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

Clinical Documentation Guide

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CalMHSA

California Mental Health Services Authority

Table of Contents

Introduction to this Guide 4
Health Care Systems 4
Medi-Cal Programs 5
SMHS Mental Health Plans 6
Drug Medi-Cal and Drug Medi-Cal Organized Delivery System 6
Managed Care Plans 7
Definition of Medical Necessity 7
Accessing DMC/DMC-ODS Services 8
Overview of criteria to access DMC and DMC-ODS for adults 21 years and older 8
Overview of criteria to access DMC and DMC-ODS for persons under 21 years of age 8
Treatment Components 9
Screening 9
Assessment 11
Assessment Requirements 12
Assessment Dimensions 12
Diagnosis 15
The Problem List 17
Problem List Requirements 17
Example of a Problem List for a Person in Care 19
Treatment/Care Plan Requirements 19
Care Coordination 21
Treatment 22
Co-Occurring Treatment 32
Progress Notes 32
Progress Notes Timeliness 33
Claiming for Services 34
Care Transitions 34
Discharge Planning 35
Conclusion 35
Questions or Feedback 35
Appendix I: Acronym List 36
Appendix II: Medi-Cal Plans by Type 38

Appendix III: Scope of Practice Matrix 40
Appendix IV: DHCS Priority SDOH Codes & All Z Codes 41
Appendix V: Sample Progress Notes 43
Appendix VI: Commonly Used Service Codes 47

Introduction to this Guide

The California Medi-Cal system is working to build a more coordinated, person-centered, and equitable health system that works for everyone. The goal of this transformation is for individuals to have access to new and improved services, to receive well-rounded care that goes beyond the doctor's office or hospital, and to address physical and mental health needs.

The intent of this documentation guide is to support implementation of the California Department of Health Care Services (DHCS) guidance around essential documentation requirements for the Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS). This guide provides guidance to providers in a setting that delivers and claims outpatient DMC or DMC-ODS services. Information from multiple guides has been complied and condensed into a single comprehensive resource for all DMC and DMC-ODS providers.

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 access not just to physical health care but quality behavioral health care, in a way that is responsive to their 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 drivers. Social drivers of health (SDOH) play a significant role in individual health and wellness. SDOH are the conditions in the environments in which 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.

Economic stability (ability to access and maintain food, clothing, shelter, and mobility as well as other basic needs within their community)

1. Education (opportunities to learn and build skills);
2. Health care access and quality (to prevent and treat illness and injury);
3. Neighborhood and built environment (safe, free from pollutants, and access to nature); and
4. Social and community context and connectedness.

SDOH contribute to health disparities and inequities 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 access, 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 individual seeking care. This, again, impacts an individual's ability to receive care that meets their unique 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 attainment.[1] Medi-Cal behavioral health delivery systems must work to address disparities by enhancing

[1] Variation in Covid-19 Mortality in the US by Race and Ethnicity and Educational Attainment: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786466

community partnerships and fostering better coordination among systems. This involves breaking down barriers to accessing essential services, identifying and addressing SDOH that have been overlooked, and promoting trauma-informed care that considers the entirety of an individual's experience. Although there are statewide efforts aimed at addressing health disparities, there is still much to be done. As providers, 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.

Medi-Cal Programs

In California, DHCS is the state agency responsible for administering the state's Medicaid program, known as Medi-Cal in California. Medi-Cal operates under a combination of federal and state regulations. At the federal level, it is governed by Medicaid laws, which set minimum standards for coverage, eligibility, and benefits. However, each state also has the flexibility to design its own program within those federal guidelines. This allows California to tailor Medi-Cal to meet the unique needs of its residents, resulting in a program that serves approximately 15.5 million people, or about one-third of the state's population. Medi-Cal provides coverage for 40 percent of children and youth, and half of individuals with disabilities in California.[2]

Medi-Cal behavioral health services are "carved out," meaning that they are managed separately from the general Medi-Cal health plans. Instead of receiving these services through their usual Medi-Cal plan, individuals (also referred to as "members") access them through specialized programs run by counties and specific networks. For example, county Mental Health

[2] https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-July2023.pdf

Plans (MHPs) provide care for serious mental health conditions, while the DMC-ODS offers a range of substance use disorder (SUD) treatments. This approach ensures that individuals get the specialized care they need from providers with expertise in these areas. Additionally, it allows for better coordination with other health care services, ensuring that all aspects of an individual's health are addressed comprehensively. This structure aims to improve access to care, enhance service quality, and ultimately lead to better health outcomes for those enrolled in Medi-Cal. The focus of this guide is to examine DMC, and DMC-ODS services that are provided by county behavioral health departments. While the purpose of this guide is focused on DMC and DMC-ODS, this section will briefly discuss the broader behavioral health system, including Managed Care Plans (MCPs) and Mental Health Plans (MHPs).

County				State
MCP	MCP/FFS	MHP	DMC-ODS/DMC	Dental
Physical Healthcare	Non-Specialty Mental Health Services - Mild to Moderate Mental Health	Specialty Mental Health Services - Serious Emotional Disturbance	Substance Use Treatment Services	Dental

SMHS Mental Health Plans

Fifty-six county MHPs are contracted with DHCS to administer the SMHS benefit, which is designed to meet the needs of individuals with Medi-Cal who have significant and/or complex care needs. In addition to managing the benefit, MHPs directly deliver and/or contract with community-based organizations or group/individual providers to deliver an array of services and programs including therapy, community-based services, and intensive case management. The term “case management” is used at different points because this service type is defined in federal regulation for SMHS.[3] However, it is important to remember that each individual in care is not a “case” to be managed, but rather a human being with care needs. (See Appendix II for a list of covered services)

SMHS are provided to individuals with complex mental health conditions that require intervention to support the individual’s ability to successfully participate in their communities and achieve well-being. The Medi-Cal populations served by county MHPs include low-income individuals across the lifespan. Individuals living at or below federal poverty levels can experience complex psychosocial issues, such as being unhoused, being involved in the child welfare system, being justice-involved, or having experienced trauma, to name a few examples. In short, MHPs serve some of the most vulnerable individuals living in our state.

Drug Medi-Cal and Drug Medi-Cal Organized Delivery System

California counties administer Substance Use Disorder (SUD) services through one of two systems: Drug Medi-Cal (DMC) or the Drug Medi-Cal Organized Delivery System (DMC-ODS). While both systems provide SUD treatment to Medi-Cal beneficiaries, they differ in their service offerings and operational requirements.

[3] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.169

Under DMC, counties offer a set of defined services, including Narcotic Treatment Program services, Outpatient Drug-Free services, Intensive Outpatient Treatment (IOT), Perinatal Residential Substance Use Disorder services, Naltrexone Treatment services, Mobile Crisis services and Justice Involved Reentry services. DMC-ODS, in contrast, is an opt-in program that allows counties to provide an expanded continuum of care for Medi-Cal-eligible individuals with SUD. It is designed to align with the American Society of Addiction Medicine (ASAM) Criteria® and incorporates additional elements such as increased local oversight, utilization management, evidence-based treatment practices, and enhanced coordination with other systems of care. Counties that participate in DMC-ODS offer a broader range of SUD services beyond those available under DMC. Covered services for each system are provided in Appendix II.

Managed Care Plans

Managed care plans (MCPs) are responsible for the majority of the physical health care benefits and non-specialty mental health services (NSMHS) for individuals. The MCPs provide mental health services to members with less significant or complex care needs and, therefore, may provide a lower frequency/intensity of mental health services. In terms of mental health treatment, MCPs provide medication evaluation and treatment, group and individual therapy, psychological testing, and prescription medications including psychotropic medications. For SUD, MCPs provide Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT) (see Appendix II for a list of covered services). MCPs may operate within one county or across an entire region and deliver services across a managed network of providers (hospitals, Federally Qualified Health Centers, and other organizations). Some counties may have multiple MCPs in one county, and Medi--Cal members can choose which MCP they would like to belong to. In other counties, there may be a single MCP providing coverage to all Medi-Cal members. To find out which MCPs provide coverage in which county, check the DHCS website.

All systems discussed here — MHPs, DMC State Plan/DMC-ODS, and MCPs — administer and/or 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, DMC/DMC-ODS, or NSMHS. To simplify navigating this complex system for people seeking services, DHCS has provided guidelines for accessing medically necessary care.

Definition of Medical Necessity

All Medi-Cal services provided to individuals 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 individual in care. For individuals 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."[4] For individuals under 21, the definition of medically necessary falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT) Services language under a specific section of Title 42.[5] 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 restorative, and

[4] Welfare and Institutions Code §14059.5
[5] Section 1396d(r) of Title 42 of the United States Code

can be delivered to sustain, support, improve, or make more tolerable a substance misuse or an SUD condition.

American Society of Addiction Medicine Criteria®

Providers of DMC and DMC-ODS services are required to use the ASAM Criteria®, formerly known as the ASAM patient placement criteria for all service types.[6] 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 SUDs. The ASAM Criteria® relies on a comprehensive set of guidelines for level of care (LOC) 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

Accessing DMC/DMC-ODS Services

The following are the technical criteria for accessing SUD services. We encourage providers to continue to view the information with empathy, considering the perspective of the individual in care and prioritizing their voice in all health care decisions.

The following criteria are for two distinct age cohorts: individuals 21 years and older and individuals under 21 years of age. Each of these cohorts has distinct criteria due to their developmental needs. It is important to note early on that individuals can start receiving clinically appropriate services as long as they would benefit from SUD services, even if a final diagnosis eligibility determination has not yet been made and a full ASAM assessment has not yet been completed.

Overview of criteria to access DMC and DMC-ODS for adults 21 years and older

One of the following criteria must be met:

- Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorder (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders
- Have had at least one diagnosis from the 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

Overview of criteria to access DMC and DMC-ODS for persons under 21 years of age

- Individuals under age 21 qualify to receive all medically necessary DMC and DMC--ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require states to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan.
- Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that

[6] DHCS Behavioral Health Information Notice (BHIN) 23-068

sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

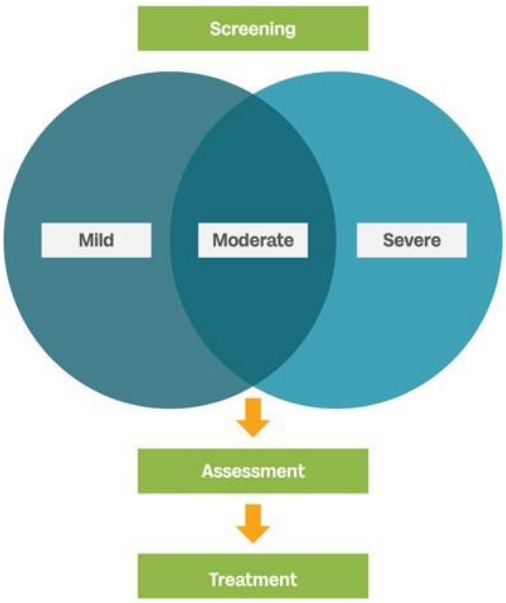
Access to medically necessary services, including all Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder (OUD) cannot be denied to persons in care if they meet criteria for DMC-ODS services. DHCS has also alerted counties that individuals seeking substance use treatment cannot be placed on wait lists.[7]

Treatment Components

SUD treatment is made up of distinct components that are individualized and delivered to ensure that individuals in care receive the best possible support and outcomes. This structured approach allows for thorough evaluation and tailored interventions, facilitating continuity and coordination among providers. We will cover each component in detail, highlighting its importance in the overall process. These components include Screening, Assessment, Problem List, Care Coordination, Treatment, Care Transitions, and Discharge. Each of these components plays a crucial role in delivering comprehensive and effective care.

Screening

Individuals seeking care may access treatment in several ways including self-referral, referral from another behavioral health provider, or a primary health care provider, etc. No matter how an individual initiates care, the individual can expect to receive timely access to SUD services. If we keep the individual's care needs at the forefront of treatment decisions, there is no wrong door through which the individual 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.



DMC and DMC-ODS systems are not required to use a standard screening tool across programs, nor is the completion of a screening tool required to begin receiving covered services. However, to assist with an initial placement into an appropriate LOC pending completion of a comprehensive ASAM assessment, DMC and DMC-ODS providers utilize standardized screening tool across their respective networks to support staff with making initial placement recommendations. DHCS allows SUD providers to use an abbreviated ASAM-based screening tool for initial screening, referral, and access to clinically appropriate services. The brief ASAM-based screening tool may be used when individuals call the plan's member access number or may be used by plan providers to determine placement(s) prior to completion of the ASAM assessment or another multidimensional LOC placement tool.

Please note that no preliminary LOC recommendation or screening tool is a substitute for a comprehensive ASAM Criteria® assessment. The screening tools are used to identify immediate behavioral health needs and determine the most appropriate setting(s) to initiate care. Immediate needs include crisis intervention, withdrawal management services, medication for addiction treatment (MAT) services, and many others.

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[7] DHCS Behavioral Health Information Notice (BHIN) No: 24-001

Once the screening is complete, the person seeking care may be referred to initial services indicated on the screening tool. Care coordination services may also begin at this time to support the individual with access and engagement. Care coordination should always be conducted in collaboration with the client to ensure their needs and preferences are considered.

Immediately following the screening, the assessment phase (also referred to as the "assessment process" in regulations) begins and includes the completion of an ASAM multi-dimensional assessment to develop a clinical understanding of the person's care needs. It confirms that the person meets diagnostic criteria for an SUD, the appropriate LOC, and which services are medically necessary. Because humans are complex, the assessment may take more than one session to fully determine the overall care needs. During the assessment phase, the person in care may also receive covered and clinically appropriate services based on the initial screening findings or any subsequent care needs identified. More information about the ASAM assessment is described in the section entitled "Assessment" below.

Covered and clinically appropriate services include prevention, screening, assessment, and treatment services (e.g., individual, group, recovery services) and are reimbursable under Medi--Cal even when:[8]

1. Services are provided prior to determination of a diagnosis, during the assessment process, or prior to determination of whether DMC or DMC-ODS access criteria are met. While a person may access necessary services prior to determining a diagnosis, an International Classification of Diseases, Tenth Revision (ICD-10) code must be assigned to submit a service claim for reimbursement.
    - In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for a Licensed Practitioner of the Healing Arts (LPHA) in the Centers for Medicare & Medicaid Services (CMS)--approved ICD-10 diagnosis code list, which may include Z codes. The LPHA may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified disorders," or "Factors influencing health status and contact with health services."
    - ICD-10 Code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during the assessment phase of a person's treatment when a diagnosis has yet to be established.
    - 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 LPHA.[9]
2. The prevention, screening, assessment, treatment, or recovery services were not included in the person in care's treatment plan.
3. The person in care has a co-occurring mental health condition.

For DMC and DMC-ODS, covered and clinically appropriate services are Medi-Cal reimbursable during the assessment process. Counties shall not disallow reimbursement for these services provided during the assessment process even if the assessment subsequently determines that

[8] Welfare and Institutions Code section 14184.402(f)
[9] DHCS Behavioral Health Information Notice (BHIN) No: 22-013

the person does not meet access criteria.[10]

We should note that the responsibility for providing covered services by each of the plans remains in place, with each plan responsible for providing covered services per its contract with DHCS. This remains true even when persons in care are receiving services from multiple plans (e.g., DMC-ODS and MHP), as each plan has separate and distinct services for which it provides coverage.

Assessment

The goal of a multi-dimensional assessment is to understand the person's needs and circumstances, to recommend the best care possible and help them recover. An assessment using the 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. It determines a person's LOC needs for placement, continued stays, transitions of care, and discharge. The ASAM Criteria® uses six dimensions to identify conditions that may be caused by substance use or that may impede or otherwise complicate the person's treatment. 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, including withdrawal potential, overdose potential, and the efficacy of MAT or harm reduction strategies. The practitioner then moves on to discuss other matters of urgency to the person in care and completes assessment activities to inform the treatment of the person in care.

Central to the completion of a comprehensive assessment is collaboration with the person in care. Centering the voice of the individual and remaining curious and humble about their experiences, culture, and needs during the assessment process are 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 individual feels seen as a whole person. Assessments must be approached with the knowledge that one's own perspective is comprised of many assumptions so that one can maintain an open mind and respectful stance toward the person in care.

Curiosity and reflection indicate humility and a deep desire to truly understand the individual 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 individual, as well as how to best address those needs. The assessment process generates a hypothesis/clinical summary, developed in collaboration with the individual, that helps to organize and guide service planning.

The assessment using ASAM Criteria® serves to identify the LOC needs and outline recommendations for service provision. For both DMC and DMC-ODS providers, the assessment can be completed by an LPHA, within their scope of practice, or a registered/certified Alcohol and Other Drug (AOD) counselor. When completed by an AOD counselor or LPHA whose scope does not allow them to diagnose health conditions, an LPHA whose scope includes diagnosing health conditions is responsible for reviewing the assessment

[10] DHCS Behavioral Health Information Notice (BHIN) No: 24-001

with the assessor and determining the diagnosis(es), making LOC determinations, and establishing medical necessity for DMC or DMC-ODS services. The consultation between the LPHA and the counselor can occur in person, via live telephone or live telehealth video chat, and the consultation must be documented.[11]

In NTPs, the history and physical exam completed by the medical director, physician, or physician extender (nurse practitioner or physician's assistant) qualifies for the purpose of determining medical necessity for people receiving NTP services.[12]

Assessment Requirements

DHCS requires practitioners to complete an assessment using ASAM Criteria® for persons of all ages for the determination of LOC placement. LOC determination is separate and distinct from establishing medical necessity.

The following apply to assessments in the DMC and DMC-ODS:

- A full ASAM assessment is not required to deliver prevention and early intervention services for persons in care under 21; a brief screening ASAM Criteria® tool is sufficient for these services.
- A full ASAM assessment, or initial provisional referral tool for preliminary LOC recommendations, shall not be required to begin receiving DMC-ODS services.
- A full ASAM assessment does not need to be repeated unless the individual's condition changes.
- Providers of residential treatment services, excluding providers of residential withdrawal management services, shall ensure each person in care receives a multidimensional LOC assessment within 72 hours of admission.
    - This initial LOC assessment for residential treatment should be used to ensure the person in care has been admitted into the correct LOC but does not need to meet the comprehensive ASAM assessment requirements described in this manual or prescribed by ASAM.
    - Following the initial LOC assessment, the comprehensive ASAM assessment should be completed as expeditiously as possible, in accordance with each person's clinical needs and generally accepted standards of practices.[13]
- The requirements for ASAM LOC assessments apply to NTP clients and settings.[14]
- All licensed and certified SUD recovery or treatment programs are required to conduct evidence-based MAT assessments. MAT assessments do not need to meet the comprehensive ASAM assessment requirements.[15]

Assessment Dimensions

The assessment contains universally required domains (ASAM Criteria®) that should not vary from county to county or provider to provider. Below is information on the standardized ASAM Criteria® comprising the assessment for understanding the person's care needs. While each of

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[11] DHCS Behavioral Health Information Notice (BHIN) No: 23-068
[12] CCR Title 9 section 10270(a)
[13] DHCS Behavioral Health Information Notice (BHIN) No: 23-068
[14] DHCS Behavioral Health Information Notice (BHIN) No: 24-001
[15] DHCS Behavioral Health Information Notice (BHIN) No: 23-054

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 categories[16], 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.

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's past and current experiences of substance use and withdrawal of the person in care.
- **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 is sufficient support and safety available for ambulatory withdrawal management.

Biomedical Conditions and Complications (Dimension 2)

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

- **Health Factors** – Explore the person'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 OUD.

[16] https://www.asam.org/asam-criteria/asam-criteria-3rd-edition

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

Dimension 3 focuses on history of mental health needs and the current 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 History** – Explore the person'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 SUD, whether 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 served and the interventions needed to assist them.

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

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

Dimension 5 assesses the risk for returning to use or potential for continued use. It is important for providers to consider what has been effective in the past to reduce or eliminate risk to determine what helps the person in care be healthy.

- **Relapse Relationship** – Explore the person's unique relationship with relapse, continued use, or problems with substances including the individual's recognition, understanding, and ability to cope with the challenges of relapse prevention or cope with protracted withdrawal, cravings, or impulses.
- **Relapse Risk** – Determine if the person is at immediate risk of continuing or returning to use.
- **Relapse Prevention** – Identify if addiction and/or psychotropic medications have assisted in recovery in the past and how the individual copes with negative effects, peer pressures, and stressors to avoid returning to use. Include the individual's awareness of triggers and skills to control impulses.

Recovery and Living Environment (Dimension 6)

Dimension 6 assesses the environment in which the person in care lives and how this environment impacts their level of functioning and progress toward recovery goals. This environment can be on the micro-level (e.g., living situation and social supports) and on the macro-level (e.g., systemic issues and broad cultural factors).

- **Living Situation** – Explore the person'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 the likelihood of recovery.

Diagnosis

While SUD treatment may begin prior to the diagnosis of a SUD, the responsibility to provide a diagnosis has not changed.[17] Information for the determination of a diagnosis is obtained through a clinical assessment. A diagnosis captures clinical information about the individual's substance use and other conditions and is determined by an LPHA commensurate with their scope of practice (see Appendix III for the Scope of Practice Matrix). Diagnoses are used to communicate with other team members about the individual's mental health symptoms and other conditions and may document the level of distress/impairment. Diagnoses also help guide providers in their advisement about treatment options to the individual.

Diagnoses may change over time. For example, the individual's clinical presentation may change over time and/or the provider may receive additional information about the individual's symptoms and how the individual experiences their symptoms(s) and conditions. LPHAs are

[17] DHCS Behavioral Health Information Notice (BHIN) No: 24-001

responsible for documenting all diagnoses, including preliminary diagnostic impressions and differential diagnoses, as well as updating the health record of the individual whenever a diagnostic change occurs.

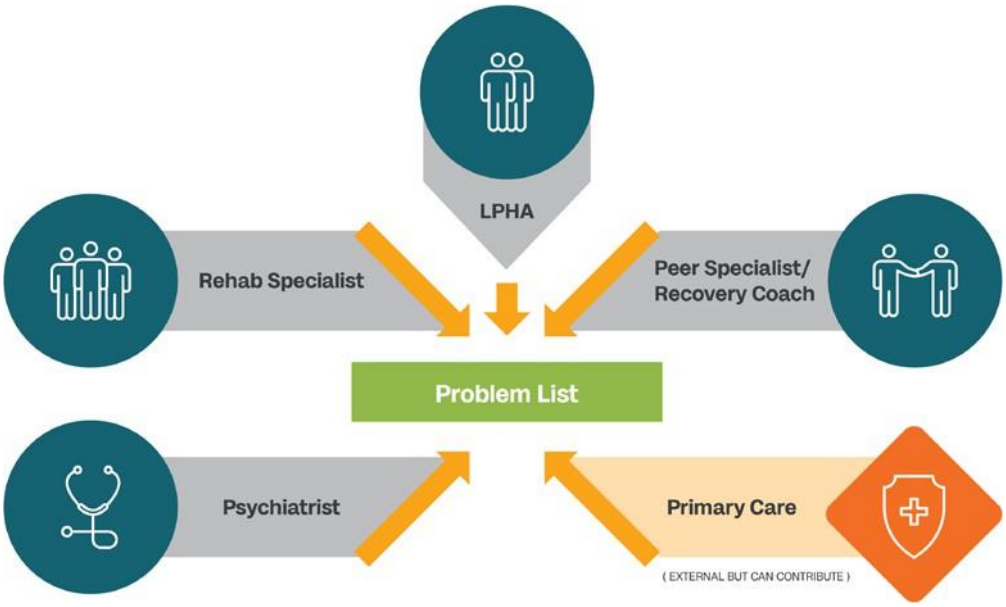
The Problem List

In the previous section we explored the assessment and how it informs the diagnosis as well as treatment recommendations. Next, we will explore how the diagnosis and 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 problem list is a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, 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 person's care create and maintain the problem list. The problem list includes clinician--identified diagnoses, identified concerns of the individual in care, and issues identified by other service providers, including those by AOD Counselors, Peer Support Specialists, and other treatment team members. 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.

Treatment teams can use the problem list to quickly gain necessary information about an individual's concerns, how long the issue has been present, the name of the provider who recorded the concern, and to 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 an individual's needs and to support care coordination.

Problem lists will contain diagnoses using ICD-10 codes, including Z codes. Some of these Z codes may also qualify as SDOH codes. DHCS has identified a list of priority SDOH codes to facilitate the collection of reliable SDOH information for the Medi-Cal population. These codes are found in Appendix IV along with a link to all Z codes.



Problem List Requirements

The problem list shall be updated on an ongoing basis to reflect the current presentation of the individual in care. Providers shall add to or remove problems from the problem list when there is

a relevant change to an individual's condition. For individuals who were receiving services prior to July 1, 2022, a problem list is not required to be created retroactively. However, a problem list should be started when the individual receives a subsequent SMHS, DMC, or DMC-ODS service.

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

- Diagnoses identified by a provider acting within their scope of practice
- Diagnostic specifiers from the current DSM, when applicable
- Problems identified by a provider acting within their scope of practice
- Problems or illnesses identified by the individual in care and/or significant support person, if any
- The name and title of the provider who identified, added, or removed the problem, and the date the problem was identified, added, or resolved

A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list. Providers may add items to problem lists that are outside their scope of practice, if they are reported to the provider by the individual or by another qualified professional. For example, a primary care physician may diagnose a chronic physical health condition and share that information with an AOD Counselor. The AOD Counselor may update the problem list to include the physical health diagnosis. The person in care's record may include information on when, by whom, and to whom the issue was reported.

DHCS does not require the problem list to be updated within a specific time frame, nor is there a specific requirement for how frequently the problem list should be updated. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.[18]

Accurate diagnoses and a comprehensive problem list are crucial for delivering appropriate treatment and supporting service claims. Inconsistencies in these areas can result in poor care coordination across teams and inadequate documentation of medical necessity, potentially leading to rejected claims.

[18] DHCS Behavioral Health Information Notice (BHIN) No: 23-068

Example of a Problem List for a Person in Care

Code	Description	Date Added	Date Resolved	Added or Resolved By	Provider Title (or credentials)*
Z65.9	Problem related to unspecified psychosocial circumstances	07/01/2022	07/19/2022	Name	Mental Health Rehabilitation Specialist
Z59.02	Unsheltered homelessness	07/01/2022	Current	Name	AOD Counselor
Z59.41	Food insecurity	07/01/2022	Current	Name	Peer Support Specialist
Z59.7	Insufficient social insurance and welfare support	07/01/2022	Current	Name	Peer Support Specialist
F33.3	Major Depressive Disorder recurrent, severe with psychotic features	07/19/2022	Current	Name	Psychiatrist
F10.99	Alcohol Use Disorder, unspecified	07/19/2022	Current	Name	Clinical Social Worker
I10	Hypertension	07/25/2022	Current	Name	Primary Care Physician
Z62.819	Personal history of unspecified abuse in childhood	08/16/2022	Current	Name	Clinical Social Worker

*Name and provider title will likely be automatically populated by your Electronic Health Record (EHR).

Treatment/Care Plan Requirements

Wherever possible, DHCS eliminated detailed care plan requirements for mental health and SUD services. In some instances, due to existing state or federal requirements, DHCS was

unable to completely remove these requirements. Below is a list of outpatient programs that still have care planning requirements as identified by Enclosure 1a of Behavioral Health Information Notice BHIN 23-068.

In addition to care planning requirements, there may be program or facility types that are required to comply with additional program/facility-specific regulations. It is recommended to refer to program-specific materials for program/facility-specific regulations.

To determine whether a care plan is required for a particular behavioral health service, follow these steps:

1. Does the program, service, or facility type have state or federal care planning requirements that remain in effect? (See Enclosure 1a of BHIN 23-068 for a non-exhaustive list.)
    - If yes, continue to step 2.
    - If no, there are no care planning requirements to follow. DHCS will not monitor or enforce the use of formal care plans, or documentation of specific care planning activities.
2. Review the relevant state and/or federal guidance to identify specific requirements (e.g., care planning activities) included in Enclosure 1a of BHIN 23-068. Some of these care planning requirements are more detailed/specific than others.
3. Adhere to all relevant care planning requirements in state and federal law.
4. Document the required care plan/care planning activities within the person in care's record. DHCS allows providers to choose where within the record to document care planning information required by state or federal law (e.g., within a care plan template, in progress notes, or in a combination of locations or formats).
5. Produce and communicate the content of the care plan to other providers, the individual, and Medi-Cal delivery systems as needed to facilitate coordinated, high-quality care.

The following services in the DMC and DMC-ODS require a treatment/care plan:

1. **Medi-Cal Peer Support Services:** Medi-Cal Peer Support Services are an optional benefit for counties. 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. Services aim to prevent relapse, empower individuals through strength-based coaching, support linkages to community resources, and educate individuals and their families about their conditions and the process of recovery. Medi-Cal Peer Support Services must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the person's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services. Medi-Cal Peer Support Services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are

specified in the service plan.[19]

2. **Narcotic Treatment Program Services:** NTP is a licensed opioid addiction treatment program, whether inpatient or outpatient, which offers all the following: evaluation, maintenance treatment and/or detoxification treatment, and other services in conjunction with replacement narcotic therapy. NTP services must be based on an individualized treatment and/or recovery plan that outlines attainable treatment goals that have been identified and agreed upon between the patient and the patient's primary counselor. The plan must specify the services to be provided, the proposed frequency and schedule for provision, and include harm reduction interventions as needed. [20][21]

Care Coordination

In previous sections, we explored SDOH and how access to resources contributes meaningfully to quality of life. Access to health care is an important driver of quality of life and health outcomes, and one that we can directly impact. We know far too well that accessing and navigating health care systems can be a challenge for anyone. This may be especially true in behavioral health because care can involve treatment providers across multiple disciplines and organizations. Appropriate access to health care requires not only that services be available and accessible at the time the person needs the services, but also that care is coordinated, streamlined, and non-duplicative, even when it is provided by multiple entities. Care that is not coordinated runs the risk of being ineffective, wasteful of health care resources, and onerous for the individuals it is designed to help. By coordinating their efforts, disparate care providers can function as a cohesive team, ensuring that the individual in care remains the focal point and has a significant role in their own treatment.

As a treatment approach, care coordination is a foundational principle that applies to all individuals receiving services. It reflects our commitment to ensuring that each person has access to well-coordinated care and is connected to the resources they need to support and maintain their wellness. As a covered service; however, Care Coordination is available only under DMC-ODS and is not a covered service under DMC. Care coordination consists of activities 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 them to their best possible functional level. Care coordination shall be provided to a person in care in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service. DMC-ODS programs, through executed memoranda of understanding, shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.

Care coordination includes one or more of the following components:[22]

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between LOCs and to recovery resources, referrals to mental health

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19 https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf

20 CCR Title 9 Chapter 4 Section 10305

21 42 CFR Part 8 Section 12(f)(4)(i)

22 DHCS Behavioral Health Information Notice (BHIN) No: 24-001

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.
- For guidance on claiming for care coordination within a LOC or as a standalone service, please refer to the most current DMC-ODS Billing Manual.

Treatment

Treatment in behavioral health refers to a range of interventions designed to address and improve the behavioral health of an individual in care. Treatment can involve a variety of evidence-based practices, such as Motivational Interviewing or Seeking Safety. Treatment approaches should be tailored to meet the unique needs of the individual in care to alleviate behavioral health symptoms, enhance coping skills, and foster overall mental wellness. Treatment involves the use of a variety of Medi-Cal services, such as individual or group counseling, medication services, or care coordination to provide supportive interventions. By taking a comprehensive and holistic approach to the treatment needs of the individual in care, providers can help individuals navigate their challenges, develop resilience, and work toward achieving optimal mental wellness and quality of life.

Evidence-Based Practices

Providers working within the DMC-ODS system are required to implement at least two of the following evidenced based treatment practices based on their county's implementation plan.[23] The two evidence-based practices 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 consider an understanding of trauma and place priority on the trauma survivor's safety, choice, and control.
- Psycho-Education – Psychoeducation is designed to educate people about substance use and related behaviors and consequences. Psychoeducation provides information

[23] DHCS Behavioral Health Information Notice (BHIN) No: 24-001

designed to have a direct application to members' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist members in recovery, develop an understanding of the process of recovery, and prompt people using substances to act on their own behalf. Psychoeducation can be provided to individuals and to groups.

The hallmark of effectiveness for evidence-based service delivery 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.

Level of Care Determination

Placement and LOC determination must be provided in the least restrictive LOC that is clinically appropriate to treat the person's condition, based on the results of the ASAM-based multidimensional assessment.[24] Covered services are based on recommendations by an LPHA, within their scope of practice, and must be provided by DMC-certified programs. 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 24--001. See Appendix III for the ASAM LOC Crosswalk.

Covered Services

While all the below LOCs are required for DMC-ODS, DMC may not incorporate every LOC outlined in this guide. Please see Appendix II for a list of services that are provided in DMC-ODS and DMC counties.

ASAM Level 0.5 - 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 LOC, a full assessment utilizing ASAM Criteria® and a SUD diagnosis are not required, and an abbreviated ASAM screening tool may be used to justify service. If the screening indicates that a person under age 21 meets criteria for a SUD, then a full ASAM assessment must be performed and the person in care referred to the appropriate LOC based on the assessment.

However, the Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT), formerly known as Screening, Brief Intervention, and Referral to 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.

[24] DHCS Behavioral Health Information Notice (BHIN) No: 24-001

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
- MAT for OUD
- 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

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 LOC. 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 nine to 19 hours per week for adults and six to 19 hours per week for adolescents. Services can occur in person, by telephone or via telehealth. IOP treatment services 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 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 LOCs. PHPs typically have direct access to psychiatric, medical, and

laboratory services and, for programs serving adolescents, educational services are also typically provided or arranged. 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 LOC is optional for counties within the DMC-OSD system. The PHP LOC 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 OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

ASAM Levels 3.1, 3.3, & 3.5 - Residential Treatment Services

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 treatment services can be provided in facilities of any size. All facilities delivering Residential treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria®. Residential treatment facilities licensed by DHCS offering ASAM Levels 3.1, 3.3, and 3.5 must also have a DHCS LOC designation and/or an ASAM LOC certification that indicates that the program can deliver care consistent with the ASAM Criteria®. Facilities licensed by a state agency other than DHCS must have an ASAM LOC certification for each LOC provided by the facility.

LOC 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 SUDs 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 cope with triggers and/or reduce high-risk behaviors.

All services are individually tailored to the person in care based on their needs, and individuals

are to be transitioned to lower LOCs as soon as 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 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 and an ASAM LOC designation and/or an ASAM LOC Certification. Per DHCS these LOCs are optional for counties participating in the DMC-ODS system, though the counties that do not opt to provide this level of treatment must have a clearly defined referral mechanism and care coordination for these LOCs.

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 LOCs as soon as 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

Narcotic Treatment Program

NTP, also described in the ASAM Criteria® as an Opioid Treatment Program, is an outpatient program that provides 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 who are 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 or 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 must comply with California Code of Regulations (CCR) Title 9 Chapter 4 regulations regarding offering counseling and other services to support the use of pharmacotherapy to treat SUDs, medical exams, and the delivery of other NTP services.

Other NTP services 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

Withdrawal Management Services

Withdrawal management services are provided to individuals experiencing withdrawal in the following outpatient and residential settings:

- 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-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)

Withdrawal management services are urgent and provided on a short-term basis. When provided as part of Withdrawal Management Services, service activities, such as the assessment, focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a LOC where comprehensive treatment services are provided.

A full ASAM Criteria® assessment shall not be required as a condition of admission to a facility providing withdrawal management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.

Withdrawal management services may be provided in an outpatient, residential or inpatient setting. If a person in care is receiving withdrawal management in a residential setting, they must reside at the facility. Everyone receiving withdrawal management services, regardless in which setting, shall be monitored during the withdrawal management process.

Withdrawal management services include the following service components:

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

Medications for Addiction Treatment

MAT includes all FDA-approved medications and biological products to treat AUD, OUD, and any SUD. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a LOC. MAT may be provided with the following service components:

- Assessment

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

For additional guidance regarding MAT requirements, please refer to the DMC-ODS MAT Policy section of BHIN 24-001 and BHIN 23-054.

Medi-Cal Peer Support Services

Medi-Cal Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, 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 members through strength-based coaching, support linkages to community resources, and to educate members and their families about their condition and the process of recovery.

Services are provided by certified Medi-Cal Peer Support Specialists. Services may be provided face-to-face, by telephone, or by telehealth with the individual or significant support person(s) and may be provided anywhere in the community. Medi-Cal Peer Support Services are based on an approved plan of care. Services may be provided with the individual or significant support person(s) and may be provided in a clinical or non-clinical setting. Medi-Cal Peer Support Services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the individual by supporting the achievement of the individual's treatment goals. Medi-Cal Peer Support Services can be claimed as a standalone service or provided in conjunction with other DMC or DMC-ODS services or LOCs, including inpatient and residential services.

Contingency Management

Contingency management (CM) is an evidence-based, cost-effective behavioral treatment for SUD that provides motivational incentives to treat individuals and reinforces positive behavior change for an individual to reduce the use of stimulants. CM is the only treatment that has demonstrated robust outcomes for individuals with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment. California is the first state in the country to receive Medicaid expenditure authority to include CM as a benefit. CM is a core component of DHCS' efforts to address the ongoing overdose crisis and further advance the state's goals to reduce racial disparities and advance health equity.

To expand access to evidence-based treatment for stimulant use disorder, DHCS began piloting Medi-Cal coverage of CM through the Recovery Incentives Program, for select DMC-ODS plans in the first quarter of 2023. Participation in the Recovery Incentives Program is optional for DMC-ODS, and it is available as an opt-in benefit for all DMC-ODS plans through Dec. 31,

2026.[25]

The Recovery Incentives Program is intended to complement SUD treatment services and other evidence-based practices already offered by DMC-ODS providers. As part of the pilot, eligible Medi-Cal members will participate in a structured 24-week outpatient CM program, followed by six or more months of additional recovery support services. Individuals will be able to earn motivational incentives in the form of low-denomination gift cards, with a total retail value determined per treatment episode.

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. Recovery services emphasize the person in care's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self--management support.

Recovery services can be delivered and claimed as a standalone service, concurrently with the other LOCs, or as a service delivered as part of an LOC. Recovery services may be provided in clinical or non-clinical settings (including the community). Persons in care may receive Recovery services based on self-assessment or provider assessment of relapse risk and do not need to be diagnosed as being in remission to access Recovery services. Persons in care may receive Recovery services while receiving other DMC-ODS services, including MAT services and NTP services. They may also receive Recovery services immediately after incarceration with a prior diagnosis of SUD.

Recovery services include the following service components:

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

Care Coordination

Care coordination consists of activities 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 them to their best possible functional level. Care coordination shall be provided to a person in care in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service. Plans, through executed memoranda of understanding, shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole -person approach to wellness.

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[25] DHCS Behavioral Health Information Notice (BHIN) No: 23-040

Care coordination includes one or more of the following components:

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between LOCs 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 consists of DMC-ODS providers who are qualified to perform assessments, as described in California's Medicaid State Plan, consulting with providers, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.

Clinician consultation is not a direct service provided to persons in care. Rather, clinician consultation is designed to support licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or LOC considerations. It includes consultations between clinicians designed to assist clinicians with seeking expert advice on treatment needs for specific persons in care. Counties may contract with one or more physicians, clinicians, or pharmacists specializing in addiction to provide consultation services.

Mobile Crisis Services

Community-based mobile crisis intervention services provide rapid response, individual assessment and community-based stabilization for Medi-Cal members who are experiencing a mental health crisis. Mobile crisis services are designed to provide relief to individuals experiencing a behavioral health crisis, including through de-escalation and stabilization techniques that reduce the immediate risk and subsequent harm and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Mobile crisis services include warm handoffs to appropriate settings and providers when the individual requires additional stabilization and/or treatment services with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the individual is connected to ongoing care. Mobile crisis services are directed toward the individual in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the individual in addressing their behavioral health crisis and restore the individual to the highest possible functional level. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate, and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the individual is experiencing a behavioral health crisis. Locations may include, but are not limited to the individual's home, school or workplace, on the street, or where an individual socializes. Mobile crisis services cannot be provided in hospitals or other facility settings. Mobile

crisis services shall be available to members experiencing behavioral health crises 24 hours per day, seven days per week, 365 days per year.[26]

Co-Occurring Treatment

Co-occurring treatment, also known as dual diagnosis treatment, refers to an integrated approach to addressing both mental health and SUD that present simultaneously. Co-occurring treatment recognizes that mental health and SUD often coexist and interact, influencing each other's severity and progression.

Co-occurring treatment is based on the understanding that treating one condition while ignoring the other can lead to incomplete recovery and an increased risk of relapse. By providing co-occurring treatment, providers can deliver comprehensive and coordinated care that addresses both the mental health and substance use aspects of the well-being of an individual in care.

The No Wrong Door policy aims to ensure that members have access to the right care at the right time.[27] No Wrong Door specifies that clinically appropriate SMHS are covered and reimbursable whether or not the individual in care has a co-occurring SUD, without delay and regardless of the delivery system where they seek care. Similarly, clinically appropriate and covered DMC and DMC-ODS services are covered by DMC and DMC-ODS plans whether or not the individual in care has a co-occurring mental health disorder. Co-occurring diagnoses can interact and influence each other, leading to more complex treatment. By recognizing and understanding the interplay between co-occurring diagnoses, providers can provide more effective treatment tailored to the individual's needs.

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 providers work with individuals to address their needs.

Progress notes have multiple functions. First and foremost, progress notes are used to document the treatment that has occurred (the intervention), and the intended next steps (the plan). Progress notes can also serve as communication tools to alert other providers (or the individual in care themselves) of the status of treatment. For these reasons, each progress note should be understandable when read independently of other progress notes, providing an accurate picture of the individual's condition, treatment provided, and response to care at the time the service was provided. To facilitate clear and accurate communication, abbreviations should be avoided, unless universally recognized, so that they will be accessible to a range of providers with whom you may wish to coordinate care. Keep in mind that progress notes can be used in legal proceedings and may also be accessed by the individual in care themselves. Individuals should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described below, but the nature and extent of the information included may vary based on the service type and the individual's clinical needs. Some notes may

[26] DHCS Behavioral Health Information Notice (BHIN) No: 23-025
[27] DHCS Behavioral Health Information Notice (BHIN) No: 22-011

appropriately contain less descriptive detail than others. If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note. Should more than one provider render a service to an individual, the note must be signed by at least one provider and does not need to be signed by all providers but must clearly document the specific involvement and duration of direct care for each provider of the service.

Appendix V provides sample note narratives demonstrating sufficient documentation of interventions and next steps.

Required Progress Note Service Information[28]

Below are requirements for progress notes for services in the DMC and DMC-ODS:

- ☐ The type of service rendered.
- ☐ The date that the service was provided to the member.
- ☐ Duration of direct patient care for the service.[29]
- ☐ Location or place of service
- ☐ A typed or legibly printed name, signature of the service provider, and date of signature.
- ☐ A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).
- ☐ A brief summary of next steps.

Additional Requirements for Group Progress Notes

In addition to the progress note requirements above, group progress notes also require the following:

- ☐ When a group service is rendered, a list of participants is required to be documented and maintained by the provider (not to be included in the individual progress notes for each participant).
- ☐ Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in above.
- ☐ The progress note for the group service encounter shall also include a brief description of the member's response to the service.

Progress Notes Timeliness

Documentation should be completed in a timely manner to support the provider'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:

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[28] DHCS Behavioral Health Information Notice (BHIN) No: 23-068

[29] Under Payment reform, rates include the costs of travel and documentation time which supports streamlined claims processing. However, travel time and documentation time should still be documented separately in progress notes to support future rate setting efforts.

Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0).

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.

If a note is submitted outside of the required timeframes, it is good practice to document the reason the note is delayed. Late notes remain billable and should not be withheld from the claiming process.

While late progress notes do not lead to recoupments, timely documentation is essential for ensuring high-quality client care. Medi-Cal recoupments focus on fraud, waste, and abuse within service provision and claims, and will only occur when clear evidence of these issues is present. Nonetheless, timely documentation supports overall care quality and compliance.[30]

Claiming for Services

In an earlier section we explored the importance of identifying needs, assessing 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. Different code sets and their uses include:

- **DSM Diagnosis** – Captures clinical information about the person's behavioral health needs and other conditions (clusters of symptoms) based on the current version of the DSM. The selection of appropriate treatment interventions is informed by the diagnosis, assessed need and problem list.
- **ICD Clinical Modification 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).
- **CPT and HCPCS Codes** – These codes are used to capture uniform information for claiming for medical services and products. SMHS use a combination of HCPCS codes and CPT codes to bill Medi-Cal. Please see Appendix VI for a list of commonly used HCPCS/CPT codes by provider type.

The above code sets are used throughout health care settings and offer standardization and uniformity for data collection, claims processing, and evaluation of disease prevalence and service provisions.

Care Transitions

Care transitions are the process of moving individuals in care between different health care settings or providers. These transitions are crucial periods where effective communication and coordination are essential to ensure continuity of care, prevent gaps, and avoid potential complications. In the context of whole person care, which focuses on addressing all aspects of an individual's health and social needs, care transitions are integral. They ensure that all

[30] 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.

providers are informed and that care plans are consistently followed. By prioritizing smooth care transitions, whole person care aims to improve overall health outcomes and enhance the quality of life for individuals in care.

Discharge Planning

SUD treatment should always commence with the understanding that recovery is possible. Appropriate treatment and supports benefit people with a wide variety of conditions, reducing disability and improving the ability to live full and fulfilling lives. For this reason, the discussion about discharge planning should begin at the time of initial assessment (as clinically appropriate) and continue throughout treatment. Routinely asking yourself and the individual in care how they 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 individual in care and their social support as full partners in the planning process and should be done as far in advance as practical. If the individual in care is being discharged to a different kind of treatment, including other treatment providers in the process can help pave the way 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 individual 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 individual in care includes how the person's needs may be addressed, information on prescribed medications, the type of care the individual is expected to receive and by whom, information on crisis supports, and available community services, to name a few.

Conclusion

This documentation guide is designed to support both new and experienced clinicians who are navigating the intricacies of California's behavioral health plans and the Medi-Cal system and providing effective clinical care that aligns with all applicable regulations. Whether you are just beginning your journey or have years of experience, our goal is to provide a resource that equips you with the knowledge and tools to deliver high-quality, client-centered care across every stage of service delivery. For seasoned providers, this guide may reinforce and refine existing practices, offering updated perspectives and aligning your work with the latest developments in Medi-Cal transformation. For newer providers, it serves as a critical foundation upon which to build a career of effective and compassionate client care.

While accurate documentation is a vital part of this process, the broader purpose of this guide is to foster an integrated, thoughtful approach to behavioral health care that benefits behavioral health staff providing services to Medi-Cal members across California. As you engage with the assessment, planning, and service delivery processes, remember that each component plays a role in improving outcomes and contributing to a more cohesive system of care. We encourage you to use this guide as an ongoing resource, whether to refresh your knowledge or to stay up--to--date on best practices.

Questions or Feedback

Thank you for your dedication to providing high-quality care to the members you serve.

If you need further assistance or have feedback, please reach out to:
managedcare@calmhsa.org

Appendix I: Acronym List

- ACE: Adverse Childhood Experience
- ASAM: American Society of Addiction Medicine
- AUD: Alcohol Use Disorder
- BHIN: Behavioral Health Information Notice
- BIPOC: Black, Indigenous and People of Color
- CalAIM: California Advancing and Innovating Medi-Cal
- CCR: California Code of Regulations
- CM: Contingency Management
- 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 System
- DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
- EPSDT: Early & Periodic Screening, Diagnosis and Treatment
- FDA: Food and Drug Administration
- HCPCS: Healthcare Common Procedure Coding System
- HIPAA: Health Insurance Portability and Accountability Act
- ICD-10: International Classification of Diseases, Tenth Revision
- IOP: Intensive Outpatient
- LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and all sexual and gender minority identities
- LOC: Level of Care
- LPHA: Licensed Practitioner of the Healing Arts
- MAT: Medication for Addiction Treatment
- MCO: Managed Care Organization
- MCP: Managed Care Plan
- MHP: Mental Health Plan
- NSMHS: Non-Specialty Mental Health Services
- NTP: Narcotic Treatment Program
- OUD: Opioid Use Disorder
- PCP: Primary Care Physician

- PHP: Partial Hospitalization Program
- SABIRT: Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment, formerly known as Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- SDOH: Social Drivers of Health
- SMHS: Specialty Mental Health Services
- SUD: Substance Use Disorder

Appendix II: Medi-Cal Plans by Type

Medi-Cal Benefits		
System	Services	Service Definition
Mental Health Plan (MHP)	Specialty Mental Health Services (SMHS) — Carved out of overall Medi-Cal benefit within 1915b Waiver[31]	SMHS includes the following:[32] • Inpatient Psychiatric Services • Outpatient services, including intensive and community-based services, such as individual, family and group therapy, care planning 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 • Intensive Care Coordination • Therapeutic Foster Care • Intensive Home-Based Services • Therapeutic Behavioral Services • Peer Support Services • Mobile Crisis Services
Managed Care Plan (MCP)	Non-Specialty Mental Health Services (NSMHS) and Physical Health Care	NSMHS include the following: • 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

[31] https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx

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

Medi-Cal Benefits Cont'd		
System	Services	Service Definition
Drug Medi-Cal Organized Delivery System (DMC-ODS)	Substance Use Treatment Continuum of Care Modeled after ASAM Criteria®	Continuum of Care modeled after the American Society of Addiction Medicine (ASAM) criteria[33] including: • Early Intervention Services (ASAM Level 0.5) • Outpatient (ASAM Level 1) • Intensive Outpatient (ASAM Level 2.1) • Partial Hospitalization (ASAM Level 2.5) • Residential Treatment (ASAM Levels 3.1, 3.3, 3.5) • Inpatient (ASAM Levels 3.7 and 4.0) (Medically Monitored or Medically Managed) • Narcotic Treatment Program • Withdrawal Management Services (ASAM Level 1-WM, Level 2-WM, Level 3.2-WM, Level 3.7-WM, Level 4-WM) • Medications for Addiction Treatment • Peer Support Services (optional benefit) • Contingency Management (optional benefit) • Recovery Services • Care Coordination • Clinician Consultation • Mobile Crisis Services • Justice Involved Reentry Services
Drug Medi-Cal (DMC)	Substance Use Treatment	Includes the following:[34] • Narcotic Treatment Program services • Outpatient Drug Free services • Day Care Habilitative services • Perinatal Residential Substance Use Disorder services • Naltrexone Treatment services • Mobile Crisis services • Justice Involved Reentry services

[33] https://www.asam.org/asam-criteria/asam-criteria-3rd-edition

[34] https://www.law.cornell.edu/regulations/california/22-CCR-51341.1

Appendix III: Scope of Practice Matrix

	Medical Doctor / Doctor of Osteopathy	Pharmacist	Medical Director of a Narcotic Treatment Program	Licensed or Waivered Psychologist (post doctorate)	Licensed or Registered ACSW/ LCSW, AMFT/ LMFT, APCC / LPCC (post MA/MS)	Nurse Practitioner	Registered Nurse	Physician Assistant	Licensed Vocation Nurse/ Licensed Psychiatric Technician	Licensed Occupational Therapist	Certified Peer Specialist+++	AOD Counselor (certified or registered)	Medical Assistant (MA)++++	Clinical Trainee/Clerk (for Licensed Practitioner of the Healing Arts)
Assessment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes*
Counseling (Individual and Group)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes*
SUD Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes*
Care Coordination	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes*
Medical Psychotherapy	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No
Medication Prescribing and Monitoring of MAT for OUD, AUD, and Other Non-Opioid SUDs	Yes	Yes	Yes	No	No	Yes	No	Yes	No	No	No	No	Yes	Yes*
Medication Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes*
Patient Education	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes*
Observation+	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes*	Yes	Yes*
Recovery Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes*
Peer Support Services	No	No	No	No	No	No	No	No	No	No	Yes++	No	No	No

* Within provider's scope of practice and under the direct supervision of a Licensed Practitioner of the Healing Arts (LPHA), who is also qualified to provide the service under their scope of practice.
+ Withdrawal management training required prior to provision of this service for all practitioner types.
++ Services must be provided under the direction of a behavioral health professional or Peer Support Specialist Supervisor.
+++ Certified Peer Specialists can only utilize Peer Support Service codes, which must be claimed under the Peer taxonomy; if they are also another practitioner type, the different practitioner taxonomy must be used to claim any non-Peer Support Services that they provide.
++++ The licensed physician, or nurse practitioner or physician assistant that has been delegated supervising authority by a licensed physician, must be physically present in the facility during the provision of services by a medical assistant.

Appendix IV: DHCS Priority SDOH Codes & All Z Codes

Please click here for the complete list of ICD-10-CM Z Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.4	Educational maladjustment and discord with teachers and classmates*
Z55.5	Less than a high school diploma*
Z56.0	Unemployment*
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)
Z62.21	Child in welfare custody*
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

Code	Description
Z64.0	Problems related to unwanted pregnancy*
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.4	Victim of crime and terrorism*
Z65.5	Exposure to disaster, war and other hostilities*

*Indicates codes that are not listed on the DHCS Priority SDOH Codes list

Appendix V: Sample Progress Notes

Progress notes should capture essential information that supports service delivery but do not need to include unnecessary detail. Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described in the Progress Notes section of this guide, but the nature and extent of the information included may vary based on the service type and the individual's clinical needs. Some notes may appropriately contain less descriptive detail than others. If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note.

There are no established guidelines dictating how a progress note writer should refer to themselves or the client, as this may vary based on personal style or common practices within a given organization.

Note: Certain service types billable to other insurance providers, including Medicare, may necessitate additional documentation detail. It is essential to consult with your county to confirm whether enhanced documentation is required for these services.

ASAM Assessment

G0396 (5-14 mins), G0397 (15-30 mins), G2011 (31-1440 mins) Alcohol and/or substance (other than tobacco) abuse structured assessment

Counselor conducted an ASAM assessment with the client, who seeks treatment for AUD, which is affecting their relationships and mental health. The client has been enrolled in residential withdrawal management for three days, referred by the county MAT clinic, where they were diagnosed with severe alcohol use disorder and prescribed Naltrexone.

Counselor gathered responses across ASAM dimensions, noting the client's challenges in the Biomedical, Emotional, and Relapse Potential areas. The client expressed a desire to regain lost aspects of life and manage alcohol use. Based on severity scores, the client is eligible for residential 3.5 level of care but expressed preference for intensive outpatient due to concerns about being away from their spouse. The client is open to committing 20 hours per week to intensive outpatient care.

The client will continue residential withdrawal management until deemed ready to transition. The counselor will coordinate with the prescriber to ensure continuity of Naltrexone treatment and will facilitate the client's transition to an intensive outpatient once clinically indicated. A LPHA will review the assessment and complete the level of care decisions.

Crisis Intervention

H2011 Crisis Intervention Services

Therapist met with client today for crisis intervention due to acute emotional distress triggered by family conflict and job-related stress, which the client identified as significant triggers for opioid use. Crisis de-escalation techniques, including grounding exercises and guided deep breathing, were utilized to prevent potential opioid use as a coping mechanism. A safety plan was collaboratively developed, including identification of supportive contacts, coping strategies, and alternatives to opioid use in high-risk situations.

Therapist will follow up with the client later this week to assess the effectiveness of the safety plan, review coping strategies, and evaluate whether additional supports or interventions are

necessary.

Individual Counseling

H0004 Individual Counseling

Counselor met with the client for a scheduled session where client reported feeling "a little better" but still struggles with cravings and the temptation to return to places where they previously drank, particularly social events at bars. While the client expressed ambivalence about avoiding these environments, they also recognized the potential risks and a desire to maintain social connections.

Counselor used Motivational Interviewing to explore the client's feelings about attending or avoiding these events. The client acknowledged the importance of avoiding high-risk situations but expressed concern about losing social connections. They showed insight into the impact of alcohol use and voiced a commitment to work on strategies for managing cravings and social pressures.

The client is currently taking Naltrexone with no reported side effects. They will continue attending weekly individual and group counseling sessions to develop specific strategies for handling cravings and social situations involving alcohol. Client will continue with Naltrexone as prescribed.

Family Therapy

90847 Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present)

Clinician met with the client and family members today for family therapy to address relational issues exacerbated by the client's alcohol use, including mood swings and impulsivity during periods of intoxication or withdrawal. The session focused on helping the family understand how alcohol use impacts communication and contributes to ongoing conflict. Clinician provided psychoeducation on alcohol use disorder to improve the family's understanding of the client's behavior and taught strategies for managing conflict, including active listening and de-escalation techniques. The family agreed to practice these skills between sessions and monitor how the client's symptoms affect their interactions.

Clinician will continue holding family therapy sessions monthly to support the family in navigating challenges related to the client's symptoms and to reinforce effective communication and conflict resolution skills.

Group Counseling

H0005 Group Counseling

(Group portion) Clinician facilitated "Coping with Triggers" group counseling session for clients enrolled in the intensive outpatient program. The topic of the session was "Coping mechanisms to manage cravings." Clinician conducted a brief check-in and icebreaker activity prior to introducing the topic. Clinician provided handouts 4 and 5 from the "Coping with Triggers" handbook and used the handouts to facilitate discussion. Clinician introduced coping strategies, including mindfulness, exercise, and support groups, specifically tailored to help manage moments of distress brought on by cravings. Clinician utilized motivational interviewing techniques throughout the session to explore ambivalence and resistance. Clinician encouraged

ongoing peer support outside of the group to reinforce the strategies discussed in the session.

(Individualized client portion) Client participated in group discussion and engaged with peers and clinician. Client assisted in reading aloud portions of the handout materials and responded positively to several coping strategies discussed, including mindfulness, to which he stated, "Mindfulness really works for me and helps the cravings go away."

Care Coordination

T1017 Targeted Case Management

This staff contacted the local county community center to inquire about programs that could assist with addressing the client's mental health needs. After discussing the types of programs that could be beneficial for the client, the community center staff confirmed that the center's wellness group and social support activities would be appropriate. This staff requested information about next steps for the client to enroll and participate in upcoming sessions.

This staff will contact the client to explain the available resources, assist with the enrollment process, and prepare the client for potential participation in these programs.

Medication Services

H0034 Medication Training and Support (Prescriber)

Physician met with the client for scheduled MAT assessment. Client meets 7/11 criteria for alcohol use disorder, severe. The client has a significant trauma history, likely contributing to current issues. Vital signs: BP: 126/80 mmHg, HR: 74 bpm, Temp: 98.6°F, Resp: 16 breaths/min, O2 Sat: 98% on room air, Weight: 185 lbs.

Client initiated on Naltrexone 50mg daily. Client and physician will monitor for any side effects, including gastrointestinal discomfort or liver function abnormalities. Physician to consult with client's primary care physician. Follow-up scheduled in four weeks.

H0034 Medication Support (Non-Prescriber)

Registered Nurse met with the client to provide medication education regarding their new prescription for naltrexone 50mg daily. Client reports being motivated to reduce alcohol consumption but had follow up questions about the medication and how it works.

Writer provided comprehensive education on the risks and benefits of Naltrexone, including that it helps reduce alcohol cravings and has potential side effects such as nausea, headache, and liver toxicity. Client verbalized understanding of the information.

Client will continue taking naltrexone as prescribed and notify provider of any adverse side effects. Client will attend next scheduled appointment with provider in approximately four weeks.

Peer Support

H0038 Self-Help/Peer Services

Peer Specialist met with the client to provide peer support services aimed at addressing the client's ongoing symptoms of severe depression, characterized by persistent feelings of hopelessness and difficulty engaging in daily activities. The Peer Specialist facilitated a discussion about the client's challenges and shared personal experiences to offer support and foster connection. Coping strategies that have been effective in similar situations were shared, including mindfulness techniques and structured daily routines.

A follow-up session is scheduled for next week to monitor the client's progress and process strategies that can effectively address symptoms of depression.

H0025 Behavioral Health Prevention Education Services (delivery of services with target population to affect knowledge, attitude, and/or behavior)

Peer Specialist met with the client today to provide prevention education services aimed at reducing the risk of substance use and increasing awareness of its long-term effects on mental health. The Peer Specialist discussed the physical, psychological, and social consequences of substance use with the client. Over the next week, the client will reflect on their personal experiences with substance use and identify its impacts on their functioning.

A follow-up session will be scheduled to explore prevention strategies further and track any behavioral changes.

Clinician Consultation

99451 Care Coordination/Clinician Consultation

Physician contacted client's primary care physician (PCP) to discuss client's treatment with Naltrexone and ongoing management of their alcohol use disorder. The purpose of the consultation was to review the client's physical health status, ensure coordination of care, and discuss potential interactions between Naltrexone and other medications. Client is prescribed Naltrexone 50mg daily to help manage alcohol cravings and is actively participating in concurrent intensive outpatient treatment. Client reports no adverse side effects of medication. There are no known liver issues or contraindications to Naltrexone; no medical history that would complicate Naltrexone treatment.

During the consultation, PCP confirmed that client has no contraindications for Naltrexone and did not express any concerns regarding medication initiation. This writer and PCP agreed that the current course of treatment is appropriate.

Client will continue Naltrexone as prescribed and attending scheduled appointments with this writer and PCP. Both physicians will continue to monitor client's health, medication adherence, liver function, and any other potential side effects, and consult as needed.

Appendix VI: Commonly Used Service Codes

The table below identifies commonly used service codes, and the disciplines allowed to bill each code. This list of codes is not comprehensive. Every county's implementation of service codes in their EHR is different. For example, some EHRs use the code description set by CMS, whereas others use simplified code descriptions. For additional information on service codes, please refer to the CalMHSA CPT for Direct Service Providers Learning Management System Training here.

Assessment		
Code	CMS Code Description	Allowable Discipline
G2011, G0396, G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment, 5-14 Minutes (G2011); 15-30 Minutes (G0396); 31-1440 Minutes (G0397). Use these codes for the ASAM assessment.	AOD, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT, Other
H0001	Alcohol and/or drug assessment, 15 minutes. Use this code for non-ASAM assessment and measurement tools.	AOD, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, RN, RN-CT, Other
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 15-29 minutes total time on the date of the encounter. (Different but related codes must be used when total time and level of medical decision-making increase). Use this code for a visit by a MAT prescriber with a new patient.	MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 10-19 minutes total time on the date of the encounter. (Different but related codes must be used when total time and level of medical decision-making increase). Use this code for a visit by a MAT prescriber with an established patient.	MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT

Crisis Intervention		
Code	CMS Code Description	Allowable Discipline
H0007	Alcohol and/or drug services; crisis intervention (outpatient), 15 Minutes	AOD, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, RN, RN-CT
Community-Based Mobile Crisis Intervention Services		
Code	CMS Code Description	Allowable Discipline
H2011	Mobile Crisis, per encounter	Not applicable
Counseling		
Code	CMS Code Description	Allowable Discipline
H0004	Individual Counseling, per 15 Minutes	AOD, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, RN, RN-CT
H0005	Group Counseling, per 15 Minutes	AOD, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, RN, RN-CT
Therapy (DMC-ODS Only)		
Code	CMS Code Description	Allowable Discipline
90846	Family Psychotherapy (Without the Patient Present), 50 minutes	LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
90849	Multiple-Family Group Psychotherapy, 84 Minutes	LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD

Recovery Services		
Code	CMS Code Description	Allowable Discipline
H2015	Comprehensive community support services, 15 Minutes	AOD, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, RN, RN-CT, Other
H2017 (DMC-ODS Only)	Psychosocial rehabilitation services, 15 Minutes	AOD, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, Pharm, Pharm-CT, Other
Peer Support Services		
Code	CMS Code Description	Allowable Discipline
H0038	Self-help/peer services (individual), 15 minutes	Certified Peer Specialist, MA
H0025	Behavior health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior) [Peer Support group session], 15 minutes	Certified Peer Specialist
Care Coordination		
Code	CMS Code Description	Allowable Discipline
T1017 (DMC-ODS Only)	Targeted case management, each 15 Minutes	AOD, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT, NP, Other
24-hour Service Codes		
Code	CMS Code Description	Allowable Discipline
H0019	Behavioral Health; Long Term Residential (must be accompanied by modifier for LOC: U1=3.1, U2=3.3, and U3=3.5). Use this code and modifier for residential treatment at the respective level of care.	Not applicable
H0012 (DMC-ODS Only)	Alcohol and/or drug services: (residential addiction program outpatient). Subacute detoxification (must be accompanied by modifier U9). Use this code for residential withdrawal management.	Not applicable

Day Service Codes		
Code	CMS Code Description	Allowable Discipline
H0014 (DMC-ODS Only)	Alcohol and/or drug services; ambulatory detoxification (must be accompanied by appropriate modifiers to indicate level of withdrawal management and LOC it is delivered in). Use this code for ambulatory withdrawal management.	Not applicable
S0201 (DMC-ODS Only)	Partial Hospitalization. Use this code for a Partial Hospitalization day service.	Not applicable
H0020	Alcohol and/or drug services; methadone. Use this code for a bundled NTP day service (counseling not included in bundled service and claimed separately).	Not applicable
Clinician Consultation		
Code	CMS Code Description	Allowable Discipline
99451 (DMC-ODS Only)	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time (5-30 minutes). Use this code when physician is providing clinician consultation.	MD/DO, MD/DO-Clerks