through MCP, however typically through private practitioners or clinics.
County Drug Medi-Cal Organized Delivery System (DMC-ODS)	County Behavioral Health Departments	ASAM Level of Care Substance Use Treatment	Continuum of Care modeled after the American Society of Addiction Medicine (ASAM) criteria ⁵¹ including: <ul style="list-style-type: none"> • Outpatient • Intensive Outpatient • Partial Hospitalization • Residential Treatment (low and high intensity) • Inpatient (Medically Monitored or Medically Managed) • Opioid Treatment Program OTP and other Medication Assisted Treatment (MAT)
Drug Medi-Cal (DMC)	State Department of Health Care Services (DHCS)	Substance Use Treatment	Includes the following ⁵² : <ul style="list-style-type: none"> • Narcotic Treatment Programs • Outpatient drug free treatment, including medication services, treatment planning, crisis intervention, collateral, individual counseling, and group counseling. • Day Habilitative services • Perinatal residential • Naltrexone treatment

⁵¹ ASAM LOC Criteria

⁵² <https://govt.westlaw.com/calregs/Document/112C91B008DA411E4A0F094BBA3CAFB62?transitionType=Default&context-Data=%28sc.Default%29>

Appendix III: Sample Progress Note Treatment Plan Template

Client's goal(s) in their own words: _____

To meet these goal(s), client participated actively in the development of this plan and will receive case management/peer support services to address the below concerns:

Activities of Daily Living	<input type="checkbox"/>	Food Insecurity	<input type="checkbox"/>
Access to IDD Services	<input type="checkbox"/>	Housing Instability	<input type="checkbox"/>
Accessing Medical/Dental Care	<input type="checkbox"/>	Legal Concerns	<input type="checkbox"/>
Access to Non-SHMS	<input type="checkbox"/>	Parenting Support	<input type="checkbox"/>
Educational Concerns	<input type="checkbox"/>	Recreation/Leisure	<input type="checkbox"/>
Employment/Vocational Support	<input type="checkbox"/>	Access to Substance Use Treatments	<input type="checkbox"/>
Family/Social Support	<input type="checkbox"/>	Transportation Issues	<input type="checkbox"/>
Financial Concerns	<input type="checkbox"/>	Other (Describe)	<input type="checkbox"/>

Appendix IV: DMC-ODS Staff Service Categories

	LPHA Physician	LPHA Non- Physician	Counselor	Peer
PHYSICIAN ONLY				
Physician-to-Physician Consultation <ul style="list-style-type: none"> DMC physician consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists (<i>Note: Counties may contract with one or more physicians or pharmacists to provide consultation services</i>) 	X			
NTP Medication Psychotherapy <ul style="list-style-type: none"> Face-to-face discussion conducted by the Medical Director of the NTP/OTP on a one-on-one basis with the patient 	X			
LPHA (PHYSICIAN AND NON-PHYSICIAN) ONLY				
Intake and Assessment: <ul style="list-style-type: none"> Determination of Medical Necessity 	X	X		
Medication Services <ul style="list-style-type: none"> Prescribe and Dispense Medication by staff authorized to provide services within their scope of practice or licensure Buprenorphine, naloxone and disulfiram reimbursed for onsite administration and dispensing at NTP programs Long-acting injectable naltrexone reimbursed for onsite administration Ordering, prescribing, administering, and monitoring of medication assisted treatment reimbursed 	X	X		
LPHA + COUNSELOR				
Intake <ul style="list-style-type: none"> Assessment of Treatment Development of Client Plan Prepare individualized treatment plan 	X	X	X	

Appendix IV: DMC-ODS Staff Service Categories (cont.)

	LPHA Physician	LPHA Non-Physician	Counselor	Peer
LPHA + COUNSELOR				
Counseling <ul style="list-style-type: none"> • Individual • Group (min 2, max 12) 	X	X	X	
Family Therapy <ul style="list-style-type: none"> • Incorporating family into treatment process 	X	X		
Patient Education <ul style="list-style-type: none"> • Research based education 	X	X	X	
Collateral Services <ul style="list-style-type: none"> • Sessions with therapists to support treatment goals 	X	X	X	
Crisis Intervention Services <ul style="list-style-type: none"> • Stabilization of beneficiary emergency situation 	X	X	X	
Discharge/Referral Services <ul style="list-style-type: none"> • Prepare beneficiary for referral • Prepare beneficiary to return to community • Link to community treatment 	X	X	X	
Withdrawal Management Services <ul style="list-style-type: none"> • Monitoring course of withdrawal 	X	X	X	

Appendix IV: DMC-ODS Staff Service Categories (cont.)

	LPHA Physician	LPHA Non-Physician	Counselor	Peer
LPHA + COUNSELOR				
Case Management Services <ul style="list-style-type: none"> • Transferring patient to a higher or lower level of care • Development and periodic revision of a client plan that includes service activities • Monitoring service delivery to ensure beneficiary access to service and the service delivery system • Monitoring the beneficiary's progress • Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services 	X	X	X	
Recovery Services <ul style="list-style-type: none"> • Recovery coaching, monitoring via telephone and internet • Providing linkages to life skills, employment services, job training, and education services • Providing linkages to childcare, parent education, child development support services, family/marriage education; • Providing linkages to self-help and support, spiritual and faith-based support • Providing linkages to housing assistance, transportation 	X	X	X	
LPHA + COUNSELOR + PEER				
Substance Abuse Assistance <ul style="list-style-type: none"> • Peer-to-peer services and relapse prevention 	X	X	X	X

Appendix IV: DMC-ODS Staff Definitions

Licensed Practitioner of the Healing Arts (LPHA) Non-Physician: Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Non-Physician LPHAs include: Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

LPHA Physician: Physicians are a sub-category of the LPHA definition and must be licensed, registered, certified, or recognized under California State scope of practice statutes. Physicians shall provide services within their individual scope of practice.

Counselors: As defined in Section 13005(a)(2) or 13005(a)(8) of Title 9 of the California Code of Regulations.

Peers: Peer-to-peer services are eligible for reimbursement under the DMC-ODS Pilot Program when provided as substance abuse assistance services, as a component of recovery services. The county must submit a training plan to DHCS for approval prior to providing covered peer support services. See Information Notice 17-008 for more information.

Appendix V: ASAM Levels of Care Crosswalk⁵³

ASAM Criteria – Adult Levels of Care

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

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

ASAM Criteria – Adult Levels of Care (cont.)

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions and Complications	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/Living Environment
LEVEL 3.1 Clinically Managed Low Intensity Residential Service	No withdrawal risk, or minimal or stable withdrawal. Concurrently receiving Level 1-WM (minimal) or Level 2-WM (moderate) services. (See withdrawal management criteria)	None or stable, or receiving concurrent medical monitoring	None or minimal, not distracting to recovery. If stable, a co-occurring capable program is appropriate. If not, a co- occurring enhanced program is required	Open to recovery, but needs a structured environment to maintain therapeutic gains	Has little awareness and needs interventions available only at Level 3.3 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction	Environment is dangerous and patient needs 24-hour structure to learn to cope
LEVEL 3.3 Clinically Managed Population Specific High Intensity Residential Service	At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3.2 WM. (See withdrawal management criteria)	None or stable, or receiving concurrent medical monitoring	Mild to moderate severity; needs structure to focus on recovery. Treatment should be designed to address significant cognitive deficits. If stable, a co-occurring capable program is appropriate, If not, a co- occurring enhanced program is required.	Has little awareness and needs interventions available at Level 3.3 to engage and stay in treatment. If there is high severity in Dimension 4 but not in any other dimension, motivational enhancement strategies should be provided in Level 1	Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences	Environment is dangerous and the patient has skills to cope outside of a highly structured 24-hour setting
LEVEL 3.5 Clinically Managed High Intensity Residential Service	At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3.2 WM. (See withdrawal management criteria)	None or stable, or receiving concurrent medical monitoring	Demonstrates repeated inability to control impulses, or unstable and dangerous signs/ symptoms require stabilization. Other functional; deficits require stabilization and a 24-hour setting to prepare for community integration and continuing care. A co- occurring enhanced setting is required for those with severe and chronic mental illness	Has variable engagement in treatment, ambivalence, or lack of awareness of the substance use or mental health problems, and requires a structured program several times a week to promote progress through the stages of change	Intensification of addiction or mental health symptoms indicate a high likelihood or relapse or continued problems without close monitoring and support several times a week	Recovery environment is not supportive but with structure and support and relief from the home environment, the patient can cope

ASAM Criteria – Adult Levels of Care (cont.)

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions and Complications	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/Living Environment
LEVEL 3.7 Medically Monitored Intensive Inpatient Services	At high risk of withdrawal, but manageable at Level 3.7 WM and does not require the full resources of a licensed hospital. (See withdrawal management criteria)	Requires 24-hour medical monitoring but not intensive treatment	Moderate severity; needs a 24-hour structured setting. If the patient has a co-occurring mental disorder, requires concurring mental health services in a medically monitored setting	Low interest in treatment and impulsive control is poor, despite negative consequences; needs motivating strategies only safely available in a 24-hour structured setting. If there is high severity in Dimension 4 dimension, motivational enhancement strategies should be provided in Level 1	Unable to control use, with imminently dangerous consequences, despite active participation at less intensive levels of care	Environment is dangerous, but recovery is achievable if Level 3.1 24-hour structure is achievable
LEVEL 4 Medically Monitored Intensive Inpatient Services	At high risk of withdrawal and requires Level 4 – WM and the full resources of a licensed hospital (See withdrawal management criteria)	Requires 24-hour medical and nursing care and the full resources of a licensed hospital	Because of severe and unstable problems, requires 24 hour psychiatric care with concomitant addiction treatment (co-occurring enhanced)	Problems in this dimension do not qualify the patient for Level 4 services. If the patient's only severity is in Dimension 4, 5, and /or 6 without high severity in Dimensions 1,2 and/or 3, then the patient does not qualify for Level 4	Problems in this dimension do not qualify the patient for Level 4 services. See further explanation in Dimension 4	Problems in this dimension do not qualify the patient for Level 4 services. See further explanation in Dimension 4

ASAM Criteria – Adolescent Levels of Care

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

ASAM Criteria – Adolescent Levels of Care (cont.)

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions and Complications	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/Living Environment
LEVEL 2.5 Partial Hospitalization Services	Experiencing mild withdrawal, or is at risk of withdrawal	None are stable or distracting from treatment at a less intensive level of care. Such problems are manageable at Level 2.5	The adolescent's status in Dimension 3 features one of more of the following: A) The adolescent is at low risk of harm, and he or she is safe overnight, B) Moderate interference requires the intensity of this level of care to support treatment engagement, C) Moderate impairment but can sustain responsibilities, D) The adolescent is experiencing moderate difficulties with activities of daily living and requires near/daily monitoring or interventions, E) The adolescent's history (combined with the present situation) predicts the need for near daily monitoring or interventions	Requires a near daily structured program to promote progress through the stages of change because of little treatment engagement or escalating use or impairment, or no awareness of the role of alcohol, tobacco and/or other drugs play in his/her present problems	High risk of relapse or continued use or continued problems in deterioration in level of functioning. Has minimal prevention skills and needs near daily monitoring and support	Adolescent's environment renders recovery unlikely without near/daily monitoring or support, or frequent relief from his or her home environment
LEVEL 3.1 Clinically Managed Low- Intensity Residential Services	The adolescent state of withdrawal (or risk of withdrawal) is being managed concurrently at another level of care	None or stable, or receiving concurrent medical monitoring as needed	The adolescent's status in Dimension 3 features one of more of the following: A) The adolescent needs a stable living environment, B) Moderate interference requiring limited 24-hour supervision to support treatment engagement, C) Moderate impairment needing limited 24-hour supervision to sustain responsibilities, D) Moderate difficulties with activities of daily living requiring 24-hour supervision and prompting, E) The adolescent's history (combined with the present situation) predicts instability without limited 24-hour supervision	Open to recovery, but needs limited 24-hour supervision to promote or sustain change	Understand the potential for continued use and/or has emerging recovery skills but needs supervision to reinforce recovery and relapse prevention skills, limited exposure to substances and/or environmental triggers or maintain therapeutic gains	Environment poses a risk to his or her recovery so that he or she requires alternative residential, secure placement or support
LEVEL 3.5 Clinically Managed Medium Intensity Residential Service	Adolescent is experiencing mild to moderate to severe withdrawal (or is at risk of withdrawal), but does not need pharmacological management or nursing monitoring	None or stable, or receiving concurrent medical monitoring as needed	The adolescent's status in Dimension 3 features one of more of the following: A) Moderate but stable risk of harm, B) Moderate to severe interference requiring medium-intensity residential treatment to support engagement, C) Moderate to severe impairment that cannot be managed at a less intensive level of care, D) Moderate to severe difficulties with activities of daily living requiring 24-hour supervision and medium-intensity staff assistance, E) The adolescent's history (combined with the present situation) predicts destabilization without medium-intensity residential treatment	The adolescent needs intensive motivating strategies in a 24-hour structured program to address minimal engagement in, or opposition to, treatment, or to address his or her lack of recognition of current severe impairment	High risk of relapse or continued use, or continued problems and deterioration in level of functioning. Has minimal prevention skills and needs near daily monitoring and support	Environment is dangerous to his or her recovery, so that he or she requires residential treatment to promote recovery goals, or for protection

ASAM Criteria – Adolescent Levels of Care (cont.)

Levels of Care	DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	DIMENSION 2 Biomedical Conditions and Complications	DIMENSION 3 Emotional, Behavioral or Cognitive Conditions or Complications	DIMENSION 4 Readiness to change	DIMENSION 5 Relapse, Continued Use or Continued Problem Potential	DIMENSION 6 Recovery/Living Environment
LEVEL 3.7 Clinically Managed Population Specific High Intensity Residential Service	Adolescent is experiencing moderate to severe withdrawal (or is at risk of withdrawal), but this is manageable at Level 3.7	Requires a 24-hour medical monitoring, but not intensive treatment	The adolescent’s status in Dimension 3 features one of more of the following: A) Moderate risk of harm, needing high- intensity 24-hour monitoring or treatment, B) Severe interference requiring high-intensity residential treatment to support engagement, C) Severe impairment that cannot be managed at a less intensive level of care, D) Severe difficulties with activities of daily living requiring 24-hour supervision and high-intensity staff assistance, E) The adolescent’s history (combined with the present situation) predicts destabilization without high-intensity residential treatment	The adolescent needs motivating strategies in a 24-hour medically monitored program due to no treatment engagement associated with a biomedical, emotional or behavioral condition, or because he or she actively opposes treatment, requiring secure placement remain safe; or because he or she needs high-intensity case management to create linkages that would support outpatient treatment	Unable to interrupt high-severity or high-frequency pattern of use/ or behaviors and avoid dangerous consequences without high-intensity 24-hour interventions (because of an emotional, behavioral, or cognitive condition; severe impulse control problems; withdrawal symptoms; and the like)	Environment is dangerous to his or her recovery, and he or she requires residential treatment to promote recovery goals, or for protection, and to help him or her establish a successful transition to a less intensive level of care
LEVEL 4 Medically Monitored Intensive Inpatient Services	Adolescent is experiencing severe withdrawal (or is at risk of withdrawal) and requires intensive active medical management	Requires 24-hour medical and nursing care and the full resources of a licensed hospital	The adolescent’s status in Dimension 3 features one of more of the following: A) The adolescent is at severe risk of harm, B) Very severe, almost overwhelming interference renders the adolescent incapable of participating in treatment at a less intensive level of care, C) Very severe, dangerous impairment requiring frequent medical and nursing interventions, D) Very severe difficulties with activities of daily living requiring frequent medical and nursing interventions, E) The adolescent’s history (combined with the present situation) predicts destabilization without medical management	Problems in this dimension do not qualify the patient for Level 4 services. If the patient’s only severity is in Dimension 4, 5, and /or 6 without high severity in Dimensions 1,2 and/or 3, then the patient does not qualify for Level 4	Problems in this dimension do not qualify the patient for Level 4 services. If the patient’s only severity is in Dimension 4, 5, and /or 6 without high severity in Dimensions 1,2 and/or 3, then the patient does not qualify for Level 4	Problems in this dimension do not qualify the patient for Level 4 services. If the patient’s only severity is in Dimension 4, 5, and /or 6 without high severity in Dimensions 1,2 and/or 3, then the patient does not qualify for Level 4

Appendix VI: DHCS Priority SDOH Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Appendix VII: Sample Progress Note Narratives

Assessment Session

Dave was referred to the clinic by the emergency department where he had gone due to a swollen abdomen (enlarged liver) and symptoms of severe nausea, fatigue, and diarrhea. Dave reported that he knows that he needs to cut down his alcohol consumption or he would die, as his father had at a young age. He has experienced some withdrawal symptoms in the past and reported being very concerned with this. A biopsychosocial assessment was completed with clinical data entered into the ASAM six dimensions. An analysis of the six dimensions, as well as a cross-dimensional analysis, suggested highest scores in the area of Withdrawal and Biomedical although Environment was also a concern. A consideration of immediate needs and imminent danger suggest a possible need for withdrawal management and a high intensity treatment program initially. As Dave is unwilling to leave the area for residential treatment, we discussed a clinically monitored detox with high intensity outpatient services including attendance of 1) motivational enhancement services; 2) medications for addiction treatment (MAT); 3) individual and family therapy. Dave reported that he did not want to participate in any 12-step program but that he was concerned enough regarding his health to further develop a plan with these components.

Individual Session

Session focused on identification and ranking of Bettina's triggers for using pills. Triggers are primarily emotional and included anger, sadness, loneliness. Bettina reported that she often feels empty, and it hits her in the pit of her stomach. When she takes the pills, the emptiness goes away, and she just doesn't care so much. Triggers for eating when not hungry were the same, trying to fill the emptiness, she just continues to eat. Alternatives to the triggers were brainstormed, and B began listing what she could do when she triggered. She agreed to keep a journal with the dates, times, triggers, and what she ended up doing. Next session, we will look at the list and see what is working well and what can be put in place as part of her routine.

Individual Session

Keeshawn reported that he saw in his new medical doctor and got a physical. He is waiting for the results of his blood work, and the doctor ordered an Xray of his back. Keeshawn also will get a referral to physical therapy depending upon the results. He also has an appointment with the VA, to see what kind of support is available to him. He was told of a peer led support group which he is thinking about attending. Keeshawn reported that he is proud of himself for "taking care of business". I provided affirmation for his strides in reaching out to address pain issues and connectedness to others. We explored ways to keep this momentum going and to identify ways to increase self-care.

Care Coordination

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

Group Session

Hugo actively participated in the group session, sharing that he was able to remain drug free for the past 10 days despite intense cravings. He stated that "this CM (contingency management) thing really helps me stay on track. It is so nice to be rewarded for a clean test. When I experience a craving, I think of getting a negative test and everyone supporting me and getting a gift care to share with my son.

Perinatal Group Session

Carly checked in with a craving scale of "8" today but stated that she had not drunk in the past week. She presented in the group as tired and overwhelmed, saying that the baby was fussy and teething and that it had been getting to her making her want to escape and have a drink to relax. The group discussed how these stressors could increase cravings and a desire to escape being in the house. Group members brainstormed ways to provide each other with a break when family members were not the best option. Carly identified a group member to exchange numbers with for a check in call, to meet at the park, or to check availability to trade time to watch each other's kids. Group members to commit to at least one contact during the next week and report back to the group.

Wellbriety Talking Circle

Sam agreed to be a part of the circle that began with smudging of each member. Sam identified no allergies to the ceremony. Talking Circle facilitator suggested the topic of deceptiveness of substance abuse. Sam took his turn as part of circle and spoke from the heart about alcohol allowing him to be more social and helping him to forget his problems but that it had caused separation and strife in the family. Sam voiced the power of the connection of the circle and a desire to reconnect with who he is and his desire to be in respect for his ancestors.

Discharge

Bob has successfully completed his contingency management program. To celebrate the completion of this treatment, an honoring ceremony took place outside of the clinic that included draping him with a blanket and honoring him with a song sung to him in the Paiute language. Bob became tearful with the honoring and spoke of feeling connected in a new way in his recovery from meth. He will continue to attend the Talking Circle and has identified an SUD counselor for ongoing contact. He has also developed a list of persons that he can call on for support.

