FRESNO COUNTY

SUBSTANCE USE DISORDERS

PROVIDER MANUAL

Revised 4/2021

SUMMARY OF CHANGES

NOTE: This summary table is not a definitive guide to the SUD Provider Manual and is not a substitute for reviewing and adhering to the guidelines set forth in the SUD Provider Manual in its entirety.

Section 2, pp. 3-4	Updated links to AOD Certification Standards and Technical Assistance Publication (TAP 21).
Section 2, p. 7-10	Added California Association for Alcohol and Drug (CAADE) to Key Staffing Standards for Counselors.
Section 2, pp. 12-13	Changes to the Credentialing, Re-Credentialing, and Appeals Policy for Contract Providers.
Section 2, pp. 13-14	Updates to the Annual Training Plan Requirements.
Section 2, pp. 15-16	Expanded Special Populations: Perinatal (Pregnant and Postpartum) to reflect Perinatal Practice Guidelines and CCR Title 9 Requirements.
Section 2, pp. 17-24	Changes to Medical Necessity & Diagnostic Requirements – Diagnosis, Residential Services and Naltrexone Treatment Services.
Section 2, pp. 24-30	Changes to Hospitalization Documentation, Residential Withdrawal Management, Case Management and Care Coordination, and Movement Through Levels of Care and Recovery Services.
Section 2, p. 35	Updates to Crisis Intervention.
Section 3, pp. 40-41	Updates to Access to Care, Screening, Admission and Treatment-Urgent Conditions and Provider Responsibilities When Receiving Access Line Referrals.
Section 3, pp. 42-44	Updates to Written Materials, Auxiliary Aids, Interpretation Services, and County of Responsibility.
Section 3, p. 45	Added Minor Consent Documentation and Regulatory Requirements.
Section 3, pp. 4647	Updated Admission Requirements for NTP/OTP, Updated Admission Discrimination.
Section 3, pp. 48-50	Updated Elements and Timeframes of Assessment and Reassessment.
Section 3, pp. 55-57	Updated Medication Policies and Procedures, Medication Storage and Dispensing and Medication Destruction and Disposal.
Section 3, p. 59	Updates to Treatment Planning for Withdrawal Management.

Section 3, pp. 61-62	Updates to Sign-In Sheets and Progress Notes.
Section 3, p. 64	Updates to Continuing Service Justification for NTP/OTP.
Section 4, pp. 66-67	Updates to Site Visits and Monitoring Cycle.
Section 4, p. 68	Updates to Personnel Requirements.
Section 6, p. 74-78	Updates to Desk Reviews and Reporting Requirements.
Section 6, pp. 78-87	Updates to Compliance and Grievance Processes.
Section 7, pp. 94-95	Updates to Financial Management and Fiscal Processes.
Glossary	Added Definitions for Discrimination Grievance, Physician Consultation, and Quality Assessment/Utilization Review (QA/UR).

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SECTION 1 INTRODUCTION

OVERVIEW AND PURPOSE

The implementation of the Fresno County Drug Medi-Cal Organized Delivery System (DMC-ODS) in 2019 paved the way for increased access and expanded Substance Use Disorder (SUD) treatment services for Fresno County youth and adults, regardless of Medi-Cal eligibility status. It also provided an opportunity to more fully integrate physical and mental health service needs with SUD services; raised quality standards to improve health outcomes; allowed for the provision of the right services, at the right time, in the right setting, for the right duration; established a single benefit package for individuals regardless of referral source; and reinforced SUD's status as a chronic health condition rather than as an acute condition. These enhancements enable Fresno County residents to receive quality services that match their individualized needs and preferences and improve health and social outcomes.

This document, along with other federal, state and local regulations, governs delivery of SUD treatment services in Fresno County's SUD system of care. These regulations include:

- 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records;
- 42 CFR Part 438 Managed Care;
- Health Insurance Portability and Accountability Act (HIPAA);
- California Code of Regulations (CCR) Title 9 Counselor Certification;
- CCR Title 22 Drug Medi-Cal;
- Department of Health Care Services Intergovernmental Agreement (IA)
- Drug Medi-Cal Organized Delivery System Special Terms and Conditions;
- Department of Health Care Services (DHCS) Perinatal Practice Guidelines and Youth Treatment Guidelines; and
- Agreements between DBH and Contracted Providers.

With the implementation of the DMC-ODS, Fresno County expanded the standard Drug Medi-Cal (DMC) SUD service benefits package to include additional modalities and services. These added benefits are available throughout the Fresno County SUD system of care, irrespective of funding source:

State Plan DMC Benefits	DMC-ODS Benefits
Outpatient Services	Outpatient Services
Intensive Outpatient Services	Intensive Outpatient Services
Perinatal Residential Treatment (16 bed limitation)	Residential Treatment (two non-continuous short-term (up to 90 days based upon medical necessity) episodes of treatment in a 365-day period; and one 30-day extension if medically necessary per 365-day period.
Inpatient Hospital Detoxification	Withdrawal Management (continuum)
Narcotic Treatment Program Services	Narcotic Treatment Program Services
	Recovery Services
	Case Management
	Physician Consultation

	Additional Medication Assisted Treatment

INTEGRATION AND COORDINATION OF CARE

Integrated care is the routine and systematic coordination of health services so that the varied needs of persons served are addressed comprehensively and cohesively.

A key goal of the DMC-ODS is to better integrate SUD treatment into healthcare and social service systems, and vice versa. Greater organization and coordination enable persons served to more effectively access the full continuum of SUD services and levels of care available.

Care coordination is the deliberate organization of activities and sharing of information among care providers to ensure that all areas of need are addressed. The primary goal of care coordination is to ensure that services being provided are organized such that involved entities/providers are aware of the person served's needs and preferences and are performing activities that collectively contribute to the shared goal of providing appropriate and effective care.

SUBSTANCE USE DISORDERS AS A CHRONIC DISEASE

SUDs are often chronic, relapsing conditions of the brain that cause compulsive drug seeking and use, despite harmful consequences to individuals and their social network. A chronic disease is one that cannot be easily or simply cured, but instead must be treated, managed, and monitored over time. Examples of manageable chronic health conditions are heart disease, diabetes and asthma. While some individuals may develop a SUD and achieve recovery after minimal intervention over a brief period, the majority of individuals will exhibit a more chronic and relapsing course.

Approaching SUD as a disease enables the provision of care that allows for a continuum of services to meet an individual's needs. The chronicity of SUD in adults dictates the approach necessary to effectively treat these conditions, as chronic conditions need to be managed via a model of care that offers a continuum of services that meets an individual's needs at that point in time. As persons served progress in their recovery journeys, the type and intensity of treatment services they receive should reflect the severity and nature of the SUD. Effective and efficient care for SUD is characterized by productive interactions between engaged persons served, as well as their families and caregivers, and a skilled team of providers, including counselors and other health professionals.

PERSON SERVED-CENTERED CARE

Person served-centered care is a collaborative approach to SUD service delivery that emphasizes respect for the person served and care that is responsive to an individual's preferences, needs, well-being and values. Providers, acting within the lawful scope of practice are expected to advise and advocate for the person served's right to participate in decisions regarding his or her health care and to express preferences about future treatment decisions.

ENSURING A STANDARD QUALITY OF SERVICE

The DMC-ODS is a core component of the larger healthcare system and, as such, Fresno County shall maintain standards and expectations to ensure high quality services for the population it serves. Similar to the management of other chronic conditions, these standards for SUDs ensure a reasonable degree of consistency across service providers, while also allowing sufficient flexibility to provide services appropriate to the individualized needs of persons served.

SUD services are guided by best practice and clinical standards, which include the use of evidence-based practices such as Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Psychoeducation, Trauma Informed Treatment, and Relapse Prevention techniques.

Standards-based care and individualized care are compatible and complementary. Service providers can offer individualized and person served-centered care that also meets best practice and clinical standards.

This provider manual describes a framework of standards that regulate both business administration and clinical services and processes and pertains to all providers within the Fresno County SUD System of Care. In outlining these expectations, this Provider Manual establishes an infrastructure of quality for the SUD system of care throughout Fresno County. The manual reflects "best practice" standards and seeks to prevent program deficiencies that can ultimately lead to disallowances and recoupment of monies.

SECTION 2 CLINICAL PROCESS STANDARDS

GENERAL PRACTICE GUIDELINES

Fresno County Department of Behavioral Health is committed to ensuring quality care to all individuals accessing SUD services. In an effort to improve service delivery and outcomes for persons served receiving SUD services, Fresno County DBH will require all contracted providers to adhere specific industry standard Practice Guidelines in addition to Federal and State regulations that govern publicly funded SUD treatment programs.

These guidelines have been created considering the needs of persons served. They have been created with the assistance of contracted providers and will be reviewed and updated periodically, as appropriate.

REGULATIONS

TITLE 9

https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?contextData=(sc.Default)&transitionType=Default

GUIDELINES

CENTERS FOR MEDICARE & MEDICAID STC'S /ASAM CONTINUUM OF CARE

https://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCsAmended060718.pdf

ALCOHOL AND/OR OTHER DRUG PROGRAM CERTIFICATION STANDARDS

HTTPS://WWW.DHCS.CA.GOV/DOCUMENTS/DHCS-AOD-CERTIFICATION-STANDARDS-2.7.2020.PDF

PERINATAL PRACTICE GUIDELINES

http://www.dhcs.ca.gov/individuals/Documents/Perinatal_Practice_Guidelines_FY1819.pdf

YOUTH TREATMENT GUIDELINES

http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guidelines.pdf

SAMHSA

TREATMENT IMPROVEMENT PROTOCOLS

http://integratedrecovery.org/supporting-addictions-recovery/samhsas-treatment-improvement-protocol-tip-series/

TECHNICAL ASSISTANCE PUBLICATIONS (TAP 21)

https://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171

US DEPARTMENT OF VETERAN AFFAIRS – CLINICAL PRACTICE GUIDELINES

https://www.healthquality.va.gov/guidelines/MH/sud/

EVIDENCE BASED PRACTICES

Fresno County DBH requires DMC-ODS providers to implement Motivational Interviewing and at least two of the four evidence-based practices (EBPs) listed in the Special Terms and Conditions (STCs):

- Psychoeducation
- Trauma Informed Treatment
- Cognitive Behavioral Therapy
- Relapse Prevention

CONFIDENTIALITY

All SUD treatment programs shall operate in accordance with legal and ethical standards. Federal and state laws and regulations protect the confidentiality of persons served records maintained by all DBH contracted providers. All DBH contracted providers are required to operate in accordance with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations, HIPAA standards, and California State law regarding confidentiality and disclosure of alcohol and drug use as well as other medical records.

42 CFR PART 2 – CONFIDENTIALITY OF ALCOHOL AND DRUG RECORDS

42 CFR Part 2 covers all records relating to the identity, diagnosis, and/or treatment of any person served in a SUD program that is conducted, regulated, and/or assisted in any way by any federal agency.

For a summary of 42 CFR Part 2, please see:

https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

HIPAA – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Provides data privacy and security provisions for safeguarding medical information.

As part of the HIPAA Regulations, the Privacy Rule and the Security Rule require providers to enter into a contract containing specific requirements prior to the disclosure of Protected Health Information (PHI), as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations (CFR).

These laws and regulations shall not be used as barriers to coordinated and integrated care. When appropriate releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care, as well as across systems of care (physical and mental health, etc.).

Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the SUD system of care shall cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

DBH GUIDING PRINCIPLES OF CARE DELIVERY

The DBH Guiding Principles of Care Delivery define and guide a system that strives for excellence in the provision of behavioral health services where the values of wellness, resiliency and recovery are central to the development of programs, services and workforce. The principles provide the clinical framework that influences decision-making on all aspects of care delivery including program design and implementation, service delivery, training of the workforce, allocation of resources, and measurement of outcomes. Providers shall utilize the Guiding Principles of Care delivery to inform program design and operations.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Providers shall ensure equal access to quality care to diverse populations by adopting the federal Office of Minority Health CLAS national standards and complying with 42 CFR 438.206(c)(2). Provider policies, procedures, and practices shall be consistent with the principles outlined and shall be embedded in the organizational structure, as well as being upheld in day-to-day operations. Providers shall promote the delivery of services in a culturally competent manner to all persons served, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Providers shall make information available on how to file a Discrimination Grievance with the United States Department of Health and Human Services Office of Civil Rights, California Department of Health Care Services Office of Civil Rights, and/or Fresno County Department of Behavioral Health Civil Rights Coordinator if there is a concern of discrimination based on race, color, national origin, sex, age or disability.

MODALITIES

- Outpatient Treatment for adults and youth
- Intensive Outpatient Treatment Services (IOT) for adults and youth
- Medication Assisted Treatment (Additional MAT)
- Narcotic Treatment Programs (OTP/NTP)
- Residential Treatment for adults and youth
- Withdrawal Management Services
- Case Management Services
- Recovery Services
- Recovery Residences

SCOPE OF PRACTICE

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

(Associate Clinical Social Worker-ASW, Associate Marriage and Family Therapist-AMFT, Associate Professional Clinical Counselor-APCC & Doctor of Philosophy Associate-PHDA).

This document is intended to promote awareness of how each LPHA scope of practice relates to SUD services. It is not intended to be all-inclusive or exhaustive. Please refer to the practitioner's scope of practice for a complete explanation of the permitted functions and duties under their licensure(s).

STAFFING

The movement toward a chronic disease and public health model of SUD care requires a diverse, skilled, and highly trained workforce. DBH recognizes and values the contributions of its contract providers and realizes that the composition of a successful Organized Delivery System (ODS) must reflect the diversity of needs of the population it serves. While the SUD system of care has traditionally been staffed primarily by SUD counselors, there is a recognized need to diversify the workforce to include various disciplines.

Non-professional clinical staff shall receive appropriate onsite orientation and training prior to performing assigned duties. Professional clinical and/or administrative staff shall supervise non-professional staff.

Professional Clinical and non-professional clinical staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications and licensure shall be contained in personnel files.

LPHAs shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year.

Registered and certified SUD counselors shall adhere to all requirements in CCR Title 9, Chapter 8.

Various members within an organization may perform case management duties, including registered/certified SUD counselors and LPHAs. Care coordination and navigation services may be provided by non-licensed staff, including registered counselors, peer support specialists, and staff to assist a person served to access medical, mental health, social, legal, financial and other needed services.

MEDICAL DIRECTOR

Roles and responsibilities, a code of conduct, and proof of five (5) hours of Continuing Medical Education (CME) in addiction medicine for the Medical Director shall be clearly documented, signed and dated by a provider representative and physician each year.

The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:

- Ensure that medical care provided by physicians and physician extenders meet the applicable standard of care.
- Ensure that physicians do not delegate their duties to non-physician personnel.
- Develop and implement medical policies and standards for the provider, including a signature that they have reviewed and approved the policies.
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
- Ensure that provider's physicians and LPHAs are adequately trained to diagnose SUDs for persons served and determine the medical necessity of treatment.
- Ensure that physicians are adequately trained to perform other physician duties as outlined.

- Delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards.
- The SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

KEY STAFFING STANDARDS

DBH promotes a multidisciplinary team approach to provide an array of services aimed at coordinating care between SUD treatment, mental health and physical health for adults and adolescents. In addition to staffing requirements found in CCR Title 9, Chapter 8 and the California DHCS Mental Health and SUD Services (MHSUDS) Information Notice 18-035, DBH issued additional key staffing standards to promote program integrity as well as ensure standards and continuity of care.

All clinical staff that will be providing and billing for substance use services shall first be credentialed and re-credentialed regularly according to the guidelines set forth in DBH Policy and Procedure Guide 4.1.3 –See Credentialing, Re-credentialing and Appeals Policy for Contract Providers.

POSITION	MINIMUM QUALIFICATIONS	REFERENCE (IF APPLICABLE)
Certified Counselor		
Education:	As defined by the certifying body.	9 CCR, Division 4, Chapter 8 California Association of Driving Under the influence Treatment Programs-CADTP California Consortium of Addiction Programs and Professionals-CCAPP California Association for Alcohol and Drug-CAADE
Experience:	Experience in providing counseling services to persons with alcohol and/or other drug problems preferred.	
License/Certification:	Individuals providing counseling services as defined in Chapter 8, Subchapter 1., Section 13005, 4. A-F, shall be in compliance with Chapter 8 (commencing with Section 13000) Section 9846, 10125 and 10564, Division 4, Title 9, California Code of Regulations (Counselor Certification Regulations)	
Licensed Mental Health Clinician		
Education:	A minimum of 45 hours or 3 units of SUD specific education. *<u>Substitution</u>: One year of experience as a Licensed Mental Health Clinician may be used to substitute the required education.*	

Experience:	None required.	
License/Certification:	Valid Clinical Social Worker, Professional Clinical Counselor or Marriage and Family Therapist License issued by the State of California, Department of Consumer Affairs, Board of Behavioral Sciences.	
Licensed Vocational Nurse		
Education:	Encompassed in licensure.	
Experience:	None required.	
License/Certification:	Valid Licensed Vocational Nurse's License issued by the State of California, Department of Consumer Affairs, Board of Vocational Nursing and Psychiatric Technicians	
Medical Director		
Education:	Encompassed in licensure.	9 CCR § 10110 22 CCR § 51000.24.4; 51000.70; 51341.1(b)(28)
Experience:	One (1) - two (2) years of experience in substance abuse, psychiatry or general practice.	
License/Certification:	Physician licensed by the Medical Board of California or Osteopathic Medical Board of California Current DEA license American Board of Addiction Medicine (ABAM) certification preferred	
Other:	The Medical Director may also serve as the Program Director so long as the candidate meets the supervisory and budgetary experience requirements.	
Nurse Practitioner/Registered Nurse		
Education:	Encompassed in licensure.	CCR §1484
Experience:	None required.	
License/Certification:	Nurse Practitioner: Valid Nurse Practitioner Certificate issued by the State of California, Department of Consumer Affairs, Board of Registered Nursing.	

	Registered Nurse: Valid Registered Nurse License issued by the State of California, Department of Consumer Affairs, Board of Registered Nursing.	
Program/Project Director		
Education:	Possession of a bachelor's degree in Business, Public Administration, Accounting or closely related field is preferred. *Substitution: A Master's degree in Business, Public Administration, Accounting or a closely related field may be used to substitute one (1) year of the required experience.*	9 CCR §10105
Experience:	Two (2) years of full-time work experience of a managerial or supervisory nature which involved budgetary analysis and control. Accounting or business management functions is required.	
Psychiatric Technician		
Education:	Encompassed in licensure.	
Experience:	Not required.	
License/Certification:	Possession of a valid license as a Psychiatric Technician issued by the State of California Board of Vocational Nurse and Psychiatric Technician Examiners	
Other:	The incumbent may be involved in therapeutics only as authorized by State law.	
Therapist		
Definition:	A psychologist licensed by the California Board of Psychology; A clinical social worker or marriage and family therapist licensed by the California Board of Behavioral Sciences.	22 CCR 51341.1(b)(30)
Education:	Encompassed in licensure.	
Experience:	SUD experience preferred.	
License/Certification:	Current, valid license with the California Board of Psychology or California Board of Behavioral Sciences	
Registered Counselor		

Education:	As defined by the certifying body.	9 CCR §13000 CADTP CCAPP CAADE
Experience:	None required; however, Registered Counselors must be supervised as required by certifying body.	
License/Certification:	Individuals providing counseling services as defined in Chapter 8, Subchapter 1., Section 13005, 4. A-F, shall be in compliance with Chapter 8 (commencing with Section 13000) Section 9846, 10125 and 10564, Division 4, Title 9, California Code of Regulations (Counselor Certification Regulations).	
SUD Clinical Supervisor		
Education:	Possession of a Bachelor's or Master's degree in psychology, social work or closely related field is preferred.	
Experience:	Full-time, paid SUD work experience as a Clinical Social Worker, Marriage and Family Therapist, Psychologist, Registered Nurse, or Substance Abuse Counselor as follows: AOD Certification only: 4 years Bachelor's Degree: 3 years Master's Degree: 2 years	
License/Certification:	AOD certification required if not an LPHA. Approved Clinical Supervisor (ACS) credential preferred.	
Unlicensed Mental Health Clinician		
Education:	A minimum of 45 hours or 3 units of SUD specific education.	22 CCR §51341.1 (b)(30)(c)

	<u>Substitution</u>: One year of experience as an Unlicensed Mental Health Clinician may be used to substitute the required education.	
Experience:	None required.	
License/Certification:	Current and active registration as an Associate Clinical Social Worker, Associate Professional Clinical Counselor or Associate Marriage and Family Therapist with the State of California, Department of Consumer Affairs, Board of Behavioral Sciences.	

*****Please Note: All college degrees and credits must be acceptable within the United States' accredited college or university system.***

ADDITIONAL REQUIREMENTS: GENERAL

- The provider agency shall require all employees to provide copies of college degrees, licenses and certificates that are required for the position and retain those copies in the employee's personnel file.
- Resumes, applications, reference checks and/or transcripts documenting work experience shall be kept in the employee's personnel file.
- The provider agency shall have written guidelines specifying the requirements to be employed by the provider agency. The requirements need to include a current job description and scope of work for every position, including those occupied by volunteers and interns, and a copy of this document shall be maintained in the individual's personnel file. The provider shall communicate to staff that no employee, volunteer or intern is permitted to work outside of their scope of work.
- If the provider wishes to hire a candidate that cannot meet the minimum experience, educational and/or certification requirements as described above, the provider shall submit a plan that describes how they plan to adequately train and supervise that individual. This plan must be approved by DBH before that staff member can begin conducting individual or group counseling sessions, intake interviews, discharge planning or assessments of person served's alcohol and/or other drug problems, and/or clinical supervision.

Services provided without prior written approval by the County are not billable to the County.

ADDITIONAL REQUIREMENTS: YOUTH TREATMENT SERVICES

In addition to the minimum qualifications and additional requirements, core staff working in youth treatment shall have training and skills in the following areas:

- An understanding of substance use and the addiction process in youth; the intergenerational nature of substance use, abuse and dependence and the dynamics of adolescent recovery;
- Effective and developmentally appropriate interventions and approaches for treating substance-using adolescents;
- Assessment of SUDs, mental health disorders (psychotic, mood, anxiety, behavioral and personality), and cognitive impairments as they relate to youth;
- Psychoactive medications prescribed to adolescents, their benefits and their potential side effects and interactions with other medications or substances;
- Child development and normal adolescent growth and development;

- Family dynamics;
- Detection of adolescent injury, disease, abuse and neglect;
- Community resources and other adolescent treatment systems (schools, child welfare, mental health, juvenile justice system, etc.);
- Methods of drug and alcohol testing, interpreting test results and the benefits and limitations of the tests;
- Legal issues specific to adolescents (informed consent for minors, disclosure of confidential information, child abuse/neglect reporting requirements and duty-to-warn issues);
- Program rules and procedures; and
- Person served rights and grievance procedures.

The program must provide a training and supervision plan for youth treatment counselors lacking any of the training or skills above. This plan shall be approved prior to these staff conducting individual or group counseling sessions, intake interviews, discharge planning or assessments of person served alcohol and/or other drug problems, and/or clinical supervision.

CREDENTIALING, RE-CREDENTIALING, AND APPEALS POLICY FOR CONTRACT PROVIDERS

Credentialing ensures that providers are licensed, registered, waivered, and/or certified as required by state and federal law. In accordance with DMC-ODS requirements, the Fresno County SUD system of care requires all health care, mental health and SUD practitioners seeking to contract with DBH to provide and bill for mental health and SUD services to first be credentialed and then re-credentialed every three (3) years by the DBH Credentialing Committee. Credentialing is the recognition of professional or technical competence. The process requires the following:

- Verification of current and previous professional licenses through all applicable state licensing boards;
- Ineligible screenings to be performed which consist of queries of all applicable federal/state data banks, suspensions, and exclusion lists for healthcare professionals;
- A formal presentation and acceptance by the Credentialing Committee under the conditions stated in DBH's Credentialing, Re-credentialing and appeals policy; and
- Proof of any professional certifications.

In accordance with the Policy and Procedure Guide for Credentialing, Re-Credentialing and Appeals Policy for Fresno County Behavioral Health Specialty Mental Health and SUD providers, the following practitioners must receive credentialing status prior to providing services:

- Medical Directors
- Physicians/Psychiatrists
- Nurse Practitioners
- Licensed Vocational Nurses
- Licensed Practitioners of the Healing Arts (LPHA)
- Supervising clinicians and counselors (licensed or certified professionals providing supervision for individuals accruing clinical hours toward licensure or certification)
- Certified and/or Registered Counselors
- Other staff that provide or approve treatment services (e.g. on-call physicians)

In the event an applicant/provider is denied credentialing or re-credentialing, or if privileges are reduced or terminated, the provider may appeal the decision pursuant to DBH's Credentialing, Re-credentialing and appeals

policy. All participating providers will be re-credentialed every three (3) years. Providers will respond to the DBH Re-credentialing Questionnaire and provide all information and documentation for the past three (3) years (if applicable), as requested.

Once credentialing status is granted, individuals have 30 days from this date to complete the Fresno County DBH General Compliance training, the SUD Documentation and Billing training for clinical staff and annually thereafter.

APPEAL PROCESS

If the applicant/provider is not satisfied with the decision rendered by the Credentialing Committee, they may appeal the decision using the following process:

- Within thirty (30) calendar days following the written notice, the provider may request a meeting with the credentialing committee to discuss the decision.
- The request must be in writing and must be received in the DBH Managed Care office within the thirty (30) day period.
- If the formal meeting is requested within the thirty (30) calendar day period, it shall be held between fifteen (15) and thirty (30) calendar days after receipt of the written request.
    - The provider will be served a written notice of the date/time of the formal meeting at least ten (10) calendar days prior to said meeting.
- Within fifteen (15) calendar days of the formal meeting, the provider will receive written notice of the Credentialing Committee's decision and the reason(s) for the decision.
- The Credentialing Committee's decision is final and shall be effective immediately.

ANNUAL TRAINING PLAN

All staff are required to document the completion of each training, utilizing the standardized Fresno County SUD Annual Provider Training Plan. A copy shall be placed in every employee's personnel file. If the training does not provide any type of certificate or confirmation of completion, the staff member's supervisor is required to certify the training was completed by signing and dating the Training Plan.

ALL STAFF

Annual trainings required by all staff, including contracted employees (Medical Directors, LPHA), are as follows:

- HIPAA
- Cultural Competency Training
- Compliance
- Ethics and Confidentiality

ADMINISTRATIVE & BILLING STAFF

Annual trainings for administrative and billing staff are as follows:

- Avatar - CalOMS
- DMC Billing

ANNUAL TRAININGS

Annual trainings required by clinical staff are as follows:

- ASAM A or ASAM Module I: Multidimensional Assessment
- ASAM B or ASAM Module II: From Assessment to Service Planning and Level of Care
- ASAM C or ASAM Module III: Introduction to the ASAM Criteria (beginning July 1, 2021)
- CLAS (or other Cultural Competency Training)
- Motivational Interviewing and 2 additional Evidence-Based Practices (EBP)
- Medication-Assisted Treatment (MAT)
- SUD Documentation and Billing

If clinical services are provided by a staff member that has not completed the required ASAM trainings prior to conducting, countersigning, or directing treatment services, then that service will be considered non-compliant and will be disallowed.

RECOMMENDED & OPTIONAL TRAININGS:

- Case management/Care coordination (optional, recommended)
- Co-occurring Disorders (optional, recommended)

ANNUAL MEDICAL DIRECTOR AND LPHA REQUIRED TRAININGS

- 5 hours Continuing Medicine Education (CME) in addiction medicine
- SUD Documentation and Billing
- General Compliance
- ASAM A or ASAM Module I: Multidimensional Assessment
- ASAM B or ASAM Module II: From Assessment to Service Planning and Level of Care

For contracted employees please refer to page 69 for additional instruction and training requirements.

SPECIAL POPULATIONS

PERINATAL (PREGNANT AND POSTPARTUM) PERSONS SERVED

Perinatal substance use can result in significant maternal, fetal and neonatal morbidity. In this instance, the perinatal period is described as the period during pregnancy and 60 calendar days following birth.

Federal priority guidelines for SUD treatment admission give preference to pregnant and/or parenting female substance and injection drug users. The appropriate level of care for this population shall be consistent with the ASAM criteria, with consideration of the ability to accommodate the physical stresses of pregnancy (e.g. bed rest when medically required, performing chores, etc.) and the need for safety and support during this period.

Staff working in settings that provide service for pregnant and postpartum persons served must be trained in proper procedures for accessing medical services related to prenatal care, labor and delivery, and therapeutic responses to the varied positive and negative outcomes of pregnancy. Services shall be provided in a non-judgmental, supportive and open environment.

The use of Medication Assisted Treatment (MAT) during pregnancy shall include careful and individualized consideration of the potential impact of both treatment and lack of treatment on mother and infant. For pregnant women with opioid use disorders, MAT such as methadone and buprenorphine are the standard of care. Informed consent shall be obtained in these instances including discussions regarding Neonatal Abstinence Syndrome and what to expect at delivery. Opioid detoxification should be reserved for select women because of the high risk of

relapse and potential consequences on both mother and infant. The risks and benefits of breastfeeding while persons served are receiving MAT shall be weighed on an individual basis. Methadone and buprenorphine maintenance therapy are not contraindications to breastfeeding.

Given that women may be at increased risk of resuming substance use following delivery, treatment should not end with delivery. Post-delivery treatment services include, but are not limited to: support for parenting a newborn, education about breastfeeding, integration with other children and family members, case management for practical needs such as legal assistance, equipment and clothing, coordination of physical and mental health services, coping with physical and psychological changes of the postpartum period, reproductive health planning and encouragement of the continued pursuit of recovery goals.

All SUD treatment services shall be provided in a confidential setting. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, trauma informed care and development of parenting skills. Perinatal services shall include:

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

Medical documentation that substantiates the pregnancy and the last day of pregnancy shall be maintained in the chart.

SUD treatment providers must provide or arrange for the following services and if needed provide or arrange transportation for these services for pregnant and parenting women and their children for at least the following services:

- Primary medical care, including perinatal care and, while the women are receiving such services, childcare;
- Primary pediatric care, including immunizations, for children;
- Gender specific substance use treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and childcare while the women are receiving these services; and
- Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect;
- Sufficient case management and transportation to ensure that women and their children have access to the services described above.

For NTP/OTP providers, the following documentation requirements shall apply:

- Medical Director documentation of the hospital's or attending physician's summary of the delivery and treatment outcomes for the person served and newborn OR evidence of having requested such information from the hospital;
- Pregnancy is documented in the person served's record and the Medical Director has reviewed, signed and dated confirmation of pregnancy.
- Evidence of accepting medical responsibility for the person served's prenatal care OR evidence of verification the person served is under the care of a licensed physician.
- Evidence of prenatal instruction by Medical Director or licensed health personnel
- Documentation the person served was informed of risks to themselves and unborn child from continued use of illicit and legal drugs, including premature birth.
- Benefits of narcotic replacement therapy and risk of abrupt withdrawal from opiates, including premature birth and the importance of attending all prenatal care visits.
- Basic prenatal care (for those not referred out), including instruction on nutrition and prenatal vitamins, pediatric care, immunization, health and safety.
- For persons served who refuse prenatal care, the provider shall notify the Medical Director and document the refusal.

Perinatal treatment shall be delivered in accordance with the most recent version of the Perinatal Practice Guidelines.

ADOLESCENT PERSONS SERVED

Adolescents are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate. Under the EPSDT mandate, youth under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT requirements.

Adolescence represents an opportunity to influence risk factors that are still not rooted in their development and addiction. Adolescent SUD treatment shall be approached differently from adult SUD treatment because of the differences in their stages of psychological, emotional, cognitive, physical, social and moral development. Unique characteristics of the adolescent population are reflected in both clinical practices, as well as in the ASAM criteria.

Adolescents tend to require more intensive levels of care. In treating the adolescent population, every effort shall be made to support the adolescent's larger life needs in order to maximize the likelihood of treatment success; for example, by making weekend and evening hours available to accommodate continued engagement with school and appropriate social activities. These larger life issues may be related to medical, psychological and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors and any special physical or behavioral issues. Failing to address such needs simultaneously could undermine the adolescent's treatment success.

Adolescents should be referred to a qualified adolescent/youth outpatient treatment provider where they will receive a full assessment and referral to an appropriate Level of Care (LOC), as necessary. If the individual initially presents at a SUD treatment provider that does not offer the appropriate LOC, that agency will identify alternate referral options and assist the individual in connecting with the selected agency, or the individual may elect to remain with the initial provider if clinically appropriate.

MEDICAL NECESSITY & DIAGNOSTIC REQUIREMENTS

DIAGNOSIS

The Medical Director or LPHA must diagnose the person served as having at least one SUD diagnosis from the DSM-5. Medical necessity for DMC-ODS services shall be determined as part of the assessment process and shall be performed through a face-to-face interview or via telehealth. If the full ASAM assessment yields an ASAM LOC recommendation that is not offered by the assessing provider, the person served shall be transitioned to the appropriate LOC.

Only the SUD diagnosis must be included in the DHCS list of reimbursable diagnoses are eligible for reimbursement. The DSM-5 must be utilized for diagnostic purposes and ICD-10 for billing codes. The diagnosis must be written with the ICD-10 numeric code and the DSM-5 written description. Example: F10.20 (ICD-10) Alcohol Use Disorder, Severe (DSM-5).

The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis utilizing the Fresno County Initial/Updated Diagnosis Determination form. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each person served's assessment and intake information, including their personal, medical and substance use history.

The DSM-5 diagnosis cannot be established from the Initial Needs Assessment and Treatment Plan. Furthermore, a DSM-5 diagnosis should only be considered after the Fresno County mandated assessment has been completed and/or reviewed by a LPHA or Medical Director.

The Medial Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name. The basis for the diagnosis must be written within the following timeframes:

- Outpatient Levels 1 and 2.1 and Recovery Services within ten (10) calendar days of the person served's admission.
- Residential Levels 3.1 and 3.5 within three (3) calendar days of admission.
- Withdrawal Management 3.2 within three (3) calendar days of admission.
- NTP/OTP within twenty-eight (28) days of admission.

MEDICAL NECESSITY

Medical necessity is established in accordance with current DMC Regulations [22 CCR 51341.1(a) (h)], and the Special Terms and Conditions (STC), except in the case of MAT for which there are additional requirements. Medical necessity is a standard applied to justify services as reasonable, necessary and/or appropriate, based on evidence-based clinical standards of care. Medical necessity shall be established to demonstrate and maintain DMC eligibility for SUD treatment, be consistently applied to ensure equitable access to services and be established for provided services (e.g., residential treatment, outpatient and recovery services, etc.).

The determination of Medical Necessity is described in the MHSUDS Information Notice No.: 16044, dated September 14, 2016. Counties must establish a process where there is a face-to-face or telehealth interaction at the time the Medical Director, licensed physician, or LPHA are validating or verifying the determination of medical necessity. This interaction must take place, at minimum, between the certified counselor who has completed the assessment for the person served and the Medical Director, licensed physician or LPHA. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the person served." The purpose of the face-to-face consultation between the LPHA and the counselor is to determine medical necessity and it can be billed as case management. Medical Necessity based on DSM-5 Criteria is

determined by an LPHA or Medical Director only. The requirements must be fulfilled by using the DBH mandated Initial/Updated Diagnostic Determination form.

Clinically, the counselor should address the substance use issues and linkage to other services that may be indicated by the needs identified in the assessment. When a person served no longer meets medical necessity for their current LOC, they should be informed and moved to the next indicated level of care.

ASAM & LEVELS OF CARE

The Fresno County DBH SUD system of care provides access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria. This approach provides individuals with access to the care and services they need for a sustainable and successful recovery.

The goal of the ASAM Criteria is to improve assessment and outcomes-driven treatment and recovery services. It is also used to match individuals to appropriate types and levels of care.

The ASAM criteria are used to ensure the individual receives the appropriate level of care in the correct program at the right time. The differences between treatment before and after the utilization of ASAM criteria are:

- Moving from one-dimensional to multi-dimensional assessments
- Moving from program-driven to clinical-driven and outcomes-driven treatment
- Moving from fixed length of service to variable lengths of service
- Moving from a limited number of discrete levels of care to a broad and flexible continuum of care
- Identifying adolescent-specific needs
- Clarifying the goals of treatment
- Not using previous “treatment failure” as an admission prerequisite
- Moving toward an interdisciplinary approach to care.

The ASAM Criteria considers various factors of an individual’s life to determine the most appropriate level of care. The ASAM Criteria offers to improve treatment outcomes by accurately assessing the person served’s needs and ensuring that the services provided meet those needs. Needs are assessed through each of the six dimensions of the ASAM Criteria:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and/or Complications
3. Emotional, Behavioral and/or Cognitive Conditions and/or Complications
4. Readiness to Change
5. Relapse and/or Continued Use Potential
6. Recovery/Living Environment

Persons served will receive services at the corresponding levels of care based on the severity of their functioning in each of the six dimensions. The ASAM Levels of Care are as follows:

Continuum of Care Services within DMC-ODS		
ASAM Level 0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)

ASAM Level 1.0	Outpatient Services	Less than 9 hours of service/week (adult); Less than 6 hours of service/week (adolescent)
ASAM Level 2.1	Intensive Outpatient Services	Minimum of 9 hours of service/week (adult); Minimum of 6 hours of service/week (adolescent)
ASAM Level 2.5	Partial Hospitalization Services	20 or more hours of service/week (not requiring 24-hour care)
ASAM Level 3.1	Clinically Managed Low-Intensity Residential Treatment Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week
ASAM Level 3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors; less intense milieu for those with cognitive or other impairments
ASAM Level 3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors; at least 10 hours of clinical service/week
ASAM Level 3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; 16 hours/day counselor availability
ASAM Level 4.0	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3; counseling available to engage person served in treatment
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder

EARLY INTERVENTION/PREVENTION: (ASAM LEVEL 0.5)

Individuals determined to be at risk of developing a SUD or those with an existing SUD can receive the following services: screening, brief treatment as medically necessary, and when indicated, a referral to treatment with a formal linkage.

OUTPATIENT: (ASAM LEVEL 1.0)

ASAM Level 1.0 provides outpatient counseling services to individuals when determined by a Medical Director or LPHA to be medically necessary and in accordance with the person served's individualized treatment plan. Services are designed to treat the individual who meets the diagnostic criteria for SUD and presents the ability and stability to participate in low intensity, professionally directed SUD treatment. Outpatient treatment aims to assist the person served to achieve permanent change in behaviors and improve mental functioning.

Treatment services at this level include: Up to 9 hours a week for adults (in accordance with an individualized treatment plan), and up to 6 hours a week for adolescents (in accordance with an individualized treatment plan), screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including possible referral to MAT for alcohol and opioid users), alcohol/drug testing, discharge services and case management/care coordination.

Services can be provided by a LPHA or registered/certified counselor in-person, by telephone, via telehealth or in any appropriate setting in the community, in accordance with HIPAA and 42 CFR Part 2. Providers will address

personal lifestyles, attitudes and behaviors that can impact or prevent the goals of treatment. Group size is limited to no less than two (2) and no more than twelve (12) persons served.

ASAM Level 1.0 may be the initial phase of treatment, a step down, or for the individual who is not ready or willing to commit to a full recovery program.

INTENSIVE OUTPATIENT (IOT): (ASAM LEVEL 2.1)

Intensive outpatient services treat multidimensional instability. ASAM Level 2.1 is an appropriate service for persons served with minimal risk regarding acute intoxication/withdrawal potential, biomedical and mental health conditions and generally close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting. Services are designed to treat the person served who meets the diagnostic criteria for a SUD with instabilities or complicating factors, which require higher intensity, professionally directed SUD treatment.

Treatment services at this level include: A minimum of nine (9) hours per week for adults (in accordance with an individualized treatment plan) and a minimum of six (6) hours for adolescents (in accordance with an individualized treatment plan). Providers may extend length of treatment when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with an individualized treatment plan. Intensive outpatient services include: screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including possible referral to MAT for alcohol and opioid users), alcohol/drug testing, discharge services and case management/care coordination.

Services can be provided by an LPHA or registered/certified counselor in-person, by telephone or by telehealth. Providers will address personal lifestyles, attitudes and behaviors that can impact or prevent accomplishing the goals of treatment. Group size is limited to no less than two (2) and no more than twelve (12) persons served.

RESIDENTIAL TREATMENT SERVICES

Residential services are provided in DMC-certified facilities that have been licensed for residential treatment by DHCS or the California Department of Social Services (CDSS). These programs must be designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

Under the DMC-ODS, residential services can be provided in facilities with no bed capacity limit. The length of residential services ranges from 1 to 90 days with a 90-day maximum for adults, unless medical necessity authorizes a once-per-year extension of up to 30 days.

All residential SUD treatment providers must have at least one registered, certified, licensed or license eligible staff member working on-site 24 hours a day, seven days a week. Not all monitors are required to be registered, certified, licensed or license eligible as long as at least one individual on duty meets this criterion. Additionally, the staffing ratio in the residential modality shall be one staff member on duty for every 25 persons served and must be certified in First Aid/CPR.

Adolescents, under the age of 21, shall receive continuous residential services for a maximum of 30-days. Adolescents may receive a 30-day extension if determined to be medically necessary.

- Two non-continuous 30-day (adolescent) or two non-continuous 90-day (adult) regiments may be authorized in a one-year period (365 days).
- Perinatal persons served may receive a length of stay for the duration of their pregnancy, plus 60 days postpartum.

- EPSDT allows adolescent persons served to receive a longer length of stay, if found to be medically necessary.

Components of Residential Treatment Services shall include intake, individual and group counseling, family therapy, person served education, safeguarding medications, collateral services, crisis interventions, treatment planning, transportation services and discharge services.

LOW INTENSITY RESIDENTIAL SERVICES - CLINICALLY MANAGED: (ASAM LEVEL 3.1)

ASAM Level 3.1 is a 24-hour non-medical, short term rehabilitation service for persons served with a SUD diagnosis. Services are appropriate for persons served who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment.

Treatment services at this level include screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medication and medication services (including possible referral to MAT for alcohol and opioid users), non-emergency transportation, alcohol/drug testing, discharge services and case management/care coordination and room and board.

In this level of care providers shall provide 20 hours/week of treatment hours, five (5) of which shall be clinical hours.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address persons served needs. Services must include preparation for a step down to a less intense level of treatment, when appropriate.

Residential services must be preauthorized by Fresno County DBH's Administrative Service Organization (ASO) and persons served must meet medical necessity requirements. See the Substance Use Disorder Treatment Authorization Request (STAR) section for more details.

HIGH-INTENSITY RESIDENTIAL SERVICES-POPULATION SPECIFIC & CLINICALLY MANAGED: (ASAM LEVEL 3.3)

ASAM Level 3.3 is a 24-hour non-medical short-term rehabilitation services for person served with a SUD diagnosis. Services are appropriate for persons served with significant cognitive impairment or functional limitations that require a slower pace of treatment. The impairments may be permanent or temporary and generally result in problems in interpersonal relationships, emotional coping, and/or comprehension.

Treatment services at this level include screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medication and medication services (including possible referral to MAT for alcohol and opioid users), non-emergency transportation, alcohol/drug testing, discharge services and case management/care coordination and room and board.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address persons served needs. Services must include preparation for a step down to a less intense level of treatment, when appropriate.

Residential services must be preauthorized by Fresno County DBH's ASO and persons served must meet medical necessity requirements. See the Substance Use Disorder Treatment Authorization Request (STAR) section for more details.

HIGH-INTENSITY RESIDENTIAL SERVICES- CLINICALLY MANAGE: (ASAM LEVEL 3.5)

ASAM Level 3.5 is a 24-hour non-medical short-term rehabilitation service for persons served with a SUD diagnosis. Services are appropriate for persons served who have specific functional limitations and need a safe and stable living environment in order to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances.

Treatment services at this level include screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medication and medication services (including possible referral to MAT for alcohol and opioid users), non-emergency transportation, alcohol/drug testing, discharge services and case management/care coordination and room and board.

In this level of care providers shall provide 20 hours/week of treatment hours, ten (10) of which shall be clinical hours.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address persons served's needs. Services must include preparation for a step down to a less intense level of treatment, when appropriate.

Residential services must be preauthorized by Fresno County DBH's ASO and persons served must meet medical necessity requirements. See the Substance Use Disorder Treatment Authorization Request (STAR) section for more details.

INTENSIVE INPATIENT SERVICES- MEDICALLY MONITORED: (ASAM LEVEL 3.7)

ASAM Level 3.7 is a 24-hour medically monitored setting with nursing care and physician availability for persons served with a SUD diagnosis. Medically monitored inpatient services are appropriate for persons served who have severe problems in Dimensions 1, 2, and 3 that require hospital-level care with medical oversight. Counseling must be available to engage and support persons served in treatment, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated. Transitions to and from this level of care are critical and must be carefully managed.

Treatment services at this level include a screening and an initial withdrawal assessment including a medical evaluation or referral within 48 hours of admission. If the person served is experiencing detoxification, the provider will make available daily withdrawal monitoring and ongoing screening for medical care nursing needs.

ASAM Level 3.7 services are offered through DBH's MOU with Managed Care Plans Anthem Blue Cross and CalViva Health. If a person served is determined to be in need of this level of care, the provider shall coordinate the transition to one of the mentioned Managed Care Plans for treatment.

For information on contacting CalViva and Anthem for referrals please see the MOU with Managed Care Plans section.

INTENSIVE INPATIENT SERVICES - MEDICALLY MANAGED: (ASAM LEVEL 4.0)

ASAM Level 4.0 is inpatient services are short-term, 24-hour medically managed setting with nursing care and daily physician care for persons served with SUD diagnosis. Medically managed inpatient services are appropriate for persons served who have severe and unstable problems in Dimension 1, 2, and 3 that require hospital-level care with medical oversight. Counseling must be available to engage and support persons served in treatment, with the

plan to transition to an appropriate lower level of SUD care, when clinically indicated. Transitions to and from this level of care are critical and must be carefully managed.

Treatment services at this level include a screening and an initial withdrawal assessment including a medical evaluation or referral within 48 hours of admission. If the person served is experiencing detoxification, the provider will make available daily withdrawal monitoring and ongoing screening for medical care nursing needs.

ASAM Level 4.0 services are offered through DBH's MOU with Managed Care Plans Anthem Blue Cross and CalViva Health. If a person served is determined to be in need of this level of care, the provider shall coordinate the transition to one of the mentioned Managed Care Plans for treatment.

For information on contacting CalViva and Anthem for referrals please see the MOU with Managed Care Plans section.

OPIOID (NARCOTIC) TREATMENT PROGRAM (OTP/NTP)

Opioid Treatment Programs are treatment settings that provide MAT, including methadone, buprenorphine, naloxone (for opioid overdose prevention), and disulfiram for individuals with opioid and alcohol use disorders. OTP/NTP may also offer other types of MAT to address co-morbid SUD in addition to opioid use disorder. A distinguishing feature of OTPs compared to other SUD levels of care is that OTPs are the only setting that can legally provide methadone treatment for addiction. OTPs offer a broad range of other services including medical, perinatal, and/or other psychosocial services.

An OTP/NTP is identified as an ASAM level of care and medical necessity for OTP services must be established, including the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis of a SUD and an appropriate level of care designation via an ASAM assessment.

Treatment services at this level of care include screening, assessment/intake, treatment planning, physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including prescribing methadone, naltrexone, buprenorphine, and naloxone as needed), alcohol/drug testing, syphilis testing, tuberculosis testing, discharge services and case management/care coordination.

Persons served in OTP/NTP settings must receive between 50 to 200 minutes of treatment services per calendar month, although additional services may be provided based on medical necessity.

In addition to the Provider Manual, OTPs/NTPs are regulated under the California Code of Regulations Title 9: Rehabilitative and Developmental Services.

OTP/NTP COURTESY DOSING

An OTP/NTP provider may provide replacement narcotic therapy to visiting persons served approved to receive services on a temporary basis (less than 30 days) in accordance with CCR Title 9 Section 10295:

- Prior approval must be obtained from the person served's Medical Director or program physician to receive services on a temporary basis from another narcotic treatment program. The approval shall be noted in the person served's record and shall include the following documentation:
    - The person served's signature and dated consent for disclosing identifying information to the program which provide services on a temporary basis;

- A medication change order by the referring Medical Director or program physician permitting the person served to receive services on a temporary basis from the other program for a length of time not to exceed 30 days; and
- Evidence that the Medical Director or program physician for the program contacted to provide services on a temporary basis has accepted responsibility to treat the visiting person served, concurs with his or her dosage scheduled and supervises the administration of the medication, subject to change 10210(d).

Prior to providing narcotic therapy to a visiting person served, an OTP/NTP provider must comply with CCR Title 9 Section 10210(d):

- Contact the other program to determine that it has not already provided the person served with replacement narcotic therapy for the same time period and that it will not do so; and
- Document the following information in writing in the person served's medication orders:
  - Name of the program contacted;
  - The date and time of contact;
  - The name of the program staff member contacted; and
  - The result of the contact.

NALTREXONE TREATMENT SERVICES

For each person served receiving Naltrexone Treatment Services, all of the following shall apply:

- Providers shall confirm and document that the person served meets all of the following conditions:
  - Has a documented history of opiate addiction;
  - Is at least 18 years of age;
  - Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgement. Provider shall administer a body specimen test to confirm the opiate free status of the person served.
- The physician shall certify the person served's fitness for treatment based upon the person served's physical examination, medical history, and laboratory results.
- The physician shall advise the person served of the overdose risk should the person served return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.

OTP/NTP COURTESY DOSING DOCUMENTATION REQUIREMENTS

The referring OTP/NTP must maintain documentation of the referral and treatment by a dosing OTP/NTP, in the person served medical record for each day of courtesy dosing. The referring OTP/NTP must also maintain a record of the invoice and payment for courtesy dosing for each claim submitted for reimbursement. The invoice shall include all information needed to complete a claim, including dates of service, type of service, and units of service.

- If applicable, the OTP/NTP provider shall include entries on a cost report to capture the revenue and expenses related to courtesy dosing for the purpose of cost settlement.

HOSPITALIZATION DOCUMENTATION

When appropriate, the provider shall document incidences of hospitalization. The documentation shall include:

- Date(s) of hospitalization;
- Reason for hospitalization and circumstances involved; and

- Evidence of attempted cooperation by program physician to work with hospital staff and attending physician to continue person served's replacement narcotic therapy treatment for opiate withdrawal therapy.

WITHDRAWAL MANAGEMENT

Withdrawal Management (WM), also known as detoxification, is a set of treatment interventions aimed at managing acute intoxication and withdrawal from alcohol and other substances. The goal of WM is to provide the appropriate level of support to allow for the person served safety during the withdrawal period, which then allows the person served and provider to work together to determine the optimal ongoing treatment strategy.

While WM may be an opportunity to initiate lasting abstinence from alcohol and/or other drugs, the primary goal is to minimize the health risks associated with withdrawal, not long-term abstinence. As such, WM should not be withheld from persons served due to provider uncertainty about their commitment to long-term abstinence.

WM is a critical point within the ASAM continuum of care. All SUD persons served, particularly those with alcohol and opioid use disorders, should be considered for WM and be offered access to these essential treatment services. WM alone does not constitute adequate treatment for addiction but will increase the likelihood that a person served will complete withdrawal successfully in order to transition to the next stage in the recovery treatment process. Person served who receive WM should be connected with ongoing treatment services.

Persons served who are eligible for both residential services and WM services are monitored during the detoxification process. Additionally, the person served shall be provided medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.

Withdrawal Services within DMC-ODS		
ASAM Level 1-WM	Ambulatory withdrawal management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision.
ASAM Level 2-WM	Ambulatory withdrawal management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.
ASAM Level 3.2-WM	Clinically managed residential withdrawal management	Moderate withdrawal but needs 24-hour support to complete withdrawal management with trained personnel, observation, medication services, and care coordination.
ASAM Level 3.7-WM	Medically monitored inpatient withdrawal management	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal

		management without medical monitoring.
ASAM Level 4-WM	Medically managed intensive inpatient withdrawal management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

AMBULATORY WITHDRAWAL MANAGEMENT WITHOUT EXTENDED ON-SITE MONITORING: (ASAM LEVEL 1.0-WM)

ASAM Level 1.0-WM ambulatory services are provided in outpatient settings for persons served with mild to moderate withdrawals symptoms. Services in this setting should require daily or less than daily outpatient supervision. Persons served treated in this setting should be physically and psychologically stable.

Treatment services at this level of care include screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, ambulatory detoxification, medication services (including referral to MAT for alcohol and opioid abusers), alcohol/drug testing, discharge services and case management/care coordination.

RESIDENTIAL WITHDRAWAL MANAGEMENT: (ASAM LEVEL 3.2-WM)

ASAM Level 3.2-WM services are 24-hour short-term rehabilitation services provided in residential settings for persons served with moderate withdrawal and who need 24-hour support in order to successfully complete withdrawal management. Services are appropriate for persons served treated in residential WM setting typically exhibiting, or who have a history of exhibiting or are at risk for exhibiting, moderate withdrawal symptoms with a greater need for support than can be provided in ambulatory WM settings, but less need for medical supervision and support than is provided in inpatient WM settings.

Treatment services at this level of care include screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications, and medication services (including referral to MAT for alcohol and opioid abusers), alcohol/drug testing, discharge services, case management/care coordination and room and board.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address the person served's needs.

Organizations that provide WM services shall also employ at least one registered, certified, licensed or license eligible staff member on duty 24 hours a day, seven days a week. In accordance with the 2020 Alcohol and/or Other Drug Program Certification Standards, the staffing ratio shall be one staff member on duty for every 15 persons served.

INPATIENT WITHDRAWAL MANAGEMENT- MEDICALLY MONITORED (ASAM LEVEL 3.7-WM)

ASAM Level 3.7-WM services are short-term medically monitored settings for persons served with severe withdrawal that offers 24-hour nursing care and physician visit, as necessary. Persons served treated in this setting are unlikely to complete WM without medical monitoring and have severe problems in Dimensions 1, 2, or 3 that

require hospital level-care with medical oversight. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care.

Treatment services at this level of care include screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications, and medication services (including referral to MAT for alcohol and opioid abusers), alcohol/drug testing, discharge services, case management/care coordination and room and board.

Transitions to and from this level of care are critical and must be managed carefully, with the plan to transition to an appropriate level of care, when clinically indicated.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address the person served needs.

ASAM Level 3.7-WM services are offered through DBH's MOU with Managed Care Plans Anthem Blue Cross and CalViva Health. If a person served is determined to need this level of care, the provider shall coordinate the transition to one of the mentioned Managed Care Plans for treatment.

For information on contacting CalViva and Anthem for referrals please see the MOU with Managed Care Plans section.

INPATIENT WITHDRAWAL MANAGEMENT- MEDICALLY MANAGED (ASAM LEVEL 4.0-WM)

ASAM Level 4.0-WM services are short-term medically managed settings for persons served with severe and unstable withdrawal that offers 24-hour nursing care and daily physician visits. Persons served treated in this setting are unlikely to complete WM without medical management and have severe problems in Dimensions 1, 2, or 3 that require hospital level-care with medical oversight. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care.

Treatment services at this level of care include screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, person served education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications, and medication services (including referral to MAT for alcohol and opioid abusers), alcohol/drug testing, discharge services, case management/care coordination and room and board.

Transitions to and from this level of care are critical and must be managed carefully, with the plan to transition to an appropriate level of care, when clinically indicated.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address the person served needs.

ASAM Level 4.0-WM services are offered through DBH's MOU with Managed Care Plans Anthem Blue Cross and CalViva Health. If a person served is determined to need this level of care, the provider shall coordinate the transition to one of the mentioned Managed Care Plans for treatment.

For information on contacting CalViva and Anthem for referrals please see the MOU with Managed Care Plans section.

TRANSITIONS TO OTHER LEVELS OF CARE

Fresno County DBH requires providers' case managers transition persons served to appropriate LOCs when appropriate. This may include step-up or step-down in SUD treatment services. Case managers shall have the responsibility for the successful transition to the next level of care as well as providing warm hand-offs to the new LOC when medically necessary and documented in the individualized treatment plan.

Transition of persons served to the appropriate LOC shall occur within ten (10) business days from the time of assessment or reassessment, with no interruption of current treatment services.

CASE MANAGEMENT AND CARE COORDINATION

CASE MANAGEMENT

Case Management includes a comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; transitions to higher or lower levels of SUD care; development and periodic revision of a person served plan that includes service activities, communication, coordination, referral and related activities, monitoring of service delivery to ensure member access to service and the service delivery system; monitoring of the person served's progress, member advocacy, linkages to physical and mental health care, transportation and retention in primary care services.

Case Management may include:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services.
- Transition to a higher or lower level of care. Persons served will be guided through the system of care, linkages will be made to ancillary services, and persons served will be assisted in connecting the next needed level of care from Withdrawal Management through Recovery Services.
- Development and periodic revision of a treatment plan that includes service activities.
- Monitoring service delivery to ensure person served access to service and the service delivery system. Providers may use case management services as an adjunct to outpatient and intensive outpatient treatment services to improve level of care from Withdrawal Management through Recovery Services.
- Monitoring the person served progress. Utilized as a method to provide thorough discharge planning that includes access to ongoing Recovery Support Services, vocational rehabilitation, recovery residence housing and access to childcare and parenting services to enhance the capacity of each person served to achieve long-term recovery.
- Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services. The SUD counselor advocates for and monitors the persons served progress of the linkages to physical and mental health care and other services, supporting including transitioning them to a higher or lower level of care, as needed.
- Progress notes should include the type of case management service provided such as linkage, care coordination and should include the location of services. Case Management notes must be tied to the Treatment Plan, including whether goals specified in the treatment plan have been achieved. In addition, document; a) Whether the individual has declined services in the treatment plan; b) The need for, and occurrences of, coordination with other professionals; c) A timeline for obtaining needed services; and d) A timeline for reevaluation of the plan. (Case management does not include simply leaving a phone messages for person served or others.)

CARE COORDINATION SERVICES

The primary goal of care coordination efforts is to produce a system of integrated care with high quality treatment planning, service delivery, referral and transition of care. Coordination of services may be arranged through written formal agreements (e.g. Memoranda of Understanding) or protocols and provided at separate locations.

However, care coordination services may also be delivered through co-locating services where persons served are being served or through alternative modalities such as telehealth.

Both case management and care coordination services may involve handling of Protected Health Information (PHI). Case management shall be consistent with and shall not violate confidentiality of alcohol or drug persons served disclosure laws set forth in the 42 CFR Part 2, and California law.

The following are key care coordination service components:

- **Referrals and linkages**: Providing referrals and linkages for persons served to necessary resources and services as identified on the treatment plan, which includes case management needs. The case manager or care coordinator plays an active role to reduce access barriers to ensure persons served have access to needed services by establishing relationships and/or protocols with external providers to ensure persons served will be served upon referral.
- **Navigation**: Facilitating the navigation by the person served to SUD treatment services, physical health, mental health, social, legal, financial and other services as needed, including helping persons served set up appointments and transportation arrangements, and ensuring contacts with a primary care provider. Care coordinators must follow-up with persons served in service transition or notable events. For example, care coordinator should follow up with person served within a few days of an emergency room visit, hospital discharge, or discharge from a residential facility. Additional support in providing arrangement for persons served with linkages to health, mental health, specialty care and others through co-location of services if appropriate.
- **Monitoring person served's progress**: Tracking person served progress through SUD treatment services and coordinate person served's transition through the SUD provider network.
- **Person served education and advocacy**: Helping the person served, and their families/care-givers, understand and navigate the SUD treatment system including SUD diagnosis, availability of treatment options and services, and case management options. This also includes coaching, educating and mentoring persons served (and families/caregivers) on how to self-manage their care and access needed services. Promoting the individual's self-management and autonomy through access of community resources if appropriate.

MOVEMENT THROUGH LEVELS OF CARE AND CASE MANAGEMENT

Regular review of the person served's treatment needs is important to gauge progress in treatment and to identify any new problem areas, goals, and action steps. The ASAM model guides us to ensure the person served is placed in the "least restrictive environment" for treatment. However, the criterion also directs the counselor to ensure the person served is receiving the appropriate LOC for their needs. To decrease the potential for service gaps or delays between levels of care, both referring and receiving case managers are expected to collaborate on appointment times and the confidential exchange of person served information as follows:

- No less than ten (10) days prior to discharge, case managers transitioning persons served to another program or level of care will be required to contact the receiving program to schedule an intake appointment.
- The receiving provider must ensure the person served's intake appointment is scheduled within ten (10) business days of the person served's expected discharge date from the referring provider.
- If the receiving provider cannot accommodate an intake appointment within the timeframes above and no suitable alternative is available, the current provider must facilitate an alternative referral or interim services as appropriate.

- The current provider shall maintain documentation in the person served's chart of the efforts to meet the required timeframes and of interim services provided/offered.
- Movement along the continuum of care shall be based on a reassessment utilizing ASAM criteria, review of person served progress in treatment, and the establishment of continued medical necessity as determined by the Medical Director, licensed physician or LPHA.

RECOVERY SERVICES

As part of the assessment and treatment needs of Dimension 6, Recovery Environment, of the ASAM Criteria and during the transfer/transition planning process, the provider shall make Recovery Services available. Providers shall offer Recovery Services to persons served as medically necessary. The criteria for admission to Recovery Services includes the following:

- Medical necessity must be established, which includes the person served being in remission or partial remission.
- The person served meets the requirements of having been previously diagnosed with a SUD. They may currently experience some distress dealing with relapse triggers or need additional case management services to obtain outside supports such as housing, vocational assistance, etc. However, this distress does not rise to the need for a return to a higher LOC.
- While the person served may have intermittent periods of significant challenge, they are not returning to regular use with the severity of impairment needed to meet medical necessity for Outpatient/Intensive Outpatient or Residential Treatment.
- Services are available to persons served whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.
- If a person served is referred to Recovery Services after completion of a specific treatment modality, the person served must be discharged from the treatment modality/episode and opened in Recovery Services with a new intake date.
- Persons served who have not been in treatment in the past year may also be referred to Recovery Services.

Recovery services are provided either face-to-face, by telephone, by telehealth or in an appropriate community setting with the person served, as long as confidentiality can be ensured.

Recovery Services require a Recovery Services Treatment Plan to be completed within ten (10) days of intake. Reassessment for medical necessity and/or treatment plan updates must take place every six (6) months. Persons served in Recovery Services qualify for admission or to remain in a Recovery Residence.

Recovery services shall include the following:

- Outpatient counseling services in the form of individual or group counseling to support the person served and monitor if the person served needs further care;
- Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
- Education and Job Skills: Linkages to life skills, employment services, job training, and education services;
- Family Support: Linkages to childcare, parent education, child development support services, and family/marriage education;
- Support Groups: Linkages to self-help and support, spiritual and faith-based support; and

- Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

MEDICATION-ASSISTED TREATMENT (MAT)

Research has shown that for the treatment of addiction for some, a combination of medications and behavioral counseling is more successful than either intervention alone. For this reason, MAT should be part of a comprehensive, biopsychosocial approach to the treatment of SUDs that includes psychosocial interventions such as counseling and behavioral therapies as well as case management and care coordination.

The use of addiction medications that have been approved by the U.S. Food and Drug Administration (FDA) as part of this comprehensive, whole-person approach to the treatment of SUD shall not be discouraged in any way. Similarly, persons served shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication. The passive or active discouragement of the use of addiction medications that have been approved by the FDA is contrary to the science of effective SUD treatment.[1]

MAT or Opioid (Narcotic) Treatment Programs (OTP) are an essential component of the continuum of care for SUDs. As with other levels of SUD care, ensuring a flow of appropriate referrals between MAT and other SUD providers, the provision of necessary services such as case management, and appropriate referrals to other health systems (if appropriate) are critical to MAT services.

MAT may be discussed and offered as a concurrent treatment option for appropriate individuals with an alcohol and/or opioid related SUD condition at all levels of care. Each network provider must develop policies and procedures governing the provision of MAT or linkages to other providers who offer MAT services. Providers must train staff in MAT and be able to provide evidence of this training to DBH. Providers shall ensure that persons served who meet medical necessity for MAT receive the same access to care as non-MAT persons served. Network providers that do not offer MAT must establish referral relationships with MAT prescribers. Provider staff will regularly communicate with physicians of persons served who are prescribed these medications unless the person served refuses to sign 42 CFR part 2 compliant Release of Information for this purpose.

For programs providing MAT services, required elements include obtaining informed consent and the ordering, prescribing, administering, and monitoring of all medications for SUD treatment. Given the biopsychosocial nature of addiction, all available and clinically indicated psychosocial and pharmacological therapies must be discussed and offered as a concurrent treatment option for appropriate individuals with an alcohol and/or opioid related SUD condition at all levels of care. When MAT is part of the treatment plan, licensed prescribers operating within their scope of practice should assist the person served to collaborate in clinical decision-making to ensure that the person served is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT and other factors such as side effects, alternatives, cost, availability and potential for diversion.

Persons served receiving MAT in OTP settings must receive a minimum of 50 minutes, not to exceed a maximum of 200 minutes, of counseling with a therapist or counselor, per calendar month. Additional services may be provided based on medical necessity. All prescribed MAT should be consistent with generally accepted standards of medical practice and best practice guidelines for the condition being treated.

There are currently several FDA-approved medications for the treatment of various types of addiction in adults:

- Opioid Use Disorder

[1] HSC Section 11834.26(c) (SB 992)

- Methadone
- Buprenorphine
- Naltrexone (oral and long-acting injectable formulation)

Note: In addition to the above medications for opioid use disorder treatment, Naloxone is an FDA-approved medication used to prevent opioid overdose deaths.

- Alcohol Use Disorder
  - Naltrexone (oral and long-acting injectable formulation)
  - Disulfiram
  - Acamprosate

Details regarding the availability, pharmacology and appropriate prescribing of FDA-approved medications for addiction are beyond the scope of this section. However, providers are encouraged to reference published prescribing guidelines and other available resources for additional information regarding MAT. The prescribing of MAT must be in compliance with all federal, state and local laws and regulations.

INTERIM SERVICES

If a SUD treatment program has insufficient capacity and must refer a person served elsewhere, the program must offer interim services within ten (10) days of the request for treatment.

Interim services are services that are provided until an individual is admitted to a SUD treatment program. Interim services are provided in order to reduce the adverse health effects of substance use, promote the health of the individual and reduce the risk of transmission of disease. At a minimum, interim services include counseling and education about Human Immunodeficiency Virus (HIV) and tuberculosis (TB), about the risks of needle-sharing, the risks of transmission to sexual partners and infants and about steps that can be taken to prevent the transmission of HIV and TB, as well as referral to HIV or TB treatment services if necessary. For pregnant women, interim services include counseling on the effects of alcohol and drug use on the fetus, as well as referral to prenatal care.

Records must indicate evidence that Interim Services have been provided or offered. DBH will review documentation for compliance.

EVIDENCE BASED PRACTICES (EBP)

Research and innovations have yielded significant progress in the development, standardization and empirical evaluation of psychosocial treatments for SUD. While several approaches and techniques are effective depending on the clinical situation, certain treatment approaches have a stronger evidence base and therefore serve as the foundation of a high-quality system of SUD care. Providers are expected to support the use of MAT as an evidence-based intervention, when clinically appropriate.

Fresno County DBH will require providers to implement Motivational Interviewing and at least two of the remaining four evidence-based practices (EBPs) listed in the Special Terms and Conditions (STCs):

- Psychoeducation
- Trauma Informed Treatment
- Cognitive Behavioral Therapy
- Relapse Prevention

The two additional EBPs may be chosen by each provider and must be performed by trained providers within their scope of practice. Providers are required to internally monitor staff for training needs, quality of delivery, and fidelity of EBPs.

The following descriptions of the evidence-based psychosocial interventions below are simply summaries. Providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches. Since psychoeducation and relapse prevention are standard practice in most treatment programs, providers are encouraged to implement trauma-informed treatment and cognitive behavioral approaches if these EBPs are not already being utilized and are relevant to the population the provider serves. The following are brief descriptions of the evidence-based psychosocial interventions:

MOTIVATIONAL INTERVIEWING (MI)

A person-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 person served's past successes.

RELAPSE PREVENTION

Relapse prevention is a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse, including internal and external triggers. Relapse prevention may be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a person served's overall coping capacity.

COGNITIVE-BEHAVIORAL THERAPY (CBT)

Cognitive-behavioral strategies are based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can also be learned. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use and developing strategies for coping with cravings and avoiding those high-risk situations. The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.

TRAUMA-INFORMED TREATMENT

Trauma informed treatment is a philosophy embedded into the culture of the organization. Services shall focus on understanding trauma and place priority on trauma survivors' safety, choice and control. Seeking Safety is an example of an evidence-based trauma-informed curriculum.

PSYCHOEDUCATION

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

INDIVIDUAL COUNSELING

Individual counseling is a telephone, telehealth or face-to-face session in any appropriate setting in the community between a person served and LPHA or SUD counselor that focuses on psychosocial issues related to substance use and goals identified in the person served's treatment plan.

The following are examples of individual counseling activities, such as:

- Processing issues related to substance use, such as concepts of withdrawal, recovery, and an alcohol and drug free lifestyle.

A progress note must be written for each session and documented in the person served chart. The frequency of individual counseling sessions, in combination with other treatment services, shall be based on medical necessity and the individualized person served's needs rather than a prescribed program required for all persons served.

Interventions provided in an individual counseling session must be within the scope of practice of the counselor providing the service. If EBPs are referenced it should be clear how they are being used to address the person served's treatment goals in order to individualize the treatment to the needs of the person served.

COLLATERAL SERVICES

Collateral services are sessions between SUD counselors or LPHAs and significant persons in the life of the person served. This service focuses on the treatment needs of the person served, and how loved ones can support the person served during treatment and their recovery process. These services are used to obtained useful information regarding the person served to support recovery. Significant persons are individuals having a personal, not official or professional relationship (e.g. teachers or probation officers) with the person served. A release of information must be obtained for each individual prior to engaging in collateral services. The focus of collateral services is on how to better address the treatment needs of the person served and what would support the person served in achieving his or her treatment goals. A progress note must be written for each session and documented in the person served chart.

Collateral services are available at all levels of care and are defined as contact between the provider, the significant persons in the person served's life, and/or the person served. Collateral services can be provided with or without the person served present.

The frequency of collateral services sessions, in combination with other treatment services, shall be based on medical necessity and individualized to the person served's needs rather than a prescribed program required for all persons served.

CRISIS INTERVENTION

Crisis Intervention services are defined as contact between an LPHA or SUD counselor and a person served in crisis. These services focus on alleviating crisis problems, where crisis is defined as an actual relapse or an unforeseen event or circumstance which presents imminent threat of relapse. Crisis intervention does not need to be a service that is specifically authorized on the treatment plan because it is available to any person served at any time it becomes necessary. This type of service is limited to stabilization of the person served's emergency situation. A progress note must be written for each service and documented in the person served's chart.

This service includes linkages to ensure ongoing care following the alleviation of the crisis. Crises that are not responsive to intervention shall be escalated to urgent (e.g., urgent care clinic) or emergency (e.g., medical or psychiatric emergency room) care. Crisis situations should not be confused with emergency situations, which require immediate emergency intervention, such as calling 911. Urgent and emergency situations must be properly documented and reported to DBH as necessary and appropriate (See reportable incidents and unusual occurrences, page 81).

Crisis Intervention services are not scheduled but shall be available to the person served during the agency's normal operating hours or in alignment with afterhours crisis procedures. Some examples of crises include:

- Receiving a phone call from a person served who states they have just been kicked out of the home and is reporting thoughts or plans to relapse, requiring the counselor's immediate attention; or
- The person served reports a relapse.

Crisis services that do not document the nature of the crisis and components associated with the crisis (relapse, unforeseen event or circumstance which presents imminent threat of relapse, linkage to ongoing care following the alleviation of the crisis) are subject to recoupment.

COORDINATION WITH PHYSICAL AND MENTAL HEALTH

All providers are required to utilize the ASAM criteria and DBH's standardized assessment tool which screens for both substance use and mental health disorders. In the event that a mental health disorder is identified, providers are required to include in the person served's treatment plan an objective to obtain further assessment, and a coordinated referral to mental health treatment and/or direct provision of mental health services by the provider.

Additionally, all providers are required to include a goal of obtaining a physical exam in each person served's individualized treatment (if a physical exam has not been conducted within the past 12 months) and must list any existing physical health conditions to ensure progress in this area is continually evaluated. For persons served who have obtained a physical exam within the past 12 months, providers must document attempts to obtain documentation of the exam.

Case managers will coordinate SUD services with needed medical and mental health services. Integration with mental health and physical health will be monitored through annual review of health questionnaires, assessments, reassessments, treatment plans and progress notes.

MEMORANDUM OF UNDERSTANDING (MOU) WITH MANAGED CARE PLANS

DBH has entered a MOU with Managed Care plans Anthem Blue Cross and CalViva Health to enroll persons served by the DMC-ODS. These managed care plans will be available to refer persons served for Early Intervention (ASAM Level 0.5), Medically Monitored Intensive Inpatient services (ASAM Level 3.7), and Medically Managed Intensive Inpatient services (ASAM Level 4.0) as well as the corresponding Withdrawal Management ASAM Levels 3.7-WM and 4.0-WM. For more information on these levels of care, refer to the ASAM & Level of Care Section. Anthem and CalViva network providers will screen and/or assess persons served for SUD and make appropriate referrals to DBH providers.

For referrals to CalViva please call 1-888-893-1569

For referrals to Anthem please call 1-800-407-4627

NON-EMERGENCY MEDICAL TRANSPORTATION

Managed care plan network providers will also offer non-emergency medical transportation services for persons served to DBH providers when services are medically necessary and authorized.

To assist persons served obtain non-emergency transportation please call:

CalViva	*1-888-893-1569*
Anthem	*1-877-931-4755*

TELEHEALTH AND FIELD-BASED SERVICES

The following services may be completed through telehealth or field-based services: Outpatient (Individual counseling), Intensive Outpatient, Recovery Services and Case Management.

Telehealth and field-based services qualify as Medi-Cal reimbursable units of service and are reimbursed without distinction.

Providers offering telehealth and field-based services must provide person served education at intake to ensure confidentiality.

Providers shall follow ASAM protocols and Medi-Cal procedures for treatment continuation. The standard of care for telehealth will be equivalent to that of in-person treatment. Providers must have policies and procedures to ensure informed consent, confidentiality and privacy protections in accordance with 42 CFR, Part 2, and to ensure that adequate infrastructure to support this service exists for telehealth and field-based services. Standard documentation requirements apply.

Additional Medi-Cal Telehealth Requirements can be found at:

https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-78.pdf

PHYSICIAN CONSULTATION

Physician Consultation Services include DMC physicians' consult with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS persons served; rather, they are designed to assist DMC physicians seeking expert advice on designing treatment plans for specific DMC-ODS persons served. Physician consultation services are to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. These services can only be billed by and reimbursed to DMC providers. The provider may then reimburse the Physician Consultation agency.

All local, state and federal confidentiality requirements involving HIPAA and 42 CFR Part 2 must be followed during the physician consultation process.

If a complex situation is encountered during treatment of a Drug Medi-Cal eligible person served and additional assistance is required, the service provider's Medical Director may contact the Clinician Consultation Center to request advice on the following items:

- Assessment and treatment of opioid, alcohol and other substance use disorders;
- Approaches to suspected misuse, abuse or diversion of prescribed opioids;
- Methods to simplify opioid-based pain regimens to reduce risk of misuse and toxicity;
- Urine toxicology testing; when to use it and what it means;

- Use of buprenorphine and the role of methadone maintenance;
- Withdrawal management for opioids, alcohol and other Central Nervous System depressants;
- Harm reduction strategies and overdose prevention;
- Managing substance use in special populations (pregnancy, HIV, hepatitis);
- Productive ways of discussing (known or suspected) substance use with patients; and
- Other complex cases regarding medication selection, dosing, side effect management, adherence, drug-drug interactions or level of care considerations.

CONTACTING THE CLINICIAN CONSULTATION CENTER

Option 1: (Immediate Assistance between the hours of 7am and 3pm, Monday - Friday): (855) 300-3595

Option 2: (Non-Urgent Electronic Case Submission): http://nccc.ucsf.edu/clinician-consultation/substance-use-management/

DOCUMENTATION

When a consultation service is utilized, the medical director or LPHA working within their scope of practice who provided the treatment service to the DMC person served shall record a progress note and keep in the person served's file. Progress notes shall include the following:

- Person served's name;
- The purpose of the service;
- Date, start and end times of each service;
- Identify if services were provided face-to-face, by telephone, by Electronic Case Submission, or by telehealth; and
- Typed/printed name, signature, and signature date.

GROUP COUNSELING

Group counseling services are designed to support discussion among persons served with guidance from the facilitator to share understanding and encourage participation on psychosocial issues related to substance use. Group counseling sessions shall utilize evidence-based practices. Group sign-in sheets must include signatures and printed names of persons served, the group facilitators, date, start and end times, location and group topic. Clinical group counseling services are available at all levels of care and are defined as face-to-face contact between one (1) or more registered or certified SUD counselor(s) or LPHA(s) treating two (2) or more persons served with a maximum of twelve (12) in the group. Any non-Medi-Cal participants will still count toward the twelve (12) maximum with at least one (1) Medi-Cal person served being present. For outpatient programs, a separate individualized progress note must be documented for each person served in the person served's chart or Electronic Health Record (EHR). For residential programs, groups will be documented in a weekly note and filed in the person served's chart or EHR.

According to the regulations, only "clinical" groups are billable to DMC. This means that the group content must address a need related to the substance use that helps the person served towards achieving his or her treatment goals. Groups such as house meeting are not considered "clinical" groups.

PERSON SERVED EDUCATION

Person Served Education sessions are designed to enable the facilitator to teach persons served about and encourage discussion on research-based educational topics such as addiction, treatment, recovery, and associated

health consequences with the goal of minimizing the harms of SUDs, lowering the risk of overdose and dependence, and minimizing adverse consequences related to substance use. The frequency of person served Education sessions, in combination with other treatment services, must be based on medical necessity and individualized person served needs rather than a prescribed program required for all persons served. A separate progress note must be written for each person served and documented in the person served's chart.

FAMILY THERAPY

Family therapy means including a person served's family members and loved ones in the treatment process, and education may include factors that are important to the person served's recovery as well as the family member or loved one's recovery. Family members may provide social support to persons served, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

Family therapy sessions are available at all levels of care and are defined as face-to-face contact between the LPHA level therapist, the person served and family members or loved ones. A progress note must be written for each session and documented in the person served chart.

The frequency of family therapy sessions, in combination with other treatment services, must be based on medical necessity and individualized person served needs rather than a prescribed program required for all persons served.

Family therapy brings the family into the treatment process to identify unhealthy family dynamics that enable addiction to continue. As unhealthy behaviors are identified, families can work on positive and healthy interactions with each other. Family therapy is a self-discovery process for the entire family unit and does not focus solely on the needs of the person served. This type of therapy can continue long after treatment is completed through referrals to a licensed practitioner.

For residential levels of care, family therapy falls under Individual Counseling and is part of the daily bundled rate. Time spent providing Family Therapy services may be counted towards the required number of clinical hours needed each week.

Family therapy services differ from collateral services in that the person served must be present.

SECTION 3 ACCESS TO CARE, SCREENING, ADMISSION AND TREATMENT

ACCESS TO CARE

Maximizing access and minimizing the time and barriers to care are fundamental priorities for the SUD system. Every effort must be made to minimize the elapsed time between the initial request for service, clinical need determination, referral, and the first appointment. Persons served may access services by directly contacting DMC-ODS providers or via the DBH Access Line.

While there is no "wrong door" to enter the SUD system, there are four (4) main portals of entry:

- Toll-free Access Line at 1 (800) 654-3937
- Urgent Care Wellness Center
- Youth Wellness Center
- Direct-to-provider self-referrals

TIMELINESS AND ACCESS STANDARDS

Ensuring timely access to services is essential toward the goal of improving outcomes of Fresno County's DMC-ODS, as is the ability to engage persons served when they are ready to initiate treatment.

If a person served is referred to, or presents at, a facility that is unable to meet timely access to care requirements (see table below) without placing the person served on a waitlist, the person served must be provided alternate services within 48 hours. If the person served declines the referral, the provider shall document this in the person served's records.

Distance is another component of treatment access that has been linked to person served outcomes. Unless otherwise requested by the person served, the person served shall be referred to a treatment program that is within time and distance standards shown in the table below. If this is not feasible, every effort should be made to decrease the likelihood that the commute or transportation issues serve as a barrier to accessing treatment. If persons served prefer to have some aspect of treatment delivered in a different region than where they reside or work, this preference must be considered and noted in the person served chart.

URGENT CONDITIONS

The Department of Managed Health Care defines urgent conditions as when an "enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function." Urgent conditions must have an appointment/initial contact within one (1) business day of request. Providers shall ensure that medical attention is provided immediately for emergency and crisis medical conditions.

Description	Access Standard
Appointment scheduled	Same day as screening or first contact
Intake date with SUD provider	Within one (1) business day from date of screening or first contact for urgent conditions. Within ten (10) business days from date of screening or first contact for outpatient settings. Within three (3) business days from date of screening or first contact for OTP/NTP persons served. Within ten (10) business days from the date of screening or first contact for all residential settings including withdrawal management
Distance	Every effort must be made to refer persons served to a treatment program within: Outpatient/Intensive Outpatient 60 miles or 90 minutes of travel time from the person served's place of residence. **Reference WIC 14197(d)(1)(A) Opioid (Narcotic) Treatment Program 45 miles or 75 minutes of travel time. from the person served's place of residence. **Reference WIC 14197(d)(3)

ACCESS LINE

One of the primary methods by which persons served can access SUD services in Fresno County is by calling the Access Line. Persons served can call the Access Line to initiate a self-referral, request information or make a complaint.

SUMMARY OF ACCESS LINE PROCESS

Fresno County DBH's Access Line shall be maintained by a contracted Administrative Service Organization (ASO). Their functions include:

- Screenings using the ASAM-based Screening Tool;
- Referrals to a SUD provider for an appointment based on the provisional level of care determination identified from the ASAM-based screening. Persons served will be given the opportunity to choose the provider based on preference and distance from the person served's residence, as well as the clinical judgment of the Access Line staff.
- Creating intake appointments with selected provider through the EHR within the time frames mentioned above from the date of initial contact while the caller or referring entity is on the line, except under limited circumstances (e.g., the caller's availability is unclear or if Access Line staff are unable to schedule an appointment despite reasonable efforts).
- Providing alternative options in the event that the recommended provisional level of care is not available or a SUD provider that matches the caller's needs and preferences is not immediately available for an appointment.
- Connecting the person served with emergency services, if at any point during the call it is determined that such services are required. Access Line staff will connect with 911 and remain on the line until emergency personnel have assumed responsibility for the call.

SUD TREATMENT PROVIDER RESPONSIBILITIES WHEN RECEIVING ACCESS LINE REFERRALS

To receive referrals from the Access Line the treatment provider must ensure the following:

- Treatment providers must ensure that the provider directory includes current information on the days and hours of operation for each DMC-certified site, and any specialized expertise, such as language capability or populations served. This information will be communicated by the provider to DBH monthly by completing the Monthly Status Report (MSR) by the 15th of the month.
- Prior to the scheduled appointment, SUD provider staff are encouraged to call the referred individual to provide an appointment reminder, and/or call the individual to follow up if the appointment is missed.
- If the full ASAM assessment conducted at the SUD treatment provider indicates that a different level of care is needed, the assessing SUD provider shall connect the individual with the necessary and most appropriate level of care.
- If the assessing treatment provider offers that level of care, and the facility meets the preferences and needs of the individual, the referral can be made internally.
- If the assessing provider does not offer the necessary and most appropriate level of care, or if the assessing provider does not meet the geographic and other preferences of the individual, at least two (2) alternative referral options should be provided to the person served whenever possible. The assessing provider shall identify referral options using the DBH provider directory and contact the selected provider to schedule an appointment on behalf of the individual as well as complete a Referral Form.
- In instances where transitions between SUD treatment and health providers are necessary, SUD provider staff shall connect the person served with the receiving provider. Management of these transitions through care coordination and case management is the responsibility of the referring treatment provider.
- Documentation requirements apply to all treatment services, including interactions with the Access Line.

URGENT CARE WELLNESS CENTER (UCWC)/YOUTH WELLNESS CENTER (YWC)

LOCATION OF UCWC AND YWC

To improve access to services, UCWC and YWC are included as access points to the SUD and MH systems of care.

The programs are located at the following sites:

- *UCWC – 4411 E Kings Canyon Rd. Fresno, CA 93702 – (559) 600-9171*
- *YWC – 3147 E Millbrook Ave Fresno, CA 93703 – (559) 600-6784*

HOURS OF OPERATION

UCWC is open Monday through Friday from 8:00 AM to 6:00 PM.

YWC is open Monday through Friday from 7:30 AM to 5:00 PM.

CORE ACTIVITIES OF THE UCWC AND YWC

The UCWC and YWC are DBH operated access points that provides face-to-face services to facilitate access to SUD treatment.

Activities Provided by UCWC and YWC:

- Person served engagement;
- Person served eligibility;

- Person served education;
- Person served screening and appointment setting; and
- Service navigation, ancillary referrals and linkages.

PERSON SERVED INFORMING AND TRANSLATION SERVICES

Providers are required to make written and verbal information available to persons served in their language of choice.

WRITTEN MATERIALS

Providers shall make available in the prevalent non-English languages, DBH's written/translated materials that are critical to obtaining services, including the provider directory, member handbook, appeal and grievance notices, and denial and termination notices. All other provider-specific written materials must be made available in the prevalent non-English languages. Providers shall ensure that written materials use easily understood language and formatting, use a font size no smaller than 12 point, and are made available in alternative formats upon request of the potential person served or person served at no cost.

Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number provided by DBH. Written materials for potential and current persons served shall include language taglines in at least the top sixteen non-English languages spoken by individuals with limited English proficiency of the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided in prevalent non-English languages, as well as large print. Large print means in a font size no smaller than 18 point.

AUXILIARY AIDS

Providers are required to ensure auxiliary aids and that services are provided in an appropriate manner that takes into consideration the special needs of persons served or potential persons served with disabilities or limited English proficiency be made available upon request of the person served or potential person served at no cost.

Free aids and services to persons served with disabilities to help them communicate better may include, but are not limited to, qualified sign language interpreters and written information in other formats (large print, audio, and accessible electronic formats).

INTERPRETATION SERVICES

Providers shall make interpretation services available free of charge and in a timely manner to each person served. This includes oral interpretation and the use of auxiliary aids (such as TTY/TDY and American Sign Language) and services including qualified interpreters for individuals with disabilities. Oral interpretation requirements apply to all non–English languages, not just those that DHCS identifies as prevalent. Oral interpretation services shall be provided by an interpreter that, at a minimum, meets all the following qualifications:

- Demonstrated proficiency in speaking and understanding both spoken English and the language spoken by the limited-English-proficient person served;
- The ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the limited-English-proficient person served and English, using any necessary specialized vocabulary, terminology, and phraseology; and
- Adheres to generally accepted interpreter ethics principle, including person served confidentiality.

Providers shall notify persons served that oral interpretation is available for any language and written translation is available in prevalent languages to individuals whose primary language is not English. This may include but is not limited to qualified interpreters and information in other languages. Providers shall notify persons served that auxiliary aids and services are available upon request and at no cost for non-English speaking/reading/writing persons served and persons served with disabilities. Free aides and services to people with disabilities to help them communicate better may include, but are not limited to, qualified sign language interpreters and written information in other formats (e.g. large print, audio, accessible electronic formats, and other formats). Providers must notify persons served how to access these services.

Providers shall not require a person served with limited English proficiency to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described above.

Providers shall not rely on an adult or minor child accompanying the limited-English-proficient person served to interpret or facilitate communication except under the circumstances such as emergencies and upon request that the accompanying adult provide assistance.

Providers shall not require a person served with limited English proficiency to accept language assistance services.

SCREENING

Persons served may be screened for a possible SUD by contacting the SUD Access Line, which is available 24 hours a day, seven (7) days a week. The primary purpose of the brief screening is to determine an appropriate provisional level of care for an individual, and when appropriate, to facilitate a successful referral and linkage to the identified provider capable of meeting the individualized needs of the person served. Screening is also performed by the Urgent Care Wellness Center/Youth Wellness Center and by phone call, appointment or on a walk-in basis at provider sites.

The provider shall utilize the standardized Fresno County SUD Screening tool when conducting a screening.

YOUTH (AGES 12 – 17)

If results indicate that the assessed youth is at-risk of developing a SUD, or would likely meet medical necessity for SUD services, an appointment will be scheduled with an outpatient youth treatment provider to conduct a full Fresno County SUD Assessment.

ADULTS

If results indicate the individual would likely meet medical necessity for SUD services, an appointment will be scheduled with an appropriate SUD provider.

ELIGIBILITY DETERMINATION

Providers that deliver DMC-ODS services are responsible for verifying the Medi-Cal eligibility of each person served for every month of service prior to billing for DMC services for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Billing Manual. Options for verifying the eligibility of a Medi-Cal person served are described in the DHCS DMC Billing Manual at the following web address.

https://www.dhcs.ca.gov/formsandpubs/Documents/DMC_Billing_Manual_2017-Final.pdf

These verifications shall be made available to DBH for review upon request.

COUNTY OF RESPONSIBILITY

In accordance with State policy, DBH follows a county of residence model of service delivery. This means that the county of responsibility for SUD services is the county of residence where the Medi-Cal case is active for the person served. As such, the Fresno County DBH SUD benefit package is only available to Fresno County residents. SUD providers in DBH's contracted network that render services to individuals who reside outside of the County will not be reimbursed by Fresno County for those services. These persons served must be referred to the County in which their Medi-Cal case is active, or the Medi-Cal must be transferred to Fresno County if the person served has moved to Fresno County. Only services rendered to individuals who are residents of Fresno County will be reimbursed. Questions regarding the County of responsibility policy may be directed to DBH Contracts Division.

ESTABLISHING BENEFITS AND DELIVERING CONCURRENT SERVICES

When an individual makes the decision to seek SUD treatment services, it is critical to provide services as soon as possible and to avoid any unnecessary barriers to care. In addition, it is likely that many individuals seeking care may be "eligible" for Medi-Cal but do not have active benefits at the time of assessment and intake. For these reasons no eligible individual may be denied services pending establishment of Medi-Cal. Therefore, providers should use the Case Management benefit to:

- Assist individuals to obtain Medi-Cal, initiating the process on or before the date of first treatment service to better ensure reimbursement for delivered services.
- Assist Fresno County residents to transfer Medi-Cal benefits to Fresno County if benefits are assigned to another County on or before the date of first treatment service, as reimbursement shall be denied for non-Fresno County residents.

If Medi-Cal benefits are ultimately established, SUD treatment services are reimbursable to the date of application therefore, it is essential to initiate this process as close to the date of first service as possible. It is also critical that:

- Individuals step-up or step-down to another level of care whenever clinically appropriate (e.g., from withdrawal management to outpatient) both to support improved and sustained recovery outcomes and also increase the time to support persons served in obtaining health benefits; and
- The initial case manager communicates with the new case manager regarding the status of the application as the initial provider will rely on the subsequent provider to support the person served in completing the paperwork, so all are reimbursed once the application is approved.

If the person served is Medi-Cal eligible but has Other Health Coverage (OHC) the provider must attempt to bill the OHC using the Universal Health Insurance claim form, and if the claim is denied, the provider may then bill Medi-Cal. When this is the case, the provider must provide the denial to the DBH Business Office or their assigned Analyst. For more information, please refer to SUD Services Bulletin 18-01.

NON-MEDI-CAL ELIGIBLE PERSONS SERVED

While the DMC-ODS in Fresno County is intended to serve individuals within the State and county safety net programs, individuals who are not eligible for Medi-Cal may at times seek services in the DMC-ODS. In these instances, Fresno County may utilize DBH gap funding to reimburse providers for services to these individuals. If the person served has other insurance such as Kaiser, Veterans Affairs (VA) or other funding, all attempts should be made to link the person served to the appropriate service.

INTAKE

Intake is the process of determining if a person served meets medical necessity criteria. If the person served meets medical necessity criteria, they are then admitted into a SUD treatment program.

Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral and SUD(s); and the assessment of treatment needs to provide medically necessary services. Intakes may also include a physical exam and laboratory testing (e.g., body specimen screening) necessary for SUD treatment and evaluation.

For NTP/OTP, a medical evaluation is necessary for a person served to enroll in either withdrawal management or maintenance treatment.

PERSON SERVED ADMISSION

Each provider shall include in its policies, procedures and practice, written admission and readmission criteria for determining person served eligibility and medical necessity for treatment. These criteria shall include, at minimum:

- DSM-5 SUD diagnosis;
- Use of substances;
- Physical health status; and
- Documentation of social and psychological problems.

If a potential person served does not meet admission criteria, the person served shall be referred to an appropriate service provider. If a person served is admitted to treatment, the person served shall sign a consent to treatment form prior to engaging in services. The Medical Director or LPHA shall document the basis for the diagnosis in the person served's record utilizing the mandated Fresno County Initial/Updated Determination of Diagnosis (IDD) form.

All referrals made by the provider staff shall be documented in the person served chart or EHR. Copies of the following documents shall be provided to the person served upon admission:

- Person served rights
- Share of cost, if applicable;
- Notification of DMC funding accepted as payment in full; and
- Consent to treatment.
- Minor consent shall be obtained at the time of admission. When obtaining minor consent, the mandatory Fresno County Checklist to Determine Minor's Ability to Consent to SUD Treatment Form must be utilized. Additionally, the minor consent form shall be completed by a professional person as defined in Health and Safety Code Section 124260: Mental health treatment or counseling services means the provision of outpatient mental health treatment or counseling by a professional person, as defined in paragraph (2).

Professional person means any of the following:

- A person designated as a mental health professional in Sections 622 to 626, inclusive, of Title 9 of the California Code of Regulations.
- A marriage and family therapist, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.
- A licensed educational psychologist, as defined in Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code.
- A credentialed school psychologist, as described in Section 49424 of the Education Code.

- A clinical psychologist, as defined in Section 1316.5 of the Health and Safety Code.
- A licensed clinical social worker, as defined in Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code.
- A person registered as a marriage and family therapist intern, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (g) of Section 4980.03 of the Business and Professions Code.
- A board certified, or board eligible, psychiatrist.
- A licensed professional clinical counselor, as defined in Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.
- A person registered as a clinical counselor intern, as defined in Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (h) of Section 4999.12 of the Business and Professions Code.

Copies of the following shall be provided to the person served or posted in a prominent place accessible to all persons served:

- A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay;
- Complaint process and grievance procedures;
- Appeal process for involuntary discharge; and
- Program rules and expectations.

Where drug screening by urinalysis is deemed medically appropriate the program shall:

- Establish procedures which protect against the falsification and/or contamination of any urine sample; and
- Document urinalysis results in the person served's file.

Persons served shall receive access to a member handbook at time of intake.

NTP/OTP REQUIREMENTS FOR ADMISSION

In addition to the above requirements, NTP/OTP providers shall maintain the following documentation in the person served file:

- Physical exam, including laboratory results for required tests and analyses by Medical Director or physician;
- Medical history which includes history of illicit drug use;
- Organ systems review and vital signs;
- Examination of head, ears, eyes, throat, chest, abdomen, extremities, skin and general appearance;
- Assessment of neurological system;
- Overall impression, including identification of medical conditions or health problems which warrant treatment;
- Hepatitis C, Tuberculosis, and Syphilis testing at the time of admission;
- Documentation of offered HIV testing;
- Documentation of linkages to care and treatment for persons served who test positive for the above-mentioned health issues; and
- Testing for narcotic drug use.

NTP/OTP CERTIFICATION OF FITNESS FOR REPLACEMENT NARCOTIC THERAPY:

A person served who has resided in a penal or chronic care institution for one month or longer may be admitted to maintenance treatment within one month of release without documented evidence to support findings of physical dependence, provided the person would have been eligible for admission before he or she was incarcerated or institutionalized and in the clinical judgment of the Medical Director or program physician, treatment is medically justified.

Previously treated persons served who voluntarily detoxified from maintenance treatment may be admitted to maintenance treatment without documentation of current physical dependence within two years after discharge, if the program is able to document prior maintenance treatment of six months or more and in the clinical judgment of the Medical Director or program physician, treatment is medically justified.

Persons-served admitted pursuant to this subsection may, at the discretion of the Medical Director or program physician, be granted the same take-home step level they were on at the time of discharge.

The following admission criteria shall apply:

- Confirmed documented history of at least one year of addiction to opioids.
- Documented evidence and final determination from the Medical Director of physical dependence and addiction to opioids.

The aforementioned shall be documented and verified by a physician credentialed by Fresno County Department of Behavioral Health (DBH).

ADMISSION DISCRIMINATION

Providers shall accept individuals eligible for admission in the order in which they apply without restriction, up to the limits set under the State-County Intergovernmental Agreement. Providers shall not, based on health status or need for health care services, discriminate against individuals eligible for admission. Providers shall follow all Federal and State civil rights laws. Providers shall not unlawfully discriminate, exclude people, or treat them differently, on any ground protected under Federal or State law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation and will not use any policy or practice that has the effect of discriminating on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. Providers shall ensure that persons served that meet medical necessity for MAT receive the same access to care as non-MAT persons served.

Providers shall post a DHCS-approved nondiscrimination notice and language taglines in at least the top sixteen non-English languages in the State, as determined by DHCS, in a conspicuously visible font size, in conspicuous physical locations where the Provider interacts with the public, in a conspicuous location on Provider's website that is accessible on DBH's home page, and in significant communications and significant publications targeted to persons served, enrollees, applicants and members of the public, as required by 45 CFR 92.8.

Providers shall provide information on how to file a Discrimination Grievance with DBH or DHCS if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. Providers shall also provide information on how to file a Discrimination Grievance with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age or disability.

MEMBER HANDBOOK

Providers shall utilize the County of Fresno DMC-ODS Member Handbook, which shall be provided to persons served at intake. If the provider is unable to issue a printed copy of the Member Handbook, the provider may mail a hardcopy to the person served's mailing address, email it after obtaining the person served's agreement to receive information by email, or direct the person served to the Fresno County DBH website where it can be viewed. Providers are required to have the person served fill out an Acknowledgment Form acknowledging that they were offered the Member Handbook and must place this document in the person served's chart or EHR for review purposes.

The Member Handbook contains information that enables the person served to understand how to effectively use the managed care program. The Member Handbook also includes information regarding Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, how and where to access benefits including EPSDT and grievance, appeals and fair hearing procedures and timeframes.

ASSESSMENT

The initial Fresno County mandated SUD assessment is completed after admission to treatment according to specified timeframes. This is where the documentation of medical necessity begins. As with any standard assessment, it is a compilation of information that is gathered from interviewing the person served and, if applicable, from significant others (family, friends, sponsors, probation officers, social workers, etc.) who may be involved with the person served's treatment or referral to treatment.

Providers shall ensure a counselor or LPHA completes a personal, medical, substance use history for each person served upon admission to treatment.

The Medical Director or LPHA shall review each person served's personal, medical and substance use history if completed by a counselor.

Since the initial assessment is where medical necessity is first documented, it will need to incorporate the six dimensions of the ASAM Criteria. In treatment, assessments are an essential and ongoing process that helps the provider focus their service delivery to best meet the needs of the person served.

The utilization of the DBH standardized assessment tools are a contractual requirement and applies to all SUD treatment providers (DMC and Non-DMC). Failure to utilize this tool will result in a recoupment of services.

Once the assessment information is gathered, it is determined whether the person served meets the DSM-5 criteria for a SUD. The assessing counselor and LPHA shall type or legibly print their name and sign and date the assessment. The signature shall be adjacent to the typed or legibly printed name.

ELEMENTS OF THE ASSESSMENT

Intake Assessment Element	Required Documentation in Person Served Record	Map to ASAM Dimension
1. Drug/Alcohol Use History	Describe the current episode and history of use along with withdrawal symptoms and significant issues, such as overdose or hospitalization	Dimension 1

2. Medical History	Describe any current medical problems and prescribed treatments, current medications, allergies, most recent medical evaluation, surgery history, previous head injuries or memory loss, previous emergency room visits including those due to substance-related issues and current pregnancy	Dimension 2
3. Family History	Describe the family history of substance use including previous treatment episodes	Dimension 6
4. Psychiatric/Psychological History	Describe any current or previous mental health symptoms including medications, previous diagnoses, hospitalizations and history of trauma	Dimension 3
5. Social/Recreational History	Describe any supportive relationships, enjoyable activities, interests, cultural aspects and religious or spiritual beliefs	Dimension 6
6. Financial Status/History	Description of current financial status and history	Dimension 6
7. Educational History	Description of educational history, highest level of education achieved and any plans to further one's education	Dimension 6
8. Employment History	Description of current employment status and employment history including training programs and previous military experience	Dimension 6
9. Legal Status/Criminal History	Description of current legal status, criminal history and involvement with Child Protective Services (CPS)	Dimension 6
10. Previous SUD Treatment History	Describe any previous treatment episodes including degree of successfulness, positive takeaways and previous Medication Assisted Treatment	Dimension 5

The Fresno County SUD Assessment Form is required for every intake. This includes for those who may be transitioning from one level of care to another within the same program. (e.g. Intensive Outpatient to Outpatient). Persons served who are transitioning levels of care within the same program may be reassessed in lieu of a full SUD Adult Assessment.

TIMEFRAMES FOR ASSESSMENT

1. For Residential Treatment, the Fresno County SUD mandated assessment shall be completed and signed **by the Counselor/LPHA who is completing the assessment and LPHA/Medical Director reviewing the assessment** within **three (3) calendar days** of the person served's admission.
2. For Withdrawal Management, The Fresno County SUD mandated assessment and supplemental assessment shall be completed and signed **by the Counselor/LPHA completing the assessment and LPHA/Medical Director reviewing the assessment** within **three (3) calendar days** of the person served's admission.
3. For Intensive Outpatient and Outpatient, the Fresno County SUD mandated assessment shall be completed and signed **by the Counselor/LPHA completing the assessment and LPHA/Medical Director reviewing the assessment** and signed within **seven (7) calendar days** of the person served's admission.
4. For Narcotic Treatment Programs, the Fresno County SUD mandated assessment is to be completed and signed **by the Counselor/LPHA who is completing the assessment and LPHA/Medical Director who is reviewing it** within **twenty-eight 28 calendar days** of person served's admission.

If the assessment is completed by a non-LPHA counselor, there must be a face-to-face or telehealth consultation between the non-LPHA counselor who completed the assessment and the LPHA/Medical Director reviewing the assessment prior to the determination of a diagnosis.

If the assessment is unable to be completed within the timeframes specified above, the reason(s) should be documented in the progress notes and the assessment shall be completed during next person served contact.

REASSESSMENT

The function of the reassessment is to determine the ongoing need for the current level of care, the effectiveness of the current treatment approach and ensure medical necessity continues to be met. Reassessments must be completed within the specified timeframes dependent on the level of care or when clinically appropriate. If the person served experiences a change in impairments or the development of new issues, the reassessment could determine if a change in treatment approach or level of care is needed.

All outpatient and intensive outpatient treatment persons served are reassessed at a minimum:

- Every 90 days for adults, unless medical necessity warrants more frequent reassessments as documented by the individualized treatment plan.
- Within 90 days and every 30 days thereafter for adolescents unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.

Persons served initially authorized for residential treatment are reassessed at a minimum:

- Every 30 days for adult non-perinatal persons served, unless medical necessity warrants more frequent reassessments as documented by the individualized treatment plan
- Within 30 days for adult perinatal persons served (up to the length of the pregnancy and 60 days postpartum), unless medical necessity warrants more frequent reassessments as documented by the individualized treatment plan.
- Within 30 days for adolescents and every 10 days thereafter unless medical necessity warrants more frequent reassessments as documented by the individualized treatment plan.

For withdrawal management, persons served are reassessed within seven (7) calendar days of admission.

For OTP/NTP, persons served status relative to continued maintenance treatment shall be re-evaluated at least annually utilizing the Fresno County Adult Reassessment Form (9 CCR 10165; 10410).

RESIDENTIAL TREATMENT AUTHORIZATION REQUEST

Services requiring prior authorization are services for which the treating provider must request approval before initiating treatment. In these instances, the ASO will perform prior authorization reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, when pertinent. The only service that requires prior authorization within the DMC-ODS in Fresno County is residential treatment.

Residential treatment providers must call the ASO to begin the prior authorization review process.

The phone number for Residential Treatment Authorization Request is (866) 854-5586.

Providers must complete the Fresno County ASAM Assessment Tool and the Initial Determination of Diagnosis Form to discuss with the ASO and keep them in the person served file for auditing purposes. Providers must call for preauthorized residential services prior to initiation of services unless providers elect to provide the service prior to receiving prior authorization and accept financial loss if the prior authorization is ultimately denied.

AUTHORIZATION REQUESTS FOR RESIDENTIAL PROGRAMS

The ASO shall:

- Process prior authorization determinations for residential treatment within 24 hours of the service authorization request.
- Ensure the persons served meet the DSM and ASAM criteria requirements to receive residential services.
- Ensure medical necessity for persons served presenting for residential treatment has been determined by either a Medical Director or LPHA.
- Ensure persons served are continually assessed throughout treatment and prior to the end of the initial authorization period.
    - Lengths of stay shall vary according to the assessed medical need for each person served.
    - Providers shall call the ASO for requests for continued residential services.
- Supply written notice (NOABD) to the person served of any decision to deny a service authorization request or to authorize a service in an amount, duration, scope that is less than requested, determined by medical necessity.

For requests for continuation of services that require prior authorization, providers must call the ASO at least **five (5) calendar days** in advance of the end date of current authorization. Required documentation includes, at a minimum, the most recent treatment plan and reassessment.

The ASO will perform a clinical review of the case being referred for prior authorization/reauthorization, based on the case review considerations listed above. Approval for initial prior authorization requests is based on medical necessity and ASAM level of care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress/lack of progress and engagement in treatment.

If a determination cannot be made due to insufficient documentation, the ASO will notify the provider that additional information is needed to process the request.

For Residential prior authorization and reauthorization service timeframes please refer to *Substance Use Disorder Treatment Authorization Request (STAR), Continuing STAR and Reassessment Timeframes*.

PERSON SERVED RECORD

The provider shall:

- Establish, maintain, and update as necessary, an individual person served record for each person served admitted to treatment and receiving services.
- Ensure each person served's individual person served record includes documentation of personal information that includes all of the following:
    - Information specifying the person served's identifier (i.e., name, number).
    - Date of person served's birth,
    - The person served's sex, race and/or ethnic background,
    - Person served's address and telephone number
    - The person served's next of kin or emergency contact.
- Ensure documentation of treatment episode information includes documentation of all activities, services, sessions, and assessments, including but not limited to all of the following:
    - Intake and admission data, including if applicable, a physical examination;
    - Health Questionnaire (Form 5103 or provider form with the required components);
    - Assessments and Reassessments (as applicable);
    - Treatment plans;
    - Progress notes;
    - Continuing services justifications;
    - Laboratory test orders and results;
    - Referrals;
    - Discharge plan;
    - Discharge summary;
    - ASO authorizations for Residential Services; and
    - Any other information relating to the treatment services rendered to the person served.

In addition to the aforementioned components, NTP/OTP providers shall include the following as part of the person served file:

- Physical exam, including laboratory results for required tests and analyses by Medical Director or physician;
- Medical history which includes history of illicit drug use;
- Organ systems review;
- Vital signs;
- Examination of head, ears, eyes, throat, chest, abdomen, extremities, skin and general appearance
- Assessment of neurological system;
- Overall impression, including identification of medical conditions or health problems which warrant treatment;
- TB test;
- Test for narcotic drug use; and
- Test for syphilis.

MEDICAL NECESSITY AND DIAGNOSIS REQUIREMENTS

Determination of the primary, and when appropriate, any additional Substance Use Diagnoses **must** be determined by a Medical Director or LPHA. If a certified or registered counselor completes the assessment, which may give a diagnostic impression, the review and face-to-face with a Medical Director or LPHA must occur prior to

the Medical Director or LPHA completing the Initial/Updated Determination of Diagnosis (IDD) form. The diagnosis shall include the ICD-10 code, description and severity (e.g. F12.20, Cannabis Use Disorder, Moderate).

The Medical Director or LPHA shall evaluate each person served's intake and assessment information if completed by a counselor through a face-to-face or telehealth review with the assessing counselor to establish if the person served meets medical necessity criteria. The Medical Director or LPHA shall **utilize the standardized Fresno County SUD IDD** form to document the person served diagnosis(es). If more than one diagnosis is warranted, the Medical Director or LPHA shall utilize a separate paragraph to substantiate each diagnosis. The IDD form must be completed after the Fresno County SUD assessment and within the following timeframes according to modality:

- Residential or Withdrawal Management 3.2: Three (3) calendar days of admission to treatment.
- Outpatient, IOT and Withdrawal Management 1.0: Seven (7) calendar days of admission to treatment.
- OTP/NTP: Within 28 calendar days of admission to treatment.

The Fresno County SUD assessment is separate from the initial needs assessment that is administered in accordance with regulation CCR Title 9 Section 10270.

The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each person served's assessment and intake information, including their personal, medical, and substance use history.

The Medical Director or LPHA shall type or legibly print their name, sign and date the diagnosis documentation.

For persons served to receive ongoing DMC-ODS services, the Medical Director or LPHA shall re-evaluate the person served's medical necessity qualifications at least every six (6) months through the reauthorization process (see Continuing Justification) and document their determination that those services are still clinically appropriate for the person served. For persons served to receive ongoing OTP/NTP services, the Medical Director or LPHA shall re-evaluate the person served's medical necessity qualification at least annually and determine that those services are still clinically appropriate for the person served.

PHYSICAL EXAMINATION

Physical exams are required to ensure that persons served are medically stable and receiving the physical health services they need to facilitate biopsychosocial well-being.

PHYSICAL EXAMINATION REQUIREMENTS

Persons served are required to have a physical examination within the last twelve (12) months prior to the person served's admission to treatment date. If a physical examination is not on file, a physical examination must occur within ten (10) calendar days of the person served's admission or the physical exam will need to be incorporated into the treatment plan as a goal with a specified date of completion.

- If a provider is unable to obtain documentation of a person served's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the person served's individual record.
- As an alternative to complying with above, or in addition to complying with above, the Medical Director, physician or physician extender may perform a physical examination of the person served within ten (10) calendar days of the person served's admission to treatment date for outpatient and residential treatment.

- If the Medical Director, physician or physician extender has not reviewed the documentation of the person served's physical examination within ten (10) days of person served admission to treatment or perform a physical examination of the person served per above, then the LPHA or counselor shall include in the person served's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met.
- The goal of obtaining a physical examination is not considered complete until the Medical Director, physician, or physician extender has reviewed and signed the physical examination results and has made recommendations for any ongoing medical conditions identified within the physical examination report.
- The physician or physician extender shall type or legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.
- For NTP, before admission to a program (detoxification or maintenance treatment), the Medical Director shall conduct a physical exam during medical evaluation at time of admission per regulations CCR Title 9 Section 102070 (a).

A copy of the physical exam must be included in the person served record. For significant medical illnesses, the person served's initial and updated treatment plans must incorporate a goal to obtain appropriate treatment for the illnesses.

MEDICAL CLEARANCE

If indicated or when appropriate, a person served shall be referred via consultation with medical staff to a licensed medical professional for physical, psychiatric, labs, and/or other examinations. When a person served is referred to a licensed medical professional due to medical concerns, a medical clearance or release will be obtained prior to readmission. The referral and medical clearance shall be documented within the person served Record.

MEDICATION SERVICES AND SAFEGUARDING MEDICATIONS

Medication Services include the prescription, administration, or supervised self-administration (in residential settings) of medication related to SUD treatment services or other necessary medications. These services also include assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or license. Safeguarding of medications in accordance with regulations is required in residential treatment and withdrawal management settings.

Medication Services are available at all levels of care and are defined as face-to-face contact between persons served and qualified medical staff (e.g., physicians, nurse practitioners, or physician assistants) as related to the use of FDA-approved medications for addiction or other necessary medications. Services are reported in 15-minute increments with sessions ranging from 15 to 30 minutes in length. A separate Miscellaneous Note or Progress Note must document the encounter for each person served.

DMC Certified SUD Contracted Providers can prescribe, dispense and bill for buprenorphine, naltrexone, acamprosate and disulfiram within their DMC certified clinics, providing the following:

- The medical staff allowed to prescribe and administer MAT are authorized to do so;
- Enrollment of physicians as Fee-For-Service (FFS) providers and adherence to all FFS requirements, if applicable;
- Compliance with the Federal Waiver Requirements of physicians obtaining federal DATA 2000 waiver (x number) for prescribing buprenorphine, if applicable;

- SUD providers shall have medication management policies and protocols in place to ensure the safety and effectiveness of medication practices, including, but not limited to:
    - Storage of medication;
    - Medication inventory;
    - Prescribing practices including obtaining medical histories;
    - Person served monitoring;
    - Testing associated with detoxification and medication monitoring;
    - Oversight of self-administered medications; and
    - Additional Incidental Medical Services (IMS) policies and procedures as may be required.

Medical Directors shall review all prescribed medications for safety at intake.

Prior to commencing MAT services, prescribing staff will:

- Conduct a comprehensive history of the person served;
- Conduct a comprehensive physical examination of the person served;
- Implement medical decision making of high complexity utilizing physician consultation if indicated and applicable;
- Obtain voluntary, written informed consent to treatment from the person served;
- Obtain a treatment agreement outlining the responsibilities and expectations of the treatment team and the person served;
- Ensure counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies is provided consistent with the nature of the challenges and the person served's and/or family's needs; and
- Make reasonable efforts to obtain releases of information (ROI) for any health care providers or others important for the coordination of care to the extent allowed by HIPAA and CFR, Part 2.

MEDICATION POLICIES AND PROCEDURES

All programs shall have a written policy regarding the use, storage, and destruction of prescribed medications for persons served. It is the responsibility of the SUD Program Medical Director to develop and implement medical policies and standards for the program.

At a minimum, providers shall ensure adherence to its own entity's policies and procedures, as developed by the Medical Director, to safeguard persons served medication. Policies and procedures may include, but are not limited to:

- Medical Director review of all prescribed medications for safety at intake;
- Process of observing persons served self-administration of medication;
- Security or storage/inventory system; and
- Procedure(s) to address persons served adverse reaction to medication (e.g., loss of consciousness, physical difficulties requiring hospitalization, etc.).

Persons served and program staff are responsible for reporting loss or theft of any medication.

For OTP/NTP, the following policies and procedures for medication shall include the following:

- Records which will be kept reconciled daily;
- Amounts of medications received, on hand and administered or dispensed to persons served;

- Names of staff who compound medications and who administer medication;
- Source or supplier of medications and the form of medications to be purchased for the program;
- The name of the person who will purchase medications and documentation of the federal authorization to do so;
- Name and function of anyone other than a staff member who handles the medications;
- Method used to transfer medications within and between facilities;
- Security provisions in which medications will be stored or diluted; and
- The names of the individuals with keys to where the medications are stored.

MEDICATION STORAGE

When applicable, and to ensure appropriate access, residential and NTP/OTP providers may store the person served's medication in the program facility. Provider staff may assist with persons served's self-administration of medication in accordance with all relevant regulations and the DHCS Alcohol and/or Other Drug Program Certification Standards. Medication may include over the counter (OTC) medicines or prescription medications for specific health conditions, inclusive of medications for SUD, mental health, and physical health conditions. Programs shall adhere to the following:

- Medication Storage: Medications shall be properly stored and secured. Medication needing refrigeration shall not be stored with food unless the medication is in a lockable container. Room temperature medications shall be stored between 59- and 86-degrees Fahrenheit.
- The refrigerator must have a thermometer to gauge the temperature as medications are required at an appropriate temperature, based on the manufacturer's product insert, when storing in a refrigerator. Refrigerated medications shall be stored at temperatures between 36- and 46-degrees Fahrenheit2.
- No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness. All such orders shall be in writing and signed by the person giving the order (name, quantity or duration of therapy, dosage, and time of administration of the drug, the route of administration if other than oral, and the site of injection when indicated shall be specified).
- Prescription orders may be given by telephone to a licensed pharmacist, licensed nurse, registered nurse, or licensed psychiatric technician and shall be immediately recorded in the persons served's health record.
- The prescription order has been signed by the prescriber within 72 hours.

Labeling and storage of medication shall comply with the following:

- Containers which are cracked, soiled or without secure closures shall not be used.
- Medication labels are legible.
- All medications obtained by prescription shall be labeled in compliance with state and federal laws governing prescription dispensing - No person other than a pharmacist or physician shall alter any prescription label.
- Non-legend (over-the-counter) medication shall be labeled in conformance with state and federal food and drug laws.
- Test reagents, germicides, disinfectants and other household substances shall be stored separately from medication.

[2]Medication Storage-MHP Contract, Exhibit A, Attachment 1, Section 4.L.10 CCR, Title 9, § 1810.435(b) (3)

- External use of medication in liquid, tablet, capsule or powder form shall be stored separately from medication for internal use.
- Medication shall be stored at appropriate temperatures based on the manufacturer's product insert.
- When medications are stored in the same refrigerator with food, the medication shall be kept in a closed, properly labeled container clearly labeled "MEDICATION".
- Medications shall be stored in an orderly manner in cabinets, drawers or carts of sufficient size to prevent crowding.
- Medications shall be accessible only to personnel designated in writing by the clinic director.
- Medications shall not be kept in stock after the expiration date on the labels and no contaminated or deteriorated medication shall be available for use.
- The medication of each person-served shall be kept and stored in their original individual received containers. No medication shall be transferred between containers, with the exception of take-home bottles.

MEDICATION DISPENSING

Medication shall only be dispensed by a physician, pharmacist or those persons lawfully authorized to do so. There shall be at least one program staff on duty at all times trained to adequately monitor persons served for signs and symptoms of their possible misuse of prescribed medications, adverse medication reactions and related medical complications. Medication shall be administered only by those persons lawfully authorized to do so.

NTP/OTP MEDICATION Handling, Security and Dosing

NTP/OTP programs shall maintain documentation regarding medication handling, security, and dosing that includes the following:

- Accurate records of medications traceable to specific persons served (showing dates, quantity and batch code marks);
- Records maintained by a physician, pharmacist or health professional;
- Records maintained for a period of 3 years;
- Adequate security of stocks;
- Evidence that the Medical Director is placing persons served in treatment;
- Evidence of initiating, altering and determining replacement narcotic therapy medication and dosage amounts by the Medical Doctor;
- Reasons for changes in dosage levels and medication;
- Medication orders signed by a physician; and
- Annual review or evaluation by the Medical Director.

MEDICATION DESTRUCTION AND DISPOSAL

For residential programs, any prescription medications which are not removed by the person-served upon termination of services shall be destroyed by the program director, or their designee, and one other adult who is not a resident. Programs shall utilize form DHCS 5078 to document destruction or disposal. Both shall sign a record, to be retained for at least one (1) year. Alternatively, providers may use an alternative form that contains all the components of the DHCS 5078 form. Expired medication should be placed in an approved, sealable medication disposal container, sealed and transported to a medication disposal company and/or destroyed by the program no later than one month after the expiration date. Disposal of drugs shall meet all applicable state and federal requirements.

ALCOHOL AND DRUG TESTING

Alcohol and drug testing are the examination of biological specimens (e.g., urine, blood, hair) to detect the presence of specific drugs and determine prior drug use. While there is not a widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. The frequency of alcohol and drug testing should be based on the person served's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued alcohol and/or drug use has been identified to be more common.

Where drug screening by urinalysis is deemed medically appropriate providers must establish procedures which protect against the falsification and/or contamination of any urine sample and document urinalysis results in the person served's chart or EHR.

TREATMENT PLANNING

Once the mandated Fresno County SUD Assessment has been completed, providers have the basis for building the plan. The risk ratings that are indicated for each dimension of the assessment form will help providers identify and prioritize the areas that need to be addressed in treatment. If a person served has a problem in every dimension, this does not necessarily mean that every problem must be addressed. Providers must consider how the person served is managing the problems identified, as well as, what the priorities are for the person served. Treatment plan development should be strength based and meaningful, therefore, it must be a collaborative process that includes the input of the person served. In the progress note for the session in which provider staff collaborated with the person served on the treatment planning process, it should be documented as to why a particular area will or will not be addressed on the treatment plan.

For each individual admitted to treatment services the LPHA or counselor shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process.

The LPHA or counselor shall attempt to engage the person served to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans. The initial treatment plan and updated treatment plans shall include the following:

- A statement of the problems identified through the ASAM, other assessment tool(s) or intake documentation;
- Goals to be reached which address each problem;
- Action steps which will be taken by the provider and/or person served to accomplish identified goals;
- Target dates to accomplish action steps and goals;
- Description of services, including the type of counseling to be provided and the frequency thereof;
- The assignment of primary therapist or counselor;
- The diagnosis as documented on the most recent IDD form by the Medical Director or LPHA;
- If a person served has not had a physical examination within the twelve (12) month period prior to admission, a goal that the person served have a physical examination;
- If documentation of a physical, which was performed during the prior twelve (12) months, indicates a person served has a significant medical illness, a goal that the person served obtain appropriate treatment for illness; and
- For updated treatment plans; a summary of progress or lack of progress for previous treatment plan goals.

The provider shall ensure that the initial treatment plan meets all the following requirements:

- For Outpatient, IOT, Recovery Services and Residential: the LPHA or counselor shall complete, type or legibly print their name, sign and date the initial treatment plan **within ten (10) calendar days** of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
    - The person served shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the person served participated in preparation of the plan, **within ten (10) calendar days** of the admission to treatment date.
    - The treatment plan shall be a collaborative process between the counselor/LPHA and the person served to establish mutually agreed upon goals and action steps.
    - If the person served refuses to sign the treatment plan, the provider shall document the reason for refusal and the strategy to engage the person served to participate in treatment.
    - If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan to determine whether the services are medically necessary and appropriate.
    - If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, sign and date the treatment plan within seven (7) calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.
- For Withdrawal Management: the LPHA or counselor shall complete, type or legibly print their name, sign and date the initial treatment plan within four (4) calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
    - The person served shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the person served participated in preparation of the plan, **within four (4) calendar days** of the admission to treatment date.
- For NTP/OTP: the LPHA or counselor shall complete, type or legibly print their name, sign and date the updated treatment plan based on the Fresno County SUD Assessment **within twenty-eight (28) calendar days** after initiation of maintenance treatment. The initial needs assessment/treatment plan does not fulfill the requirements of the SUD treatment plan that must be completed based on the mandated Fresno County SUD Assessment.
    - The person served shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether they participated in preparation of the plan.
    - The supervising counselor shall review the initial maintenance treatment plan, along with the corresponding needs assessment, **within fourteen (14) calendar days** from the effective dates and shall countersign these documents to signify concurrence with the findings.
    - The Medical Director shall review the initial maintenance treatment plan, along with the corresponding needs assessment **within fourteen (14) calendar days** from the effective dates and shall record the following:
        - Countersignature to signify concurrence with the findings; and
        - Amendments to the plan were medically deemed appropriate.

The provider shall ensure that the treatment plan is reviewed and updated as described below:

- For Outpatient, IOT, Recovery Services and Residential: The LPHA or counselor shall complete, type or legibly print their name, sign and date the updated treatment plan **no later than ninety (90) calendar days** after signing the initial treatment plan, and no later than **every ninety 90 calendar days** thereafter, or when there is a change in treatment modality or significant event, whichever comes first. The signature shall be adjacent to the typed or legibly printed name. The updated treatment plan shall be updated to reflect the current treatment needs of the person served.

- The person served shall review, approve, type or legibly print their name and, sign and date the updated treatment plan, indicating whether the person served participated in preparation of the plan, **within thirty (30) calendar days** of signature by the LPHA or counselor.
    - If the person served refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the person served to participate in treatment.
- If a counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are a medically necessary and appropriate for the person served.
- If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print and, sign and date the updated treatment plan, **within seven (7) calendar days** of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.
- The diagnosis or diagnoses must be on the treatment plan and must match what was indicated on the most recent Initial/Updated Determination of Diagnosis form.
- For NTP/OTP: The following distinctions apply to the updated SUD treatment plan completed within 28 calendar days from the time of admission.
    - The supervising counselor shall review the initial maintenance treatment plan, along with the corresponding needs assessment, **within fourteen (14) calendar days** from the effective dates and shall countersign these documents to signify concurrence with the findings.
    - The Medical Director shall review the initial maintenance treatment plan, along with the corresponding needs assessment **within fourteen (14) calendar days** from the effective dates and shall record the following:
        - Countersignature to signify concurrence with the findings; and
        - Amendments to the plan were medically deemed appropriate.
    - The updated treatment shall include the following:
        - A summary of progress or lack of progress toward each goal identified on the previous treatment plan;
        - New goals and behavioral tasks for any newly identified needs, and related changes in the type and frequency of counseling services as required by CCR Title 9 Section 10345; and
        - An effective date based on the day the primary counselor or LPHA signed the updated treatment plan.

SIGN-IN SHEET(S)

Providers shall establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:

- The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete;
- The date of the counseling session;
- The topic of the counseling session;
- The start and end time of the counseling session; and

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

Sign-in sheets must be documented on one (1) page, unless the number of participants requires a second page. If a second page is utilized, all the information identifying the date, topic and start and end times must be completed along with documentation that indicates the pages belong together such as (Page 1 of 2 and Page 2 of 2).

PROGRESS NOTES

Progress note shall be legible and completed as follows:

OUTPATIENT, INTENSIVE OUTPATIENT, NARCOTIC TREATMENT PROGRAM (NTP), NALTREXONE TREATMENT, & RECOVERY SERVICES PROGRESS NOTES

For each individual and group session, either the LPHA or counselor who conducted the counseling session or provided the service is required to complete a legible progress note for each person served who participated in the counseling or treatment service. The LPHA or counselor shall type or legibly printed name, and signature with date on the progress note, within seven (7) calendar days of the service provided. The signature shall be adjacent to the typed or legibly printed name.

All progress notes and individual narrative summaries shall include the following:

- Person served's name and Fresno County Avatar number;
- Information regarding attendance, including the date, start and end of service time, documentation time, and travel time;
- The topic of the session or purpose of the service;
- A description of progress as it relates to the treatment plan problems, goals, action steps, objectives and/or referrals to include new issues or problems which impact the person served's treatment or recovery plan;
- Type of support and/or interventions offered by the program and/or other system providers;
- Identify if service(s) were provided in-person, by telephone, or by telehealth; and
- If services were provided in the community, identify the location and how the provider ensured confidentiality.

RESIDENTIAL TREATMENT SERVICES PROGRESS NOTES

For each person served, the LPHA or counselor shall type or legibly print their name, sign and date progress notes within the following calendar week. The signature shall be adjacent to the typed or legibly printed name. The LPHA or counselor shall record at a minimum one progress note, per calendar week, for each person served participating in structured activities including counseling sessions or other treatment services.

All progress notes and individual narrative summaries shall include the following:

- Person served's name and Fresno County Avatar number;
- A description of progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals;
- A record of attendance at each counseling session including the date, start and end times and topic or purpose of the counseling session;
- Identify if services were provided in-person, by telephone, or by telehealth; and

- If services were provided in the community, identify the location and how the provider ensured confidentiality.

CASE MANAGEMENT PROGRESS NOTES

For each person served provided Case Management Services (at all levels of care), the LPHA or counselor who provided the treatment service shall record a progress note. The LPHA or counselor shall type, legibly print and sign their name, and date the progress note within seven (7) calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.

All progress notes shall include all of the following:

- Person served's name and person served Fresno County Avatar number;
- The purpose of the service;
- A description of how the service relates to the treatment plan problems, goals, action steps, objectives and/or referrals;
- Date, start and end of service time, documentation time, and travel time;
- Identify whether services were provided in-person, by telephone, or by telehealth; and
- Identify where services were provided. If services were provided in the community, identify the location and how the provider ensured confidentiality.

PHYSICIAN CONSULTATION, MAT & WITHDRAWAL MANAGEMENT PROGRESS NOTES

For physician consultation services, additional medication assisted treatment and withdrawal management, the Medical Director or LPHA working within their scope of practice that provided the treatment service, shall record a progress note and keep in the chart. The Medical Director or LPHA shall type, legibly print, sign and date the progress note within seven (7) calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.

Physician Consultation progress notes shall include all of the following:

- Person served's name and Fresno County Avatar number;
- Purpose of the service;
- Date, start and end times of each service; and
- Identify if services were provided face-to-face, by telephone or by telehealth.

For Withdrawal Management, Observation Logs are completed daily; observation commences as soon as the person served enters WM and occur at a minimum every 30 minutes for the first 72 hours. Daily Observation Logs shall be completed by any staff member on duty who has been appropriately trained to monitor withdrawal symptoms.

In addition to the Daily Observation Logs, the counselor/LPHA shall complete a daily progress note which includes the following documentation:

- A review of the Daily Observation Logs
- A face-to-face session with the person served
- A description of current withdrawal symptoms
- Treatment provided to the person served (groups, medication, etc.)
- Other person served interactions

OTHER COMPONENTS OF A PROGRESS NOTE

Face-to-Face Time is time with the person served, in person. If the session or service was provided by telephone, there would be no face-to-face time.

Non-Face-to-Face Time is billable time spent on a service activity that does not include interaction with the person served.

Service Time is the total time (face-to-face and/or non-face-to-face, travel, and documentation) that is billable.

Documentation Time is the time it took to complete the progress note. This should never exceed the length of the session and should correspond to what is reasonable in comparison to the interventions provided. This does not include typing or writing speed. It also does not include technical difficulties. For example, if the computer freezes and it takes 10 minutes to restart and get back to the note, this time cannot be accounted for in the documentation time.

Travel Time is the time it takes to travel from one location to another to meet with person served or provide a service. Transporting a person served does not count for this. If solely transporting a person served from point A to point B, this time is non-billable (Medi-Cal will not reimburse).

CONTINUING SERVICES JUSTIFICATION

All SUD providers within Fresno County system of care shall have a written policy and procedure regarding continuing service justification per Federal, State, County and program contractual laws, regulations, and agreements. Continuing services shall be justified as shown below:

For outpatient services, intensive outpatient services, case management and recovery services:

- No sooner than five (5) months and no later than six (6) months after admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review progress and eligibility to continue to receive treatment services. The LPHA or counselor shall recommend whether the person served should or should not continue to receive treatment service at the same level of care.
- The LPHA or counselor shall recommend whether the person served should or should not continue to receive treatment service at the same level of care. No sooner than five (5) months and no later than six (6) months after the admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services. The determination of medical necessity shall be documented by the Medical Director or LPHA in the person served's individual record and shall include documentation that all of the following have been considered:
    - Medical and substance use history;
    - Progress and treatment plan goals;
    - The LPHA or counselor’s recommendation pursuant to the above-mentioned paragraph (1);
    - Prognosis.

- The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.

- If the Medical Director or LPHA determines that continuing treatment services is not medically necessary, the provider shall discharge the person served from treatment and arrange for a transition in care to an appropriate level of treatment services within ten (10) days of this determination.

OTP/NTP providers are not required to complete a Continuing Service Justification (see reassessment).

While residential lengths of stay are limited to two (2) continuous short-term regimens per 365-day period, perinatal persons served may receive a longer length of stay. Perinatal persons served may receive a length of stay for the duration of their pregnancy, plus sixty (60) days postpartum, as medically necessary.

DISCHARGE

DISCHARGE PLAN

Discharge of a person served from treatment may occur on a voluntary or involuntary basis. The discharge plan shall be prepared **within thirty (30) calendar days** prior to the scheduled date of the last face-to-face treatment service. For WM, the discharge plan shall be completed no later than within six (6) days of admission.

Whenever possible, providers should attempt to engage persons served in completing a discharge plan, even if the discharge is not deemed successful.

For each person served that is provided with a discharge plan, the counselor or LPHA shall also complete a discharge summary.

Discharge planning sessions are defined as **face-to-face** contact between one SUD counselor/LPHA and one person served at the same time. An LPHA or counselor shall complete a discharge plan for each person served, except for a person served with whom the provider loses contact. The discharge plan must include, but not be limited to all of the following:

- A description of relapse triggers;
- A plan to assist the person served to avoid relapse when confronted with each trigger; and
- A support plan (including referrals).

If a person served is transferred to a higher or lower level of care based on ASAM criteria within the same DMC-Certified program, they are not required to be discharged unless there has been more than a thirty (30) calendar day lapse in treatment services.

For Withdrawal Management, if a person served is transferred from Withdrawal Management to another level of care within the same program, the person served must be discharged from Withdrawal Management (including CalOMS discharge) and readmitted to the new level of care. A reassessment must be administered, and a copy of the initial assessment kept on file.

During the last face-to-face session, the counselor/LPHA and the person served will legibly print their name, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy must be provided to the person served and the original should be placed in the file or EHR.

DISCHARGE SUMMARY

The LPHA or counselor will complete a discharge summary for all persons served, including those with whom the provider lost contact. The discharge summary must be completed within thirty (30) calendar days of the date of

the last face-to-face treatment contact. A discharge plan is not necessary in this instance. However, the counselor or LPHA shall document efforts made to contact the person served to complete a discharge plan. The discharge summary must be completed within thirty (30) calendar days of the date of the last **face-to-face** treatment contact with the person served.

The discharge summary must include the following:

- Length of stay in treatment (date of admission to date of discharge);
- Reason for discharge;
- Narrative summary of the treatment episode (include current alcohol/drug use, vocational/educational achievements, transfers/referrals provided); and
- Prognosis.

NON-COMPLIANT SERVICES

Non-Compliant services are defined as services that would normally be reimbursable but because something is wrong with the chart (e.g., an out of compliance treatment plan, late documentation, etc.) DBH will disallow the services. Services that are determined to be non-compliant are subject to full recoupments of rates paid. Additionally, services would be deemed non-compliant if a progress note is written **seven (7) calendar days or longer** from the date of service.

A chart can be deemed out-of-compliance for several reasons. Most commonly, charts are out of compliance due to a failed treatment plan. Treatment plans may fail for the following reasons:

- Not signed by the person served/conservator/legal guardian (Exception: If the person served refuses to sign, the plan will still pass if documented appropriately. However, mere refusal to sign because they don't agree with the plan is not a sufficient reason); and/or
- Does not document medical necessity or show impairment related to the substance use.

SECTION 4 AUDITING/SITE VISITS

SITE VISITS

DBH will conduct, at a minimum, annual site visits to all SUD providers regardless of the DMC certification status. Providers shall designate adequate and confidential space to conduct the review. The site visit may include, but is not limited to, a review of:

- Compliance with contractual scope of work;
- Review of files for compliance with:
    - Documentation Standards;
    - ASAM principles;
    - Evidence-Based Practice requirements;
    - Substantiation of medical necessity; and
    - Care coordination and case management activities.
- Building and safety issues;
- Staff turnover rates;
- Insurance, licensure, National Provider Identifier (NPI), and certification validation;
- Fiscal and accounting policies and procedures (including Policies on preventing Fraud, Waste and Abuse and paid claims verification);
- Person served informing materials requirement;

- Compliance with DHCS required processes for credentialing/re-credentialing; and
- Compliance with standard terms and conditions.

Also, to ensure program compliance with confidentiality procedures and protocols, SUD Site Review Team or assigned Contract Analyst will monitor the following as part of site visits:

- Program written confidentiality policy and procedures;
- Workforce member initial and renewed, signed Confidentiality Agreement;
- Workforce member Confidentiality Training and/or communication of updated Confidentiality Laws and/or Regulations; and
- Person served consent/authorizations/release of information forms (content and signatures).

Providers must establish, maintain, and update as necessary records for each individual admitted to treatment and receiving services. This includes, but is not limited to:

- A person served identifier;
- Date of birth;
- Gender;
- Race/ethnicity;
- Address and telephone number;
- Next of kin or emergency contact;
- Consent to treatment;
- Referral source and reason for referral;
- Date of admission; and
- Type of admission.

In addition, providers are required to include in each person served's individual record, treatment episode information that includes all activities, services, sessions and assessments including but not limited to:

- Intake and admission data, including physical examination, if applicable;
- Treatment plans;
- Evidence of compliance with minimum contact requirements;
- Progress notes;
- Continuing service justification;
- Laboratory test orders and results;
- Referrals;
- Progress notes;
- Discharge plan if applicable;
- Discharge summary;
- Evidence of compliance with multiple billing requirements;
- Evidence of compliance with specific treatment modality requirements; and
- Any other information relating to the treatment services provided to.

For pregnant and postpartum women, medical documentation also must substantiate pregnancy and last day of pregnancy.

Failure to produce a person served's file during a site visit will result in recoupment of the entire treatment episode.

RECORD RETENTION

All SUD providers must maintain the above documentation in the person served's record for a **minimum of ten (10) years** from the finalized cost settlement process. If an audit takes place during the ten-year period, the provider must maintain records until the audit is completed.

Providers shall ensure program sites keep a record of the persons served being treated at that location.

RECORD RETENTION - DIGITAL FORMATS

Providers have the option of scanning their files for record retention, as long as the County of Fresno and State have readily available access to all person served records for **ten (10) years**. The privacy of the person served's PHI must be maintained throughout this process and will need to be secure and inaccessible to unauthorized access to prevent loss, tampering, and disclosure of information, altercation, or destruction of the record in accordance with HIPAA.

FRESNO COUNTY ANNUAL MONITORING CYCLE

On-site monitoring comprises activities associated with the initial annual site visit which includes but is not limited to conducting an entrance conference, administrative review of policies and procedures, a review of personnel and person served files, group observations, facility reviews and an exit conference. A site review report is a post-audit activity that occurs after the exit conference is completed. It includes working with the agency regarding any final items requested as part of the review and drafting, editing, and submitting the site review report. The Corrective Action Plan (CAP) is the document accompanying the site review report that is intended to capture the provider's corrective action in response to the findings in the site review report. Providers have thirty (30) business days to return the CAP to Managed Care.

During this time, the corrective actions must have already taken place and documentation of the corrective actions taken must be included with the CAP. In addition to implementing corrective action prior to submission of the CAP, providers must demonstrate how the organization will maintain the corrective action in the future. Follow-up reviews may be conducted to ensure corrective actions are implemented and maintained. The annual monitoring cycle is concluded with the issuance of a closeout Letter. DBH will monitor for compliance with the Intergovernmental Agreement. These standards are required in addition to CCR Title 9 and 22 regulations for all SUD treatment programs either partially or fully funded through DMC or other Fresno County funding sources. If conflict between regulations and standards occurs, the most restrictive shall apply.

PERSONNEL POLICIES (EMPLOYEES/VOLUNTEERS/INTERNS)

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

- Application for employment and/or resume;
- Signed employment confirmation statement/duty statement;
- Job description which shall include:
    - Position title and classification
    - Duties and responsibilities
    - Lines of supervision
    - Education, training, work experience, and other qualifications for the position
- Performance evaluations conducted at least annually;
- Health records including a health screening report or health questionnaire and tuberculosis test result is required.

    - Outpatient staff: Health questionnaires shall be completed 6 months prior to or within 15 days after hire date;
    - Residential staff: Health screening reports must be signed by a health professional performing the screening and completed 60 days prior to or within 7 days after hire date;
    - Tuberculosis (TB) Test: Completed by all staff 60 days prior to or 7 days after hire date and performed annually;
- Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
- Training documentation relative to SUD and treatment;
- Current registration, certification, intern status, or licensure;
- Proof of continuing education required by licensing or certifying agency and program;
- Provider's Code of Conduct;
- Copy of Child Abuse Reporting Acknowledgement Form;
- Live scan (adolescent providers only); and
- Current California Driver License/Insurance (transport staff only).

PERSONNEL: OTHER

MEDICAL DIRECTOR

Medical directors shall develop and maintain updated written roles and responsibilities in addition to maintaining documentation of the following within the personnel chart:

- A signed agency code of conduct;
- ASAM A or ASAM Module I: Multidimensional Assessment
- ASAM B or ASAM Module II: From Assessment to Service Planning and Level of Care
- General Compliance training;
- SUD Documentation and Billing; and
- Proof of five (5) hours of Continuing Medical Education (CME) in addiction medicine. CMEs shall be clearly documented, signed and dated by a provider representative and physician.

CONTRACTED EMPLOYEES

Contracted personnel files (i.e.: Medical Director, LPHA) shall contain at a minimum:

- Memorandum of Understanding (MOU) that includes scope of work and responsibilities;
- Proof of five (5) hours of CME in addiction medicine (Medical Director). CMEs shall be clearly documented, signed and dated by a provider representative and physician.
- A signed agency code of conduct;
- General Compliance training;
- SUD Documentation and Billing; and
- ASAM A or ASAM Module I: Multidimensional Assessment
- ASAM B or ASAM Module II: From Assessment to Service Planning and Level of Care

PERSONNEL FILE RETENTION

All SUD providers must maintain the above documentation in personnel files for a **minimum of ten (10) years** from the finalized cost settlement process. If an audit takes place during the ten-year period, the provider must maintain records until the audit is completed.

JOB DESCRIPTION

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

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

CODE OF CONDUCT

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

- Use of drugs and/or alcohol;
- Prohibition of social/business relationship with person served's or their family members for personal gain;
- Prohibition of sexual contact with persons served;
- Conflict of interest;
- Providing services beyond scope;
- Discrimination against persons served or staff;
- Verbally, physically or sexually harassing, threatening, or abusing persons served, family members or other staff;
- Protection of person served confidentiality;
- The elements found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under; and
- Cooperation with complaint investigations.

VOLUNTEERS AND INTERNS

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

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

PROGRAM MANAGEMENT

ADMISSION OR READMISSION

- Each program shall include in its policies and procedures written admission and readmission criteria for determining eligibility and suitability for treatment. These criteria shall include, at minimum:
    - DSM-5 SUD diagnosis(es);
    - Use of alcohol/drugs;
    - Physical health status;
    - Documentation of social and psychological problems; and
    - ASAM Level of Care determination.
- If an individual does not meet the admission criteria, they shall be referred to an appropriate service provider.
- If an individual is admitted to treatment a consent to treatment form shall be signed by the person served.
- The Medical Director shall document the basis for the diagnosis in the chart.
- All referrals made by program staff shall be documented in the chart.
- Copies of the following documents shall be provided to the person served upon admission:
    - Person served rights;
    - Share of cost. if applicable;
    - Notification of DMC funding accepted as payment in full; and
    - Consent to treatment.
- Copies of the following shall be provided to the person served or posted in a prominent place accessible to all persons served:
    - A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference and ability to pay;
    - Complaint process and grievance procedures;
    - Appeal process for involuntary discharge; and
    - Program rules, expectations and regulations.
- Where drug screening by urinalysis is deemed medically appropriate the program shall:
    - Establish procedures which protect against the falsification and/or contamination of any urine sample; and
    - Document urinalysis results in the person served's file.

FACILITY

NON-RESIDENTIAL

- **Hours of Operation**: Posted for public viewing provider hours of operation and contact numbers along with Fresno County DBH 24/7 Access Line number and information provided for short term emergency counseling or referral services, including emergency telephone services.
- **Overall Conditions**: Programs shall be clean, safe, sanitary and in good condition at all times for safety and wellbeing of persons served, employees and visitors.
- **Health and Safety Hazards:**
    - The program shall be free from:
        - Broken glass, filth, litter or debris;
        - Flies, insects or other vermin;
        - Toxic chemicals or noxious fumes and odors;
        - Exposed electrical wiring;
        - Peeling paint or broken plaster; and

        - Other health or safety hazards.
- **Insects/Flies:** The program shall take measures to keep the facility free of flies and other insects.
- **Carpet Maintenance:** The program shall maintain all carpets and floors free from filth, holes, cracks, tears, broken tiles or other safety hazards.
- **Water/Chemical Disposal:** The program shall provide for the safe disposal of contaminated water and chemicals used for cleaning purposes.
- **Weapons Policy:** The program shall have a written policy that prohibits individuals from possessing guns, knives (other than kitchen utensils) or other weapons (except for law enforcement officers or security guards acting in the line of duty) at the program site.
- **Protective Devices:** All persons served shall be protected against hazards within the program through provisions of protective devices including but not limited to:
    - Nonslip material or rugs;
    - Functioning smoke detectors;
    - Functioning carbon monoxide detectors; and
    - Fire extinguishers charged and present.
- **Walkway/Passageways:** All outdoor and indoor passageways, stairways, inclines, ramps, open porches and other areas of potential hazard shall be kept free of obstruction and lighted for the visibility and safety of all persons served.
- **Equipment and Supply Storage:** Program equipment and supplies shall be stored in appropriate space and shall not be stored in space designated for other activities.
- **Activity Equipment Storage:** There shall be space available for storage of equipment and supplies necessary to implement the planned activity program.
- **Staff Storage:** There shall be space available for storage of staff members' immediate personal belongings.
- **Facility Records Storage:** The program shall protect records from damage, fires and other hazards and in the selection of storage spaces, safeguard records from unnecessary exposure to deterioration.
- **Room Temperature:** A comfortable temperature shall be maintained at all times.
- **Window Screens:** All window screens shall be in good condition and be free of insects, dirt and other debris.
- **Lighting:** The provider shall make available lamps or lights as necessary in all rooms and other areas to ensure the safety of all persons in the facility.
- **Bathroom Conditions:** All toilets, handwashing and bathing facilities shall be maintained in safe and sanitary operating conditions.
- **Waste Disposal:** Solid waste shall be stored, located and disposed of in such a manner that will not transmit communicable diseases, emit odors, create a nuisance or provide a breeding place or food source for insects or rodents.
    - All containers, including moveable bins, used for storage of solid waste shall have tight-fitting covers that are kept in place. The containers and covers shall be in good repair, leak proof and rodent proof.
    - Solid waste containers, including moveable bins, receiving putrescible waste shall be emptied at least once per week or more often if necessary, to comply with above.
- **Person Served Records:**
    - Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar containers when not in use; and
    - Each program shall adopt in writing, procedures which regulate and control access to and use of written records which are subject to these regulations.

- **Type of Transportation Vehicle:** Only drivers licensed for the type of vehicle operated are permitted to transport residents.
- **First Aid Supplies:**
    - The following shall be maintained and be readily available in the facility:
        - A current edition of a first aid manual approved by the American Red Cross, the American Medical Association or a state or federal health agency;
        - Sterile first aid dressings;
        - Bandages or roller bandages;
        - Adhesive tape;
        - Scissors;
        - Tweezers;
        - Thermometers; and
        - Antiseptic solution.
- **Emergency Information:**
    - The following information shall be readily available:
        - The name, address and telephone number of emergency agencies, including but not limited to the fire department, crisis center or paramedical unit; and
        - The name and telephone number of an ambulance service.
    - It is recommended that residents sign consent forms in advance to permit the authorization of emergency medical care.
- **Toxic Chemical:** Pesticides and other similar toxic substances shall not be stored in food storerooms, kitchen areas, food preparation areas, or areas where kitchen equipment or utensils are stored.
- **Cleaning Chemicals:** Soaps, detergents, cleaning compounds or similar substances shall be stored in areas separate from food supplies.

RESIDENTIAL

In addition to all the above facility requirements, residential treatment providers must adhere to regulations specific to their modality:

- **Residential Programs with Men & Women** - Where female and male residents are housed in the same facility, the provider shall ensure minimal personal security and privacy which will include but not be limited to the following:
    - Separate and adequate toilet, hand washing, and bathing facilities for females and males. Such facilities shall be in proximity of designated sleeping quarters.
    - Separate and adequate sleeping areas for females and males. Such areas shall be enclosed by permanent walls which extend from the floor to the ceiling and a permanent door.
    - Twenty-four (24) hour staff coverage.
- **Hot Water**: Hot water faucets used by residents for personal care shall meet the following requirements:
    - Hot water delivered to plumbing fixtures used by residents shall not be less than 105 degrees Fahrenheit (40.5 degrees Celsius) and not more than 130 degrees Fahrenheit (54.4 Celsius).
    - Taps delivering water at 131-degree Fahrenheit (54.9 degrees Celsius) or above shall be prominently identified by warning signs.
- **Linens:** The provider shall provide clean linen in good condition, including lightweight, warm blankets, top and bottom bed sheets, pillowcases, mattress pads, bath towels, and wash cloths. The quantity of linen provided shall permit changing at a minimum once a week or with greater frequency if needed.
- **Bathroom:** Adequate bathing, handwashing and toilet facilities shall be provided with the maximum ratio of one facility per eight (8) residents. Space for each resident's toilet articles shall be provided.

- **Bedding/Mattress:** The provider shall provide each resident with an individual bed maintained in good condition, equipped with good springs and a clean mattress and supplied with pillow(s), linen and lightweight warm blankets which are clean and in good condition. Bunk beds are not excluded provided they otherwise meet these requirements.
- **Telephone Access:** There shall be adequate telephone service on the premises for use in emergencies.
- **Medications:** Licit medications which are permitted by the provider shall be controlled as specified by the provider's written goals, objectives and procedures.
- **Medication Removal, Storage, and Logs** (See Medication Policies).
- **Participant Meals:** The total daily diet for residents shall be of the quality and in the quantity necessary to meet the needs of the residents.
- **Meal Timing:** Where all food is provided by the facility, arrangements shall be made so that each resident has available at least three meals per day. Not more than fifteen (15) hours shall elapse between the third meal on one day and first meal on the following day.
- **Snacks:** Between-meal nourishment shall be available for all residents unless limited by dietary restrictions prescribed by a physician.
- **Menus:** Menus shall be written at least one (1) week in advance and copies of the menu as served shall be dated and kept on file for at least thirty (30) days. Menus shall be made available for review by the residents and DBH upon request.
- **Modified Diet:** Modified diets shall be provided, if prescribed by a resident's physician as a medical necessity.
- **Food Container/Storage:** All food shall be selected, transported, stored, prepared and served as to be free from contamination and spoilage and shall be fit for human consumption. Food in damaged containers shall not be accepted, used or retained.
- **Milk Products:** Liquid milk shall be pasteurized. Powdered milk shall be mixed only in proportions specific in instruction on the package.
- **Canned Food:** Home canned foods from outside sources shall not be used.
- **Food Preparation:** All persons engaged in food preparation and services shall observe personal hygiene and food services sanitation practices which protect the food from contamination.
- **Refrigerated Foods:** All foods or beverages capable of supporting rapid and progressive growth of microorganisms which can infect or intoxicate food shall be stored in covered containers at 45 degrees Fahrenheit (7.2 degrees Celsius) or less. (**Must have thermometer to gauge temperature)**.
- **Food Prep/Storage Areas:** All kitchen, food preparation and storage areas shall be kept clean, free from litter and rubbish. Measures shall be taken to keep all such areas free from rodents and other vermin.
- **Food Contamination:** All food shall be protected against contamination. Contaminated food shall be discarded immediately.
- **Kitchen Items:** All equipment, fixed or mobile, dishes and utensils shall be kept clean and maintained in good repair.
- **Dish/Utensil Cleaning:** All dishes and utensils used for eating, drinking and preparing food shall be cleaned and sanitized after each usage.
    - Dishwashing machines shall reach a temperature of 165-degree Fahrenheit (74 degrees Celsius) during the washing and/or drying cycle to ensure that dishes and utensils are cleaned and sanitized.
    - Facilities not using dishwashing machines shall clean and sanitize dishes and utensils by an alternative comparable method.
- **Appliance Maintenance:** Equipment necessary for the storage, preparation and service of food shall be provided, and shall be properly maintained.

- **Tables/Dishes/Utensils:** Tableware and tables, dishes and utensils shall be provided in the quantity necessary to serve the residents.

SECTION 5 ADMINISTRATIVE DESK REVIEW

Annually DBH's Contracted Services Division-SUD will conduct an administrative desk review for each provider. This information is used to determine contract compliance. It may be used when determining extensions of contracts as well as whether to add a provider to new agreements.

FRESNO COUNTY ANNUAL DESK REVIEW CYCLE

Administrative desk reviews are comprised of activities associated with administrative processes. During this review, compliance of providers will be determined. Once a desk review is complete the results will be sent to the provider for review. If deficiencies are noted, a CAP will be sent with the results. DBH will monitor return of and compliance with items discussed in the CAP.

ADMINISTRATIVE DESK REVIEW AREAS OF REVIEW

Some contracts may have differing requirements. Below are all desk review areas that may be reviewed.

DRUG MEDI-CAL CERTIFICATION

Providers are required to have a DMC certification.

AOD CERTIFICATION

Residential and withdrawal management residential providers must have a valid DHCS residential license/AOD Certification with an ASAM Level of Care Designation. These ASAM LOC Designations may be provisional if DHCS has not performed a site review of the treatment site.

CERTIFICATES OF INSURANCE

Providers must have certificates of insurance valid for the review period for Commercial General Liability, Automobile Liability, Professional Liability, and Sexual Molestation/Molestation Liability that are compliant with the insurance limits found in the current contract. Youth treatment contracts also require that providers obtain Cyber Liability insurance. All insurance documents must name Fresno County DBH as additionally insured under the insurance policies.

MEDICAL DIRECTOR'S LICENSE

Providers must provide DBH a valid copy of their Medical Director's License.

INVOICES

DBH Contract Services Division will review invoice submissions per contract for the review period. Provider's compliance will be determined by the percentage of time a provider submitted invoices by the date required in the contract. Timeframes per contract are:

- DMC invoices are due by the 15th of every month.
- Non-DMC invoices are due by the 20th of every month.
- Room and Board invoice are due by the 20th of every month.

DATAR REPORTING

Providers will be reviewed on their ability to complete DATAR Reporting by the 5th day of the month. Compliance will be determined and reported in a percentage in the desk review. To be compliant providers must submit DATAR by the deadline 95% of the time.

COMPLIANCE WITH TIMELY ACCESS TO SERVICE REQUIREMENTS

Providers will be reviewed on their ability to meet timely access requirements which are 10 business days from the initial request to first service for outpatient, residential and withdrawal management providers and 3 days from initial request to first service for NTP providers. The DBH standard for meeting timely access to care is 70% of persons served meet the above timeliness requirements.

ACCESS FORM COMPLETION

Providers will be reviewed on the completion of access forms. Providers will be required to complete access forms for every request; compliance will be considered 90%.

MONTHLY STATUS REPORT

Providers completion of the Monthly Status Report will be reviewed. Providers are required to have the Monthly Status Report completed each month by the 20th day of the month.

INELIGIBLE PERSON SCREENING REPORT

Providers completion of the Ineligible Person Screening Report will be reviewed. Providers are required to complete screenings monthly and returning the report to DBH by the 15th of each month.

ASAM LEVEL OF CARE SUMMARY REPORT

Providers must complete the ASAM LOC Report and return the report to DBH on a monthly basis. Compliance is based on submission of this report.

AMERICANS WITH DISABILITIES SELF-ASSESSMENT SURVEY

Review of submitted ADA Self-Assessment and plans of correction.

CLAS SELF-ASSESSMENT

Review of submitted CLAS Self-Assessment, and if out of compliance, steps provider plans to take toward compliance.

ANNUALLY REQUIRED FORMS FOR SIGNATURE

The forms listed below are contractually required to be signed and returned to DBH annually:

- Trafficking Victims Protection Act Form;
- Confidentiality Oath;
- Electronic Signature Form; and
- Code of Conduct and Ethics Form.

FIRE CLEARANCE

Provider must verify that it has a valid fire clearance certification with National Alliance for Recovery Residences (NARR) affiliate.

Recovery Residence providers must maintain certification with a state affiliate of NARR and meet or exceed Level one NARR Standards.

SECTION 6 ADMINISTRATIVE PROCESSES

INFORMATION TECHNOLOGY (IT)

BEHAVIORAL HEALTH INFORMATION SYSTEM

Avatar (DBH's Behavioral Health Information System) is a certified, web-based product that consists of clinical, financial, administrative, and data reporting modules that satisfy mandatory government reporting and interoperability requirements. Avatar provides the necessary framework for overseeing and delivering SUD services in a managed care environment. It is 42 CFR Part 2 and HIPAA compliant.

To help facilitate the transition from a paper-based SUD system of care to an electronic system, DBH is leading the development, implementation, ongoing maintenance and support, and initial trainings for Avatar. DBH will use the "super-user" approach to training. Initially each provider will select individuals to be trained by DBH and from there these super-users will train individuals within the organization who will use Avatar. Super-users will be the contact person when communicating with DBH IT for support as well. SUD providers are responsible for ensuring their staff receive sufficient training in Avatar to ensure proficiency and for planning ahead to accommodate staff turnover by developing and leveraging internal super-user expertise. Providers are responsible to include IT planning into their business plans to ensure sufficient IT infrastructure including hardware, software, security and Avatar user training.

EHR REQUIREMENTS

All providers that contract with DBH will need to be able to enter directly into Avatar or supply a mutually agreed upon interface for billing, CalOMS entry, initial contact information, and any other federal, state or county requirements. Providers may also use Avatar as their EHR. DBH will use a combination of electronic forms built in Avatar and scanned documents with the goal of having all internally created medical documentation done electronically in Avatar and allowing external paper documents scanned into Avatar. The combination of these two approaches will replace paper medical records with an electronic medical record.

SUD provider sites are required to possess a certified EHR to ensure the delivery of high-quality specialty SUD services in a managed care environment. If a provider chooses to use their own EHR they must obtain certification from the Certification Commission for Healthcare Information Technology (CCHIT) for Security Access Control, Audit and Authentication and provide this certification to DBH. Additionally, these providers shall recertify their EHR annually and provide a copy of the recertification to DBH. Providers must ensure all employees who use an EHR other than DBH's current EHR sign an Electronic Signature Certification and maintain a copy in the employee's personnel file.

Providers that chose to use their existing EHR system may continue to do so if they work with DBH IT to ensure necessary data exchange. If providers choose to use their own EHR, they must allow read only electronic access to their records for any billed service to County, State, or Federal Auditors.

REPORTING REQUIREMENTS

Providers are required to submit all reports listed below:

- **Drug and Alcohol Treatment Access Report (DATAR)** – DATAR reports shall be submitted in an electronic format provided by the State and due no later than five (5) days after the preceding month;
- **CalOMS –** Provider must submit CalOMS treatment admission, discharge, annual update, and "provider activity report" record in an electronic format through DBH's information system, and on a schedule as determined by DBH which complies with State requirements for data content, data quality, reporting frequency, reporting deadlines, and report method and due no later than five (5) days after the preceding month. All CalOMS admissions, discharges and annual updates must be entered into DBH's CalOMS system within twenty-four (24) hours of occurrence;
- **Fiscal Reporting** - Providers shall submit to DBH monthly fiscal reports, including the Operational Expense Report by the 25th of the second month following the reporting month, including a general ledger, payroll register and/or salary distribution report, and supporting documentation from no less than two additional general ledger accounts to be selected by the analyst.

DMC Month Status Report (MSR) – Within twenty (20) days of the end of each month;

- **ASAM Level of Care (LOC) –** ASAM LOC data shall be submitted monthly on a form and in a format to be provided by DBH Providers must report all ASAM LOC determinations from screenings, assessments, reassessments, and provides information on actual LOCs that persons served are referred to. This requirement complies with State mandates and shall be submitted to sas@fresnocountyca.gov;
- **Waitlists** – Residential providers shall submit waitlists to provide information on the length of wait time for admission on a form provided by DBH by the 15th day of the following month. This report shall be submitted to sas@fresnocountyca.gov;
- **Monthly Status Report (MSR)** – Providers shall complete the MSR by the 15th day of the month. This report provides status on DMC programs, is used to update the Provider Directory, and is used for Network Adequacy.
- **Grievance Log –** Providers shall keep a log of all internal grievances at their program. This report shall be submitted to DBH Managed Care by the 15th of the month at mcare@fresnocountyca.gov;
- **Americans with Disabilities (ADA)** – This survey is required annually, upon request by DBH. Provider shall complete a system-wide accessibility survey in a format determined by DBH for each service location and modality and shall submit an ADA Accessibility Certification and Self-Assessment, including an Implementation Plan, for each service location;
- **Culturally and Linguistically Appropriate Services (CLAS)** – This report is required annually, upon request by DBH. Providers shall complete an agency CLAS survey in a format determined by DBH and shall submit a CLAS Self-Assessment, including an Implementation Plan;
- **Risk Assessment –** This report is required annually, upon request by DBH. Providers shall submit a Risk Assessment on a form and in a format to be provided by DBH. The Assessment must be submitted to DBH in hard copy as well as electronically by the due date set by DBH;
- **Outcomes Reports** – Provider shall submit outcomes reports as requested by DBH using the DBH Outcomes Report Template and the DBH Outcomes Analysis Template;
- **Network Adequacy Certification Tool (NACT) –** Provider shall submit the NACT as requested by DBH;
- **Ineligible Persons Screening Report –** Provider shall submit the Ineligible Persons Screening Report by the 15th of every month on the Ineligible Persons Screening Monthly Report Template. This report shall be submitted to sas@fresnocountyca.gov; and

- **Cost Reports –** On an annual basis for each fiscal year ending June 30th providers shall submit a complete and accurate detailed cost report(s). DMC cost reports must be submitted to DBH electronically with a hard copy of a cover letter and certification form with original signature. Non-DMC cost reports must be submitted electronically and in hard copy with original signature by the due date. Submittal must also include any requested support documents such as general ledgers and detailed electronic (e.g. Excel) schedules demonstrating how costs were allocated both within programs, if provider has multiple funding sources (e.g. DMC, SAPT, or non-DBH), and between programs, if the provider provides multiple SUD modalities (e.g. residential, withdrawal management, recovery residence, outpatient, etc.).

RESIDENTIAL CAPACITY REPORTING

Residential Providers are required to notify DBH if their program reaches 90% capacity. Providers must notify DBH within 72 hours of reaching 90% capacity by sending the following information to sas@fresnocountyca.gov:

- Program name;
- ASAM Level of Care;
- Population; and
- Percent to capacity.

If the original program is at capacity, the provider must refer the person served to another residential program. If all appropriate residential programs are at capacity, the original provider must place the person served on a waitlist and offer (or refer to) outpatient services until a residential admission can be initiated.

Providers must include the number of days at 90% capacity in their monthly DATAR submission.

Once the provider falls back under 90% capacity, the provider must send notification to sas@fresnocountyca.gov within 72 hours.

COMPLIANCE

REPORTING VIOLATIONS OR SUSPECTED NON-COMPLIANCE

DBH contracted providers are expected to report any activity that may violate the Compliance Program's mission, standards, and any applicable law, regulation, rule or guideline. DBH prohibits retaliation against any person making a report. Any employee engaging in any form of retaliation will be subject to disciplinary action.

Providers may report anonymously using any of the reporting methods described below.

Reporting Methods:

- **Telephone:**
  - *Compliance Hotline: 1-888-262-4174.* It is available 24/7 and is maintained by the Compliance Office. All calls are confidential and every caller has the option to remain anonymous (no caller ID or tracing).
  - *Contact the Compliance Officer directly at (559) 600-6728.*
- **U.S. Mail:**
  - Addressed to:

DBH Compliance Officer

1925 E. Dakota Ave. Rm #228

- **Intranet/Internet:**
    - Using the Compliance website Anonymous Reporting Form located at: http://www.co.fresno.ca.us/departments/behavioral-health/mental-health-compliance/report-a-violation-or-suspected-non-compliance

QUALITY IMPROVEMENT COMPONENTS

Quality Improvement (QI) activities help to ensure accessible, quality-focused, evidence-based, effective, and appropriate SUD treatment services. The purpose of the QI program is to assess performance against best practice guidelines to ensure SUD services follow generally accepted standards of clinical practice in terms of medical necessity, clinical practice, level of care guidelines and to continuously improve SUD service delivery. The QI program aligns with DBH's organizational mission and goals and strives to support the provider network in the provision of quality care and maintain programmatic, clinical and fiscal integrity.

Additional elements of the QI program include:

- Assessing outcomes on an annual basis;
- Conducting performance improvement projects;
- Submitting performance measurement data to the State;
- Having mechanisms in place to detect under and over-utilization of services;
- Assessing the quality and appropriateness of care provided to persons served with special health care needs;
- Assessing the grievance and appeals process;
- Establishing guidelines for confidentiality and unusual occurrences, including assuring service/billing integrity; and
- Ensuring Grievance and Appeals process, confidentiality guidelines, unusual occurrences and service/billing activity meet compliance.

PROVIDERS – QUALITY IMPROVEMENT EXPECTATIONS

Treatment providers within the DMC-ODS must establish a culture and infrastructure to support continuous quality improvement in order to best serve its vulnerable person served population. This focus on quality necessitates internal processes that support assessment, evaluation, identification of opportunities for improvement and follow up or action. Providers are required to have policies and procedures describing their Quality Management program. The following are a description of required quality improvement processes that will facilitate this desired quality-focused culture and infrastructure at the provider agency level.

ANNUAL PERFORMANCE AND OUTCOME MEASURES

Measuring performance and outcomes helps DBH and providers understand how well they are accomplishing the goal of providing high quality care and allows for an analysis of where and what changes need to be made in the process of striving for continual improvement.

Metrics allow providers to understand what is working well so that others can learn from their success and what is not working well so necessary steps can be taken to seek improvement.

Each provider shall engage in key performance indicators and generate reliable and valid data that measures access, effectiveness, efficiency and satisfaction of programs and persons served. Outcomes will be in alignment

with DBH and state goals and reported to DBH annually on templates provided by DBH. Please refer to the Timeliness Requirements for timeliness standards and data points needed for reporting to the State.

Providers contracting with DBH are required to input data into the electronic data collection system that resides within DBH's EHR. SUD providers are also required to have ongoing mechanisms for quality assessment and performance improvement. These metrics help to ensure that DBH has an evaluation system that allows for continuous improvement and high-quality clinical care at the system, provider, and person served level. Ensuring data integrity is of the utmost importance and to the benefit of providers and persons served.

PERSON SERVED SATISFACTION

Fresno County administers a mandated Treatment Perception Survey (TPS) to persons served biannually to measure experiences as it relates to *access to services, quality of service, care coordination,* and *general satisfaction.* DBH will notify providers when this survey will be administered to persons served and provide instructions how to administer and return the surveys. Following the completion of the TPS, DBH shall share the results with individual providers. DBH will use the reports from the surveys to determine where improvements can be made to better serve persons served.

PERFORMANCE IMPROVEMENT PROJECTS

The QI program coordinates and facilitates state mandated ongoing Performance Improvement Projects (PIPs) that focus on areas of treatment and non-treatment. These PIPs are designed to achieve, through ongoing measurements and intervention, significant and sustained improvement in areas of treatment and non-treatment that are expected to have a favorable effect on system and person served outcomes.

PIPs will be based on concepts of quality improvement and performance measurement and employs a person served-centered philosophy and long-term approach to facilitate system improvement. Additionally, this model identifies common causes for variation within a system and is driven by data, process and person served feedback. Annually, DBH QI program will work with providers to develop and implement PIPs.

DBH shall call upon providers to assist in conducting PIPs annually. Providers may be asked to aid in identifying a treatment and a non-treatment related problem. As required by the State, DBH will develop a study design and data collection procedure. Providers will assist DBH in brainstorming causes and barriers affecting the defined problem. DBH and providers will develop reasonable interventions for the identified problems and, if necessary, implement these interventions. Additionally, providers may be enlisted to assist in the analysis of the intervention and adjust if necessary. Providers shall assist in the planning and initiation of activities for increasing or sustaining improvement.

DBH ADMINISTRATIVE FUNCTIONS - QUALITY IMPROVEMENT

ANNUAL QUALITY MANAGEMENT, ASSURANCE AND PERFORMANCE IMPROVEMENT WORK PLAN (QIWP)

The purpose of DBH's Quality Improvement Work Plan (QIWP) is to ensure that all persons served and families receive the highest quality and most cost-effective mental health and substance use disorder services available.

The QIWP delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance use services provided. In addition, the QIWP will incorporate DBH Quality Management responsibilities.

The QIWP is a mechanism tool which allows DBH to monitor services provided for safety, effectiveness, responsiveness to persons served, timeliness, efficiency, access to services and satisfaction. Key variables related

to practices and processes performed or delivered by service providers that affect the outcome of services to and family members are measured and analyzed on a monthly, quarterly, or annual basis. Access times, unusual occurrences and complaints and grievances are tracked and trended. Surveys are conducted to monitor person served and provider satisfaction.

QUALITY IMPROVEMENT COMMITTEE (QIC)

The Department of Behavioral Health QIC is dedicated to continuous quality improvement with utilization of quality improvement tools and providing guidance, direction and technical support throughout DBH. The QIC consists of DBH management level staff, mental health and SUD staff, contracted provider representatives, persons served, and family of persons served.

Duties and responsibilities of the QIC include:

- Recommending policy decisions;
- Review and evaluate the results of QI activities, including performance improvement projects;
- Institute needed QI actions;
- Ensure follow-up of QI processes; and
- Document QI Committee meeting minutes regarding decisions and actions taken.

The QIC has several sub-committees that discuss more specific QI processes. These sub-committees include: Access, Outcomes, Intensive Analysis, Cultural Competency and Data.

INCIDENT REPORTING AND INTENSIVE ANALYSIS

Intensive Analysis refers to strategies that minimize the possibility of an adverse outcome or a loss and maximize the realization of opportunities. Good intensive analysis techniques improve the quality of person served care and reduce the probability of an adverse outcome and resulting liability to the health care provider. Standards of care, quality improvement, and the systematic gathering, analysis, and utilization of data are the foundations of intensive analysis.

INTENSIVE ANALYSIS COMMITTEE

DBH has an Intensive Analysis Committee that reviews all reportable incidents as well as tracks and trends all reports. The goals and activities of the Intensive Analysis Committees include:

- To assure a review, tracking and documentation system for all reportable incidents, including follow up and implementation of any corrective action until follow up is no longer indicated;
- To provide thorough investigation on all reportable incidents, which must be reported to DBH;
- To determine if an incident is an Unusual Occurrence, as necessary and appropriate;
- To review safety and incident related data and to identify trends and patterns associated with risks or to identify problem areas; and
- To promote quality improvement activity through identifying opportunities towards maximizing safety of physical and therapeutic environment and reducing agency, staff, and persons served risks.

REPORTABLE INCIDENTS

Reportable incidents are any event which jeopardizes the health and/or safety of persons served, employees or members of the community.

Reportable incidents must be reported to DBHIncidentReporting@fresnocountyca.gov and the provider's designated Contract Staff Analyst within 24 hours of an incident or first knowledge of an incident. These incidents may result in corrective actions and are viewed as learning opportunities to improve care and internal analysis processes.

UNUSUAL OCCURRENCE

Unusual Occurrence is defined as incidents that may include, but not be limited to, physical injury and death and are required to be investigated and evaluated at the provider agency level by means of Intensive Analysis, Critical Incident review or similar process. This information should be used on a routine basis to improve accessibility, health and safety and address other pertinent internal analysis issues.

GRIEVANCE

NOTICE OF ADVERSE BENEFIT DETERMINATION

What is a Notice of Adverse Benefit Determination?

A Notice of Adverse Benefit Determination (NOABD)is a form that DBH will use to tell persons served when DBH or one of its contracted providers makes a decision regarding their Medi-Cal SUD treatment service. A NOABD is also used to tell persons served if their grievance, appeal or expedited appeal was not resolved in time or if they did not receive services within DBH's timeliness standards for providing services.

When Will a Person Served Get A Notice of Adverse Benefit Determination?

An NOABD letter will be issued to a person served when any of the following actions are taken by DBH or one its contracted providers:

- Person served does not meet medical necessity criteria for DMC-ODS services.
- Denial or limited authorization of a requested service.
- Reduction, suspension or termination of a previously authorized service.
- Modification or limit of a provider's request for a service and approval of alternative services.
- Denial, in whole or in part, of a payment for service.
- Failure to provide services in a timely manner.
- Failure to process authorization decision in a timely manner.
- Failure to act within the required timeframes for grievance and appeals decisions.
- Denial of a person served's request to dispute financial liability.
- Discharge or transition to another level of care

Will Persons Served Always Get A Notice of Adverse Benefit Determination If They Do Not Get the Services They Want?

There are some cases where a person served may not receive a NOABD. Persons served may still file an appeal with DBH. Information on how to file an appeal is included below. Information should also be available in the provider's office.

What Will the Notice of Adverse Benefit Determination Tell Persons Served?

The NOABD will tell Persons Served:

- What DBH did that affects persons served and their ability to get services.
- The effective date of the decision and the reason DBH made its decision.
- The state or federal rules DBH was following when it made the decision.
- What the person served's rights are if they do not agree with the decision.
- How to file an appeal with DBH.
- How to request an expedited appeal.
- How to get help filing an appeal.
- How long persons served have to file an appeal.
- If persons served are eligible to continue to receive services while they wait for an appeal.
- When persons served must file their appeal if they want the services to continue.

What Should Persons Served do When They Get a Notice of Adverse Benefit Determination?

When persons served get a NOABD, they should read all the information on the form carefully. If persons served do not understand the form, DBH or one of its contracted providers can assist them. Persons served may also ask another person to help or represent them.

Persons served can request a continuation of the service that has been discontinued when they submit an appeal or a request for State Fair Hearing. Persons served must request the continuation of services no later than 10 days after receiving a NOABD or before the effective date of the change.

What Is the Process that Providers Follow When Issuing a Notice of Adverse Benefit Determination?

Providers are encouraged to issue any NOABD face-to-face with the person served at the time of the decision. If issuing the NOABD face-to-face is not possible, efforts must be made to send the NOABD within DBH specified timeframes below.

If it is not possible to issue the NOABD to the person served due to lack of face-to-face contact or current contact information, efforts to issue the NOABD must be documented in the person served file.

A copy of any issued NOABD must be kept in the person served file.

There are three required attachments for all NOABD letters. They are the NOABD "Your Rights" Attachment, the Nondiscrimination Notice, and Language Taglines.

A copy of any issued NOABD must be sent to the Managed Care inbox: mcare@fresnocountyca.gov within the specified timeframes below.

NOABD	Timeframe	Criteria for NOABD
Financial Liability	Issue at time of action	A person served's request to dispute financial liability, including share of cost and other person served financial liabilities. E.g. Medi-Cal eligibility shows a share of cost.

Timely Access	Issue within 2 business days of action	Where there is a failure for intake to be offered within the required timelines of the screening or first contact. Outpatient Drug Free (ODF)/IOT = 10 calendar days NTP/OTP = 3 calendar days Residential = 10 calendar days
Termination	Issue at least 10 calendar days before date of action	When a decision is made to terminate service(s). E.g. Violation of program rules or when a person served fails to return after admission or never returns to treatment.
Denial	Issue within 2 business days of action	Denial of requested service(s) when criteria is not met, or person served refuses recommended service(s). E.g. person served wants Residential treatment but only qualifies for Outpatient.
Discharge/Level of Care Transition	Issue within 2 business days of action	Successful discharge and/or transitioning to a lower level of care. E.g. person served successfully completes Residential Treatment and transitions to Outpatient.

PROBLEM RESOLUTION PROCESSES

What If a Person Served Does Not Get the Services They Want From DBH?

DBH has a way for persons served to work out a problem about any issue related to the SUD treatment services they are receiving. This is called the problem resolution process and it could involve the following process:

- The Grievance Process – an expression of unhappiness about anything regarding the person served's SUD treatment services.
- The Appeal Process – review of a NOABD (e.g. denial or changes to services) that was made about a person served's SUD treatment services by DBH or one of its contracted providers.

- The State Fair Hearing Process – review to make sure persons served receive the SUD treatment services which they are entitled to under the Medi-Cal program.

Filing a grievance or appeal or a State Fair Hearing will not count against the person served and will not impact the services they are receiving. When the person served's grievance or appeal is complete, DBH will notify the person served and others involved of the final outcome. When the person served's State Fair Hearing process is complete, the State Hearing Office will notify the person served and others involved of the final outcome.

Learn more about each problem resolution process below.

Can a Person Served Get Help to File an Appeal, Grievance or State Fair Hearing?

DBH will have people available to explain these processes to persons served and to help them report a problem either as a grievance, an appeal, or as a request for State Fair Hearing. Persons served may also authorize another person to act on their behalf, including their SUD treatment provider.

If the person served *would like help, call Fresno County Access Line 1-800-654-3937.*

What If a Person Served Needs Help to Solve a Problem with DBH But Does Not Want to Contact DBH?

Persons served can get help from the State if they are having trouble finding the right people at DBH to help them find their way through the system.

Persons served may get free legal help at their local legal aid office or other groups. Persons served can ask about their hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call Toll free:	*1-800-952-5253*
If the Person served is deaf and needs TDD, call:	*1-800-952-8349*

THE GRIEVANCE PROCESS

What Is A Grievance?

A grievance is an expression of dissatisfaction about any matter other than Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect a persons served's rights regardless of whether remedial action is requested. Grievances include a person served's right to dispute an extension of time proposed by DBH to make an authorization decision. The Grievance Process:

- DBH encourages a person served to speak with his or her provider prior to submitting a grievance.
- A person served, a provider or an authorized representative may file a grievance, at any time, either orally or in writing. The provider or authorized representative must be acting on behalf of a person served and with the person served's written consent.
- At a minimum, a grievance request will include the name, mailing address and the phone number of the person served who is submitting the grievance.

How Can a Person Served File a Grievance?

Grievance forms and envelopes addressed to DBH are to be made available at all provider sites in a common area that is easily accessible to all persons served. A person served should speak with the provider first; however, it is not required. They may complete the grievance form and mail to the address provided below:

Fresno County Department of Behavioral Health

P.O. Box 45003

Fresno, CA 93718-9886

Alternatively, if a person served does not wish to fill out the grievance form, they may call (559) 600-4645 Monday through Friday 8:00 am – 5:00 pm. Persons served may also call 1-800-654-3937 after hours to file a grievance.

How Does the Person Served Know If DBH Received Their Grievance?

DBH will let the person served know that it received the grievance by sending the person served written confirmation.

When Will the Grievance Be Decided?

- DBH will "resolve" each grievance as expeditiously as a person served's health condition requires not to exceed 90 calendar days from the day it is received. Resolved means that DBH has reached a decision with respect to a person served's grievance and notified the person served of the grievance resolution.
- Timeframes may be extended if the person served requests an extension or if DBH believes there is a need for additional information the delay is for the person served's benefit.

How Do Persons Served Know If DBH Has Decided About Their Grievance?

DBH will prepare a written Notice of Grievance Resolution (NGR) to notify a person served of the results of his or her grievance and notify the person served via United States Postal Service (USPS).

- The NGR will include a clear and concise explanation of the decision.
- If a person served cannot be contacted via USPS (e.g. returned mail), DBH will attempt to notify them of the grievance resolution by other means (e-mail, telephone).
- If a person served is not satisfied with the resolution of their grievance or has additional concerns, they may file another grievance.

If DBH fails to notify the person served or any affected parties of the grievance decision on time, then DBH will provide the person served with a NOABD advising them of their right to contact the State Medical Managed Care Ombudsman Office. The State Medi-Cal Managed Care Ombudsman Office can help persons served with any questions. *They may be reached Monday through Friday, 8 AM to 5 PM PST, excluding holidays, at 1-888-452-8609.*

Is There A Deadline to File A Grievance?

Persons served may file a grievance at any time.

DISCRIMINATION GRIEVANCE

What Is A Discrimination Grievance?

A discrimination grievance is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group, identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

How Can a Person Served File A Discrimination Grievance?

Persons served may file Discrimination Grievances in any of the following ways:

- A person served may file a Discrimination Grievance with the DBH Civil Rights Coordinator at *(559) 600-9180.*
- A person served may file a Discrimination Grievance directly with the DHCS Office of Civil Rights within 365 days from the alleged unlawful discrimination at the Department of Health Care Services Office of Civil Rights at *(916) 440-7370.*
- A person served may also file a Discrimination Grievance with the U.S. Health and Human Services Office for Civil Rights within 180 days from the alleged discriminatory act at *(800) 368-1019.*

Persons served are not required to file a Discrimination Grievance with DBH prior to filing with the DHCS Office of Civil Rights and/or the U.S. Health and Human Services Office for Civil Rights.

THE APPEAL PROCESS (STANDARD AND EXPEDITED)

DBH is responsible for allowing persons served to request a review of a NOABD that was made about their SUD treatment services by DBH or the person served's provider. There are two ways a person served can request a review. One way is using the standard appeals process. The second way is by using the expedited appeals process. These two forms of appeals are similar; however, there are specific requirements to qualify for an expedited appeal. The specific requirements are explained below.

What Is A Standard Appeal?

A standard appeal is a request for review of a NOABD a person served has received from DBH or their provider that involves a denial or changes to services. If a person served requests a standard appeal, DBH may take up to 30 calendar days to review it. If the person served thinks waiting 30 calendar days will put their health at risk, the person served should ask for an 'expedited appeal.'

The standard appeals process will:

- Allow the person served to file an appeal in person, on the phone or in writing. If the person served submits their appeal in person or on the phone, the person served must follow it up with a signed written appeal. Person served can get help to write the appeal. If persons served do not follow-up with a signed written appeal, their appeal will not be resolved. The date that the person served submitted the oral appeal is the filing date.
- Ensure filing an appeal will not count against the person served or their provider in any way.
- Allow the person served to authorize another person to act on their behalf, including a provider. If a person served authorizes another person to act on their behalf, DBH might ask the person served to sign a form authorizing DBH to release information to that person.
- Have person served's benefits continued upon request for an appeal within the required timeframe, which is 10 days from the date the person served NOABD was mailed or personally given to the person served. Persons served do not have to pay for continued services while the appeal is pending. If the person served does request continuation of the benefit, and the final decision of the appeal confirms the decision to reduce or discontinue the service the person served is receiving, the person served may be required to pay the cost of services furnished while the appeal was pending.
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous level of review or decision-making.

- Allow the person served or their representative to examine their case file, including person served's medical record, and any other documents or records considered during the appeal process, before and during the appeal process.
- Allow the person served to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Allow the person served, their representative, or the legal representative of a deceased member's estate to be included as parties to the appeal.
- Let the person served know their appeal is being reviewed by sending them written confirmation.
- Inform the person served of their right to request a State Fair Hearing, following the completion of the appeal process.

When Can the Person Served File an Appeal?

Persons served can file an appeal with DBH:

- If DBH or one of its contracted providers determines cost sharing or other financial liabilities by the Person-served for SUD services provided.
- If DBH or one of DBH's contracted providers decides that a person served does not qualify to receive any Medi-Cal SUD treatment services because the person served does not meet the medical necessity criteria.
- If the person served's provider thinks they need a SUD treatment service and asks DBH for approval, but DBH does not agree and denies the request or changes the type or frequency of service.
- If the person served's provider has asked DBH for approval, but DBH needs more information to make a decision and does not complete the approval process on time.
- If the provider does not provide services to the person served based on the standards DBH has set up.
- If the person served's grievance, appeal or expedited appeal was not resolved in time.
- If the person served and their provider do not agree on the SUD services the person served needs.
- If the person served discharges or transitions to a different level of care.

How Can the Person Served File an Appeal?

Persons served may call DBH's toll-free phone number to get help with filing an appeal. DBH will provide self-addressed envelopes at all provider sites for person served to mail in their appeal.

How Do the Persons Served Know If Their Appeal Has Been Decided?

DBH will issue a Notice of Appeal Resolution to the person served or the person served's representative in writing about their decision for the appeal. The notification will have the following information:

- The results of the appeal resolution process.
- The date the appeal decision was made.
- If the appeal is not resolved wholly in the person served's favor, the notice will also contain information regarding the person served's right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

Is There a Deadline to File an Appeal?

Persons served must file an appeal within 60 days of the date of the action they are appealing when they receive a NOABD. Keep in mind that the person served will not always receive a NOABD. There are no deadlines for filing an appeal when the person served does not receive a NOABD. A person served may file an appeal at any time.

When Will a Decision Be Made About the Person Served's Appeal?

DBH must decide on the person served's appeal within 30 calendar days from the date the appeal was filed/received. Timeframes may be extended if the person served requests an extension, or if DBH believes that there is a need for additional information and that the delay is for the person served's benefit.

What if the Person Served Cannot Wait 30 Days for the Appeal Decision?

The appeal process may be faster if it qualifies for the expedited appeals process.

What is an Expedited Appeal?

An expedited appeal is a faster way to decide an appeal. If the person served thinks that waiting up to thirty (30) days for a standard appeal decision will jeopardize their life, health or ability to attain, maintain or regain maximum function, the person served may request an expedited resolution of an appeal. If DBH agrees that the appeal meets the requirements for an expedited appeal, DBH will resolve the person served's expedited appeal within 72 hours after they receive the appeal. Timeframes may be extended if the person served requests an extension, or if DBH shows that there is a need for additional information and that the delay is in the person served's interest. If DBH extends the timeframes, they will give the person served a written explanation as to why the timeframes were extended.

If DBH decides that the person served's appeal does not qualify for an expedited appeal, DBH must make reasonable efforts to give the person served prompt oral notice and will notify them in writing of the decision. The person served's appeal will then follow the standard appeal timeframes outlined earlier in this section. If the person served disagrees with DBH's decision that the appeal does not meet the expedited appeal criteria, person served may file a grievance.

Once DBH resolves the person served's expedited appeal, they will notify the person served and all affected parties orally and in writing.

THE STATE FAIR HEARING PROCESS

What is a State Fair Hearing?

A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure person served receive the SUD treatment services to which they are entitled under the Medi-Cal program.

What are the Person Served's State Fair Hearing Rights?

Persons served have the right to:

- Have a hearing before the California Department of Social Services (also called a State Fair Hearing).
- Be told about how to ask for a State Fair Hearing.
- Be told about the rules that govern representation at the State Fair Hearing.
- Have the person served's benefits continued upon their request during the State Fair Hearing process if they ask for a State Fair Hearing within the required timeframes.

When Can the Person Served File for a State Fair Hearing?

Persons served have 120 days from the date DBH provided its appeal decision notice to ask for a State Fair Hearing. Persons served can file for a State Fair Hearing once they have completed the appeal process.

- If the person served and their provider do not agree on the SUD treatment services the person served needs.

How Does the Person Served Request a State Fair Hearing?

Persons served can request a State Fair Hearing directly from the California Department of Social Services. They can ask for a State Fair Hearing by writing to:

State Hearings Division

California Department of Social Services

P.O. Box 944243, Mail Station 9-17-37

Sacramento, California 94244-2430

Persons served can also call 1-800-952- 5253 or for TDD 1-800-952-8349.

Can a Person Served Continue Services While They Are Waiting for a State Fair Hearing Decision?

Persons served can continue treatment services while they are waiting for a State Fair Hearing decision if their provider deems treatment services should continue and requests approval from DBH. If DBH does not agree with the provider's request, DBH may change the type or frequency of services. Persons served will receive a NOABD from DBH when this happens. Persons served are not financially responsible for services received while the State Fair Hearing is pending.

If the persons served requests continuation of the benefit, and the final decision of the State Fair Hearing confirms the decision to reduce or discontinue the service the persons served is receiving, the persons served may be required to pay the cost of services furnished while the State Fair Hearing was pending.

Persons served may ask for an expedited State Fair Hearing if they think the normal 120-day timeframe will cause serious problems with their health, including problems with their ability to gain, maintain, or regain important life functions. The Department of Social Services, State Hearings Division, will review the request for an expedited State Fair Hearing and decide if it qualifies. If the expedited hearing request is approved, a hearing will be held, and a decision will be issued within three (3) business days by the State Hearings Division.

INELIGIBLE PERSONS SCREENING

The DMC-ODS requires all providers to complete a monthly Ineligible Persons Screening for all employees with responsibilities pertaining to the ordering, provision, coding or billing of services payable by a Federal health care program to verify that they are not an ineligible person monthly. These reports are due by the 15th of every month. They shall be submitted to SAS@fresnocountyca.gov.

The how-to and the screening report template are available at the SUD Services Provider page under Provider Resources:

https://www.co.fresno.ca.us/departments/behavioral-health/substance-use-disorder-services/provider-page

CONTRACT MANAGEMENT

The DBH Contract Services Division maintains contract management of the DMC SUD system of care in Fresno County. Contract management includes the development, monitoring, and maintenance of all SUD treatment, prevention and related contracted programs.

With the implementation of the DMC-ODS, the number of contracted providers is expected to dramatically grow. DBH provides critical contract management functions through the Contract Services Division.

Each provider's Contract Analyst is responsible for monitoring contracts and reviewing the provider network's performance, including review of the following:

- Administrative review of the program;
- Requested and needed administrative technical assistance; and
- Provider's billing to verify appropriate use of funds and delivery of services.

The Contract Services Division is also the primary contact for providers who have questions in relation to their contract and/or program. In accordance with its goal of overseeing a provider's performance, Contracts staff serve as the primary supplier of technical assistance to the provider. This assistance can include best practices in administering a program such as appropriate and timely record keeping, mandated employee forms, etc.

The Contract Services Division is responsible for all activities related to initiating new contracts and amending existing contracts to remain current with relevant regulations that govern the delivery of SUD treatment services. The activities include solicitation, development, and execution of contracts. The Contracted Services Division initiates contract development and amendments to ensure they reflect the most current needs of the county and state, persons served and the provider and reflect changes in the SUD field. These amendments may come in the form of a new contract or via a SUD Bulletin. Providers will be notified of all pending changes in a timely manner.

PROVIDER REQUIRED POLICIES

For contracts with Fresno County DBH, providers must have policies and procedures for the following and will be reviewed by the provider's Contract Analyst before contracts are awarded:

- MAT Services including offering or facilitating access to MAT services, and may not exclude persons served concurrently enrolled in MAT
- Safety and Effectiveness of Medication Practices
- Case Management
- Coordination with Physical and Mental Health
- Continuous Quality Improvement/Management
- Quality Assurance
- Grievance
- Compliance/Fraud, Waste and Abuse
- Continuity of Care/Care Coordination
- Fidelity for EBPs
- Field based and/or Telehealth (if offered)
- CLAS
- Interim Services
- Personnel (in accordance with the DHCS "Minimum Quality Drug Treatment Standards")
- Persons Served Rights

LAWS AND REGULATIONS

This provider document, along with other federal, state and local regulations, governs the delivery of SUD treatment services in Fresno County. Below is an extensive listing of laws and regulations that are to be followed,

except where the DMC-ODS Special Terms and Conditions waive the requirements. For a comprehensive and detailed listing, please refer to the DHCS and Fresno County Intergovernmental Agreement.

FEDERAL

- 42 Code of Federal Regulation (CFR) Part 2 of Substance Use Disorder Consumer Records
- 42 CFR Part 438 Managed Care
- Health Insurance Portability and Accountability Act (HIPAA)
- Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
- Title IX of the Education Amendments of 1972 (Regarding education programs and activities).
- Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
- The Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6601-6107), which prohibits discrimination on the basis of age.
- Age Discrimination in Employment Act (29 CFR Part 1625).
- Title I of the Americans with Disabilities Act (29 CFR Part 1630).
- 1Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
- Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
- The Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
- Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
- Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
- The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
- The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.
- The Americans with Disabilities Act of 1990 as amended.
- Section 1557 of the Consumer Protection and Affordable Care Act.
- Record keeping requirements for providers are to retain, as applicable, the following information: consumer grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- National Culturally and Linguistically Appropriate Service (CLAS) standards.
- 42 United States Code section 300x-5.
- 31 USC sections 7501-7507 (Single Audit Act of 1984; Single Audit Act Amendments of 1996.
- 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards.
- Title 45, Part 96, Subparts B, C and L of Code of Federal Regulations (Block Grants)
- Title 5 USC, Sections 1501-1508 (Hatch Act)

STATE

- California Code of Regulations CCR Title 9 Counselor Certification
- CCR Title 9, Division 4, Chapter 8, commencing with Section 10800.
- CCR Title 22 Drug Medi-Cal: https://govt.westlaw.com/calregs/Document/I12C91B008DA411E4A0F094BBA3CAFB62?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
- Sobky v. Smoley (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994),
- Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).
- California non-discrimination act. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
- Division 10.5 of the California Health and Safety Code.
- California Government Code sections 16366.1 through 16367.9 and 53130 through 53138
- Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135

AGENCY – DHCS

- Drug Medi-Cal Special Terms and Conditions, Section X, Drug Medi-Cal Organized Delivery System and Attachments X through DD.
- Department of Health Care Services (DHCS) Perinatal Practice Guidelines, FY 2018-19
- DHCS Youth Treatment Guidelines
- DHCS Alcohol and/or Other Drug Program Certification Standards

SABG LICENSED AND CERTIFIED PROGRAMS

Providers shall be licensed, registered, AOD certified (residential programs only) and DMC certified and approved in accordance with applicable laws and regulations. Providers shall comply with the following regulations and guidelines:

- Title 21, CFR Part 1300, et seq. Title 42, CFR, Part 8
- Title 22, Sections 51490.1(a)
- Title 9, Division 4, Chapter 4, Subchapter 1, Sections 50000, et seq. References
- Title 22, Division 3, Chapter 3, Sections 55000 et. seq.

SECTION 7 FINANCIAL MANAGEMENT AND FISCAL PROCESSES

RATE SETTING PROCESS/BUDGET DEVELOPMENT

Providers may be required to participate in an annual rate setting process to establish provider-specific rates for the upcoming fiscal year for each modality of service/level of care under their respective DMC certifications. DBH will provide a budget template for rate setting purposes that will be due to the designated DBH Fiscal Analyst by a date specified in the annual rate setting instructions. The rate setting process will include projecting admissions, utilization, counselor caseloads productivity and estimated expenditures to determine the average cost per unit of service. Providers will rely on current service levels and historical service data to determine projected access and units of service.

Providers that do not submit the budget template by the established deadline may be denied a contract for the related fiscal year. To be reinstated as a contracted provider a current budget template must be submitted and approved with rates at or below the County's maximum allowable DHCS-approved rate for the fiscal year. Reinstated providers would be at risk of not receiving a rate sufficient to cover projected costs.

Budget templates submitted by network providers will be a component of the County's maximum rates submitted to DHCS for approval. All provider-specific rates must be at or below the County's maximum rates as approved by DHCS annually. To receive DHCS-approved rates, Fresno County must submit to DHCS an updated Fiscal Plan by a DHCS established deadline of February 28th.

In lieu of the rate setting process described above, County reserves the right to set rates for the next fiscal year based on historical cost and service data.

BILLING/CLAIMS SUBMISSIONS AND REIMBURSEMENT PROCESS

Contracted treatment providers will enter all services into the County's EHR on a monthly basis. DMC billable services must be entered by the 15th of the month following the month of service. Non-DMC billable services must be entered by the 20th of the month following the month of service. Providers that have cost reimbursement agreements must submit line item invoices by the 20th of the month following the month of service.

No later than the 25th of the second month following the month of service, all providers must submit each program's general ledger, payroll register, labor distribution report (if applicable[3]), and cost allocation report (either a DBH provided or approved by DBH provider cost allocation template) to their assigned Contracts Analyst who will select at least two ledger accounts to request original supporting documentation for verification of compliance with state/federal regulations. For additional information on allowable expenditures, allocation methodologies and documentation requirements refer to the Cost Reference Manual available at: https://www.co.fresno.ca.us/departments/behavioral-health/substance-use-disorder-services/provider-page.

Payments by County shall be in arrears for services provided during the preceding month, within forty-five (45) days after receipt, verification and approval of provider's invoices. Any services subsequently denied or disallowed will be withheld from the next reimbursement.

Providers must accept as payment in full the amounts paid by DHCS in accordance with the DMC-ODS Standard Terms and Conditions, including attachments. Providers may not demand any additional payment from DHCS, person served, or other third-party payers.

Verification and approval of invoices includes the receipt and complete review of the general ledger and line item cost supporting documentation. Invoices will not be submitted to the Business Office for payment prior to the completion of the review process.

COST RECONCILIATION

The assigned Contracts and Fiscal Analysts will review the monthly expense documentation and communicate back to provider for any follow up. The Fiscal Analyst will also periodically compare the program's year-to-date actual expenditures to DMC/non-DMC reimbursements to evaluate reasonableness of the provider's reimbursement rates for each type of service. If a significant variance is identified between the provider's actual cost per unit of service and the interim rate, the reimbursement rate will be adjusted accordingly to ensure that annual reimbursement is aligned with actual costs.

[3] A Labor Distribution report is required in instances, including but not limited to the following: where personnel providing billable services (e.g. group and individual sessions) to persons served during a billing month either work in multiple counties (i.e. Fresno County and Kings County), multiple modalities classifications (e.g. Residential and Outpatient, Recovery Residence and Outpatient, etc.), and/or multiple DMC certified sites (each DMC site is required to submit a cost report which includes reporting direct labor costs attributable to that location).

OTHER HEALTH COVERAGE

Providers are required to bill third party Other Health Coverage (OHC) carrier or Medicare Advantage Plan when persons served have OHC. Providers must provide proof of denial for the third party OHC or Medicare Advantage Plan prior to billing County for services funded through SAPT or other sources. Refer to ADP Bulletin 11-01 and MHSUDS Information Notices 15-001, 16-064 and 17-058 for further guidance.

RECORDS RETENTION

Contracted providers must maintain records and accounts for inspection by State, Federal and County agencies for a period of ten (10) years from the finalized cost settlement process or, if an audit by the Federal government or DHCS has been started before the expiration of the ten (10) year period, the completion of the audit and final resolution of all findings. Records and accounts include person served files, general ledgers, audited financial statements, and original source documentation such as receipts and invoices. Bank statements as well as copies of checks reflecting purchases are not original source documents and will not be accepted as such. All costs found to not be supported by original source documentation will be disallowed. Total unallowable costs shall be allocated their percentage share of the indirect costs along with the Contractor's direct costs.

COST REPORTING

On an annual basis for each fiscal year ending June 30th contracted providers shall submit a complete and accurate detailed cost report(s). The County will issue instructions for completion and submittal of the annual cost report, including the relevant cost report template(s) and due dates. All cost reports must be prepared in accordance with Generally Accepted Accounting Principles (GAAP).

DMC cost reports must be submitted to DBH electronically with a hard copy of a cover letter and the certification form with original signature. Non-DMC cost reports must be submitted electronically and in hard copy with original signature by the due date. Along with the DHCS and County-provided cost report templates provides must submit the following:

- General ledgers
- Cost allocation schedules (e.g. Excel) demonstrating how costs were allocated both within programs (e.g. provider has multiple outpatient funding sources such as DMC and SAPT) and between modalities (e.g. residential, outpatient, recovery residences, etc.).

Unallowable costs such as those denoted in 2 CFR 200 Subpart E, Cost Principles, 41 U.S.C. 4304, and the Center for Medicare and Medicaid Studies (CMS) Provider Reimbursement Manual (PRM) 15-1, must not be included on the cost report. Unallowable costs must be kept in the provider's General Ledger in accounts entitled Unallowable followed by name of the account (e.g. Unallowable – Food) or in some other appropriate form of segregation in the provider's accounting records. For further information on unallowable costs refer to regulations provided above or the DBH Cost Reference Manual available at:

https://www.co.fresno.ca.us/departments/behavioral-health/substance-use-disorder-services/provider-page.

If the cost report(s) is not submitted by the due date, including any extension period granted, the County may withhold payment of pending invoices until the cost report(s) has been submitted and clear the desk audit for completeness and accuracy.

COST SETTLEMENT

DHCS cost settlement process is approximately eighteen (18) to thirty-six (36) months following the close of the State fiscal year. The County may choose to appeal DHCS settlement results and therefore reserves the right to defer payback settlement with providers until resolution of the appeal.

GLOSSARY OF TERMS

Abuse (Misappropriation): means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Person-served practices that result in unnecessary cost to the Medicaid program.

Adolescents: means persons served between the ages of twelve and under the age of twenty-one.

Appeal: is the request for review of an adverse benefit determination.

Assessment: means an assessment based on the ASAM criteria for the purpose of determining a level of care and medical necessity.

ASAM Criteria: pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the person served. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Clinical Necessity," "necessity of care," or "clinical appropriateness."

Authorization: is the approval process for SUD services prior to providing Residential Treatment Services.

Person Served: means a person who:

- Has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria; and has been determined eligible for Medi-Cal or an alternative funding source;
- Is not institutionalized;
- Meets the admission criteria to receive SUD system of care covered services.

Calendar Week: means the seven-day period from Sunday through Saturday.

Case Management: means a service to assist a person served to access needed medical, educational, social, prevocational, vocational, rehabilitative or other community services.

Certified Provider: means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

Collateral Services: means sessions with therapists or counselors and significant persons in the life of a person served, focused on the treatment needs of the person served in terms of supporting the achievement of the person served's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the person served.

Complaint: means requesting to have a problem solved because the person served is not satisfied. A complaint is sometimes called a grievance.

Corrective Action Plan (CAP): means the written plan of action document which the provider develops and submits to County and/or DHCS to address or correct a deficiency or process that is non-compliant with contract, laws, regulations or standards.

County: means the county in which the provider physically provides covered substance use treatment services.

Crisis Intervention: means a contact between a therapist or counselor and a person served in crisis. Services shall focus on alleviating crisis problems. Crisis means an actual relapse or an unforeseen event or circumstance, which present to the person served an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the person served's emergency situation.

Delivery System: DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

Discharge Services: means the process to prepare the person served for referral into another level of care, post treatment return or reentry into the community and/or the linkage of the individual to essential community treatment, housing and human services.

Discrimination Grievance: means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

Drug Medi-Cal Program: means the state system wherein persons served receive covered services from DMC-certified substance use disorder treatment providers.

Drug Medi-Cal Termination of Certification: means the provider is no longer certified to participate in the Drug Medi-Cal program upon the state's issuance of a Drug Medi-Cal certification termination notice.

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT): means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal- covered persons served less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness or other condition, such as a substance-related disorder, that is discovered during a health screening.

Education and Job Skills: means linkages to life skills, employment services, job training and education services.

Emergency Medical Condition: means a medical condition manifesting itself by acute symptoms of enough severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman of her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Services: means to respond to and deal with emergencies when they occur, especially those that require police, ambulance, and/or firefighting services. These services shall be provided by a qualified

staff to furnish these services (e.g. physician, emergency room, etc.) to evaluate or stabilize an emergency mental or medical condition.

Excluded Services: means services that are not covered under the DMC-ODS.

Face-to-Face: means a service occurring in person.

Family Support: means linkages to childcare, parent education, child development support services and family and marriage education. Family support is only available under recovery services.

Family Therapy: means including a person served's significant support members, i.e., family members, friends and loved ones in the treatment process, and education about factors that are important to the person served's recovery as well as their own recovery can be conveyed. Family members may provide social support to persons served, help motivate their loved one to remain in treatment and receive help and support for their own family recovery as well.

Fair Hearing: means the state hearing provided to Persons-served upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6 Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

Final Settlement: means permanent settlement of the provider's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the state. If the audit is not completed within three years, the interim settlement shall be considered the final settlement.

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law.

Grievance: means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes a person served's right to dispute an extension of time proposed by DBH to make an authorization decision.

Grievance and Appeal System: means the processes DBH implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

Group Counseling: means contacts in which one or more therapists or counselors treat two (2) or more persons served at the same time with a maximum of twelve (12) in the group, focusing on the needs of the individuals served. A person served that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a person served who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

Hospitalization: means that a person served needs a supervised recovery period in a facility that provides hospital inpatient care.

Individual Counseling: means contact between a person served and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service and are reimbursed without distinction.

Intake: means the process of determining whether a person served meets the medical necessity criteria and whether a person served is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders. The assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g. body specimen screening) necessary for substance use disorder treatment and evaluation.

Intensive Outpatient Treatment (ASAM Level 2.1)**:** means structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours per week for adults and a minimum of six (6) hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth.

Licensed Practitioners of the Healing Arts (LPHA): includes Physicians, Nurse Practitioners (NP), Physician Assistants (PA), Registered Nurses (RN), Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Work (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Medical Necessity and Medically Necessary Services: means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

Medical Necessity Criteria: means the persons served must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition for Substance-Related and Addictive Disorders (DSM-5) with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders. Additionally, persons served must meet the requirements for the appropriate level of care for services based on the ASAM Criteria. Youth under 21 may be also be assessed to be at risk for developing a substance use disorder, and if applicable, shall meet the ASAM Adolescent Diagnostic Admission Criteria. Persons-served under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, Persons-served under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

Medical Psychotherapy: means a type of counseling service that has the same meaning as defined in 9 CCR § 10345.

Medication Services: means the prescription or administration of medication related to substance use disorder treatment services or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.

Member Handbook: is the state developed model enrollee handbook.

Opioid (Narcotic) Treatment Program: means an outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

Naltrexone Treatment Services: means an outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

Network: means the group of entities that have contracted with Fresno County DBH to provide services under the SUD system of care.

Network Provider: means any provider, group of providers, or entity that has a network provider agreement with DBH and receives Medicaid funding directly or indirectly to order, refer or render covered services.

Non-Perinatal Residential Program: services are provided in DHCS licensed residential facilities that also have DMC Certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

Notice of Adverse Benefit Determination: means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

Observation: means the process of monitoring the person served's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the person served and the level of care the person served is receiving. This may include but is not limited to observation of the person served's health status.

Outpatient Services (ASAM Level 1.0)**:** means outpatient service directed at stabilizing and rehabilitating persons up to nine (9) hours of service per week for adults, and less than six (6) hours per week for adolescents.

Overpayment: means any payment to a network provider by DBH to which the network provider is not entitled to under Title XIX of the Act or any payment to DBH by State to which DBH is not entitled to under Title XIX of the Act.

Participating Provider: means a provider that is engaged in the continuum of services under their agreement with DBH.

Person Served Education: means providing research-based education on addiction, treatment, recovery and associated health risks.

Perinatal DMC Services: means covered services as well as mother/child habilitative and rehabilitative services. Services access (i.e., provision or arrangement of transportation to and from medically necessary treatment). Education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant and coordination of ancillary services (Title 22, Section 51341.1(c)(4)).

Physician: as it pertains to the supervision, collaboration and oversight requirements. A Doctor of Medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

Physician Consultation: services are to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions or level of care considerations.

Physician Services: means services provided by an individual licensed under state law to practice medicine.

Postpartum: as defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.

Post-service Post-payment (PSPP) Utilization Review: means the review for program compliance and medical necessity conducted by the state after service was rendered and paid. DHCS may recover prior payments of

Federal and State funds if such a review determines that the services did not comply with applicable statutes, regulations or terms under the DMC-ODS.

Preauthorization: means approval by DBH, or their designee, that a covered service is medically necessary.

Prescription Drugs: means simple substances or mixtures of substances prescribed for the cure, mitigation or prevention of disease or for health maintenance that are:

- Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law;
- Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and
- Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Primary Care: means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Physician (PCP): means a Physician responsible for supervising, coordinating and providing initial and Primary Care to persons served and serves as the medical home for members. The PCP is a general practitioner, internist, pediatrician, family practitioner or obstetrician/gynecologist.

Primary Care Provider: means a person responsible for supervising, coordinating, and providing initial and Primary Care to persons served, for initiating referrals and maintaining the continuity of person served care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

Projected Units of Service: means the number of reimbursable SUD units of service, based on historical data and current capacity, the provider expects to provide on an annual basis.

Provider: means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

Quality Assessment/Utilization Review (QA/UR) activities are reviews of physicians, health care practitioners and providers of health care services in the provision of health care services and items for which payment may be made to determine whether:

1. Such services are or were reasonable and medically necessary and whether such services and items are allowable.
2. The quality of such services meets professionally recognized standards of health care.

Re-Certification: means the process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

Recovery Monitoring: means recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in recovery services.

Recovery Services: are available after the person served has completed a course of treatment. Recovery services emphasize the person served's central role in managing their health, use effective self-management support strategies and organize internal and community resources to provide ongoing self-management support to persons served.

Rehabilitation Services: includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a person served to his best possible function level.

Relapse: means a person served's return to a pattern of substance use.

Relapse Trigger: means an event, circumstance, place or person that puts a person served at risk of relapse.

Residential Treatment Services: means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to persons served. Each person served shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five (5) hours of clinical service a week to prepare person served for outpatient treatment.

Room and Board: means payment of the cost of the lodging (or a room) and food.

Safeguarding Medications: means facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

Substance Use Disorder Residential Treatment Authorization Request: means a provider's request for the provision of residential treatment services.

Short-Term Resident: means any person served receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

State: means the Department of Health Care Services or DHCS.

Subcontract: means an agreement between the County and its subcontractors (providers). A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct person served/person served services.

Subcontractor (Provider): means an individual or entity that is DMC certified and has entered into an agreement with the County to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with DBH to provide any of the administrative functions related to fulfilling DBH's DMC-ODS obligations.

Substance Abuse Assistance (Peer Support): means peer-to-peer services and relapse prevention. Substance abuse assistance is only available in Recovery Services.

Substance Use Disorder Diagnosis: are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Substance Use Disorder Medical Director: has the same meaning as in 22 CCR§ 51000.24.4.

Support Groups: means linkages to self-help and support, spiritual and faith-based support.

Support Plan: means a list of individuals and/or organizations that can provide support and assistance to a person served to maintain sobriety.

Telehealth between Provider and person served: means office or outpatient visits via interactive audio and video telecommunication systems.

Telehealth between Providers: means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

Temporary Suspension: means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

Threshold Language: means a language that has been identified as the primary language, indicated on the Medi-Cal Eligibility System (MEDS), of 3000 persons served or five percent of the person served population whichever is lower, in an identified geographic area. Fresno County's threshold languages are English, Spanish and Hmong.

Transportation Services: means provision of or arrangement for transportation to and from medically necessary treatment.

Unit of Service Description:

- For case management, intensive outpatient treatment, outpatient services, services and recovery services, contact with a person served per minute increments on a calendar day.
- For additional medication assisted treatment, physician services that includes ordering, prescribing, administering and monitoring of all medications for substance use disorders per minute increments.
- For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.
- For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists per minute increments.
- For residential services, providing 24-hour daily service, per person served, per bed rate.
- For inpatient withdrawal management per person served per bed rate.

Urgent Care: means a condition perceived by a person served as serious, but not life threatening. A condition that disrupts normal activities of daily necessary, treatment within 24-72 hours.

Utilization: means the total actual units of service used by persons served and participants.

Withdrawal Management: means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to SUD system of care persons served.