Riverside University HEALTH SYSTEM

Behavioral Health

Substance Abuse Prevention and Treatment Program

Practices Guidelines

&

Procedure Manual

Contract Providers

V.3 December 2019

SUBSTANCE ABUSE AND PREVENTION TREATMENT PRACTICES AND PROCEDURE MANUAL INTRODUCTION

PAGE

DMC-ODS AND COUNTY CLINICAL REQUIREMENTS

PAGE

QUALITY ASSURANCE AND MONITORING

SAPT ADMINISTRATIVE OVERSIGHT

PAGE

RESOURCES

PAGE

1. SUBSTANCE ABUSE AND PREVENTION TREATMENT PRACTICES AND PROCEDURE MANUAL INTRODUCTION

100 PRACTICES AND PROCEDURE MANUAL INTRODUCTION

The Riverside University Health System – Behavioral Health Substance Abuse Prevention and Treatment (RUHS-BH SAPT) Practices Guidelines and Procedure Manual offers user friendly guidance to all County of Riverside contracted SUD treatment providers, including Drug Medi-Cal (DMC) certified providers, in complying with all Federal, State and County SUD treatment requirements and standards. The Practices and Procedure Manual reflects "best practice" standards and seeks to prevent program deficiencies that can ultimately lead to disallowances and recoupment of monies. This manual has been developed in partnership with SUD treatment providers in the spirit of collaboration and transparency.

Required information to both the consumers and contracted providers will be provided in a manner and format that may be easily understood and is readily accessible.

The Practices and Procedure Manual is available to providers on RUHS-BH website and will be managed to provide required and necessary updates.

100.1 Practice guidelines will meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of providers in a particular field.
- Consider the needs of the consumers.
- Are adopted in consultation with contracting health care professionals. and
- Are reviewed and updated periodically as appropriate.

The practices and procedure manual is specifically designed to be used by all administrative and direct service staff to ensure understanding of core values for the SUD system of care and adherence to the clinical and business expectations within Riverside County.

100.2 This document, along with other federal, state and local regulations govern the delivery of SUD treatment services in Riverside County. An extensive list of laws and regulations that are to be followed are listed in Section 5 – Resources.

101 SUBSTANCE USE DISORDER TREATMENT SERVICES PROGRAM OVERSIGHT

The Department of Health Care Services (DHCS) is responsible for administering SUD Treatment in California. RUHS-BH SAPT contracts with DHCS to fund local SUD treatment services. As part of the contract with DHCS, RUHS-BH SAPT ensures that state SUD treatment requirements and standards are met by maintaining fiscal management systems, monitoring provider billing, conducting compliance visits, processing claims for reimbursement, and offering training and technical assistance to SUD treatment providers.

101.1 In the event of conflicts between the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and Title 22, provisions of Title 22 shall control if they are more stringent.

101.2 Riverside Provider SAPT programs shall be licensed, registered, AOD (as applicable) licensed and DMC certified and approved in accordance with applicable laws and regulations. Providers shall comply with the regulations and guidelines as outlined in Section 5-Resources.

102 THE DISEASE CONCEPT OF SUBSTANCE USE DISORDER

Substance use disorders are often chronic, relapsing conditions of the brain that affect behavior by reinforcing compulsive drug seeking and use, despite catastrophic consequences to individuals, their families, and others around them (National Institute on Drug Abuse). Although most diseases cannot be cured, they can be monitored and managed over time. Examples of manageable chronic diseases include diabetes, HIV infection, asthma, and heart disease. While there is no cure for these diseases, when managed and monitored properly, individuals with such diseases are able to live a fairly normal life. While some individuals may develop a substance use disorder and achieve recovery after minimal intervention over a brief time, others will succumb to an intensified and relapsing course.

Approaching substance use disorders as a disease, assists with framing interventions aimed at managing the condition through a model of care that provides a continuum of services tailored to an individual's needs. As individuals, progress through their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the person's substance use disorder. This approach also highlights the need for person centric care coordination to ensure that service delivery matches consumer need. Effective and efficient care for chronic conditions requires productive interactions between consumers, their families, and allied health providers including Substance Abuse counselors and other health professionals.

103 CONSUMER CENTERED CARE, INTEGRATION AND COORDINATION OF CARE

Retention in treatment is one of the most important factors that lead to successful outcomes of SUD care. In order to engage and retain consumers in treatment, it is paramount that care be delivered in a consumer-centered manner. In consumer-centered care, respect for the consumer is the guiding principle that ensures care is responsive to the consumer's individual needs, preferences, and values. Consumer preferences and values are considered and used as a guide in any decision making process.

103.1 Consumers accessing services through RUHS-BH and its providers are entitled to receive services that meet industry standards and are of the highest quality. RUHS-BH's SAPT Clinics and contracted providers make available services that are based on peer-reviewed Evidence Based Practices (EBP) that have undergone stringent evaluation and meet clinical standards. Such practices

include, but are not limited to, Motivational Interviewing (MI), Cognitive Behavior Therapy (CBT) and curriculum based concepts such as Matrix Model and Living in Balance.

103.2 Additionally, RHUS-BH strives to provide integrated care and care coordination. Efforts are made to ensure that primary care, mental health services are easily accessible, and that connections or referrals to social services are available. Case management of consumers is also of great importance. Our clinics and providers will organize consumer care activities and coordinate the sharing of information to ensure that the needs of the consumers are addressed.

103.3 Providers shall allow each consumer to choose his or her network provider to the extent possible and appropriate.

103.4 For a counseling or referral service that the provider does not cover because of moral or religious objections, the provider shall provide information to the consumer about where and how to obtain the service.

- The Provider for sectarian worship, instruction, and/or proselytization shall use no State or Federal funds. The provider to provide direct, immediate, or substantial support to any religious activity shall use no State funds.

104 SPECIAL POPULATIONS

RUHS-BH and its contractors shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and post-partum women, and (2) adolescents under age 21 who are eligible under the EPSDT program.

104.1 SUD services are provided to pregnant and post-partum women. Coverage for post-partum women begins the day after termination of pregnancy, plus sixty (60) days, then until the end of the month if the 60th day falls mid-month.

104.2 Providers who offer perinatal DMC services are required to be properly certified to provide these services and shall comply with the Perinatal Services Network Guidelines.

104.3 Individuals under age 21 are eligible to receive Medi-Cal services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, consumers 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. No provisions in the DMC-ODS will override any EPSDT requirement. Medical necessity for an adolescent individual (an individual under the age of 21) is determined using the following criteria:

The adolescent shall be assessed to be at risk for developing a SUD. The adolescent shall meet the American Society of Addiction Medicine (ASAM) adolescent treatment criteria.

104.4 Contracting providers shall follow the Youth Treatment Guidelines in developing and implementing adolescent treatment programs funded through the DMC-ODS Waiver.

104.A Perinatal Services Network Guidelines, 2018-19

104.B Youth Treatment Guidelines, 2002

105 RUHS-BH MISSION STATEMENT

Improve the health and well-being of our consumers and communities through our dedication to exceptional and compassionate care, education, and research.

106 SAPT VISION STATEMENT

We are the passionate guides that will help individuals navigate a journey of understanding and healing.

107 RUHS-BH CULTURAL COMPETENCY STATEMENT

Riverside University Health System – Behavioral Health is proud of its commitment to cultural competency – the acceptance and valuing of people from all ethnic and religious backgrounds, regardless of their age, gender, sexual orientation, or disability. Embracing diversity will make us stronger mental health professionals for the benefit of our consumers. We do not discriminate.

DMC-ODS AND COUNTY CLINICAL REQUIREMENTS

200 ACCESS

200.1 Provider will have hours of operation during which services are provided to Medi-Cal consumers that are no less than the hours of operation during which the provider offers services to non-Medi-Cal consumers.

200.2 Provider shall post and record the Substance Use Community Access Referral Evaluation and Support (SUCARES) 24-hour phone line (800) 499-3008 during hours of non-operation.

200.3 All consumers requesting SUD screening services shall be screened for need and ASAM level of care the same day, or given an appointment for screening the next business day. The consumer shall complete the SUD 6-dimension screening during the initial phone call, initial face-to-face interaction, or during the scheduled appointment.

200.4 Once the ASAM predetermination level of care is made through the screening tool, the consumer shall be scheduled for an appointment with a County clinic or Provider for a complete intake and assessment to determine diagnosis and medical necessity.

200.5 If the provider determines the consumer requires residential or withdrawal management services, they will contact the SU CARES personnel to coordinate the consumer's appointment with a contracted residential provider.

200.6 From February 1, 2018 forward, consumers shall receive an intake assessment within seven (7) calendar days after the initial screening or request for services.

200.7 Consumer preferences shall be considered such as cultural, geographical, gender, language and personal schedule. These preferences and special circumstances shall be documented in the Provider consumer chart if applicable. CFR_42_431201.

200.8 Urgent conditions shall be addressed by the counselor while in contact with the consumer. Counselor shall reach out to police, a 24-hour crisis behavioral health team, or emergency personnel as the need arises. Additionally, the SU CARES will be informed of the emergency and details about how the consumer accessed any services.

201 SCREENING

201.1 Providers shall only admit Riverside County residents directly for County funded programs and work cooperatively with RUHS-BH SAPT and the Substance Abuse Program Administrator (or designee) to form an integrated network of care for individuals experiencing substance abuse problems. The Provider shall maintain close communication with RUHS-BH SAPT program in the coordination

of consumer admission and transition so that contracted treatment services can be accessed in a timely manner.

201.2 Provider shall use the County initial screening tool for the American Society of Addiction Medicine (ASAM) consumer placement criteria.

201.3 The process for walk-in screenings and call-in screenings shall be identical. When a consumer calls by telephone, they will receive a complete County approved SUD screening. Once the predetermination of the ASAM level of care is made, the consumer shall be scheduled with a County clinic or a Provider for a complete assessment to determine diagnosis and medical necessity. The SUD screening and predetermination level of care will be entered into the Provider's Electronic Health Record (EHR) at that time and the consumer shall be linked to an appointment before the call or appointment is terminated.

201.4 The Provider must verify Medi-Cal eligibility of the individual. When the Provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the County prior to payment for services.

201.5 A certified substance abuse counselor, or licensed clinician shall be available to screen consumers, enter consumer information into the Provider's EHR system and place the consumer in an appropriate ASAM level of care, including pre-treatment education classes and individual prevention services.

201.6 Upon determination of ASAM level of care, the Provider will utilize the Secured File Transfer Protocol (SFTP) file folder between Provider and RUHS-BH SAPT Administration to exchange information for Authorization of Services.

201.7 Providers shall admit on a priority basis, pregnant women who are using or abusing substances, women who are using or abusing substances and who have dependent children, injecting drug users, and substance abusers infected with HIV or who have tuberculosis. Consumers shall not be required to disclose whether they are HIV positive. Priority admissions shall be given in the following order:

- Pregnant women who are using or abusing substances,
- Women who are using or abusing substances who have dependent children,
- Injecting drug users,
- Substance abusers infected with HIV or who have tuberculosis,
- AB 109,
- All others.

201.A 42 CFR 431.201

202 PLACEMENT

202.1 Enrollment discrimination is prohibited.

202.2 The Provider accepts individuals eligible for enrollment in the order in which they apply without restriction.

202.3 The Provider will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

202.4 The Provider will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California, and will not use any policy or practice that has the effect of discriminating. See Section 5 – Resources for Laws and regulations.

202.5 Outpatient placement may be conducted by either the Provider or the SU CARES team. Residential/Withdrawal Management placement may only be conducted by the SU CARES team.

202.6 When a predetermination of placement is conducted and the ASAM level of care is decided, the Provider's MD and/or LPHA must then complete a full assessment to determine a diagnosis and confirm medical necessity. The Provider's MD and LPHA are responsible for confirming consumers have been appropriately placed and shall redirect consumer to another level of care when appropriate.

202.7 When applicable, a medical and/or psychiatric clearance will be obtained and noted.

202.8 Assessments shall consist of a completed screening, diagnosis, and ASAM Level of Care. This assessment will include an in-person appointment within the time frame required to determine diagnosis and assess if ASAM level of placement was appropriate. If the ASAM level is determined to be different by the Medical Director, Licensed Physician, or LPHA, the consumer will be assisted by the Provider, SU CARES and Care Coordination team to access a higher or lower level of care.

202.9 If MD or LPHA determines the consumer should be in another level of care, they will:

- Contact the consumer's assigned Care Coordinator and notify the SU CARES placement counselor to transition the consumer to the appropriate level of care. Provider is responsible for completing the additional paperwork, which shall be processed to transition the consumer to the appropriate level of care.

202.10 Providers are required to provide written notice of action (NOABD) to a Medi-Cal consumer of any decision to deny a service authorization request or to authorize a service in an amount duration, or scope that is less than the request made by a health care professional who has appropriate clinical expertise in treating the consumer's condition or disease at least ten (10) days before the date of action.

Withdrawal Management and Residential Providers

202.11 SU CARES personnel are the only staff authorized to place a consumer in withdrawal management or residential treatment. This is in accordance with Department of Health Care Services (DHCS) information notice 16-042, withdrawal management or residential placement guidelines.

202.12 Withdrawal Management and Residential Providers are required to submit Bed Availability daily to identify available bed slots for the day.

202.13 SU CARES personnel will complete the SAPT Placement Referral Form and forward it to the Provider through SFTP file when the bed has been secured.

202.14 County Care Coordinators will be assigned to a consumer when determined the consumer requires Withdrawal Management and/or Residential Treatment.

202.15 Providers are to collaborate and work closely with Care Coordinators to ensure engagement, re-engagement and warm hand-offs are present as the consumer proceeds through treatment.

202.16 Providers shall ensure that each consumer has an ongoing source of care appropriate to his or her needs and have the information needed to contact their designated Care Coordinator.

202.A DHCS Information Notice 16-042

203 ASSESSMENT

203.1 The Provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each consumer upon admission to treatment.

203.2 Assessment for all consumers shall include at a minimum:

- Drug/Alcohol use history,
- Medical history,
- Family history,
- Psychiatric/psychological history,
- Social/recreational history,
- Financial status history,
- Educational history,
- Employment history,
- Criminal history, legal status, and
- Previous SUD treatment history.

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

204 RE-ASSESSMENT (CONTINUING SERVICES)

204.1 Continuing services shall be justified for case management, outpatient services, intensive outpatient, and Naltrexone treatment.

204.2 For each consumer, no sooner than five (5) months and no later than six (6) months after the consumer's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the consumer progress and eligibility to continue to receive treatment services, and recommend whether the consumer should or should not continue to receive treatment services at the same level of care.

204.3 For each consumer, no sooner than five months and no later than six months after the consumer's 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 for the consumer. The determination of medical necessity shall be documented by the Medical Director or LPHA in the consumer's individual consumer record and shall include documentation that all of the following have been considered:

- The consumer's personal, medical, and substance use history.
- Documentation of the consumer's most recent physical examination.
- The consumer's progress notes and treatment plan goals.
- The LPHA's or counselor's recommendation pursuant to the consumer's progress or lack of progress.
- The consumer's prognosis
- The MD or LPHA shall type or legibly print their name, and sign and date the documentation. The signature shall be adjacent to the typed or legibly printed name.

204.4 If the MD or LPHA determines that continuing treatment services for the consumer is not medically necessary, the provider shall discharge the consumer from treatment and arrange for the consumer to proceed to an appropriate level of treatment services.

204.5 Residential Providers shall adhere to the guidelines set forth in Section 214 Residential Treatment.

205 MEDICAL NECESSITY

Medical necessity refers to the applicable evidence based standards applied to justify the level of services provided to a consumer so the services can be deemed reasonable, necessary and/or appropriate. It is imperative that medical necessity standards are consistently and universally applied to all consumers.

205.1 Physician (or LPHA) shall:

- Review personal, medical, and substance use history.
- Evaluate each consumer and diagnose using DSM-5.
- Document basis for diagnosis within seven (7) days of admission via face-to-face session with the counselor and consumer.
- Exceptions: Withdrawal Management and OTP/NTP must be documented on day 1.

205.2 The Medical Director or LPHA shall evaluate each consumer's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor and consumer to establish whether the consumer meets medical necessity criteria or not. A telephone interview is not acceptable for establishing medical necessity.

205.3 The Medical Director or LPHA shall document, in narrative format, separately from the treatment plan, the basis for the diagnosis in the consumer's record within seven (7) calendar days of each consumer's admission to treatment date.

The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each consumer'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 narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

205.4 After establishing a diagnosis and documenting the basis for diagnosis, the ASAM criteria shall be applied by the diagnosing LPHA to determine or confirm placement into the appropriate modality or level of assessed services.

205.5 The Diagnostic and Statistical Manual of Mental Disorders, Version 5 (DSM-5) will be utilized by Providers for all consumers accessing SUD services.

- DSM-5 diagnosis
- Youth (ages 12 – 17) and Young Adults (ages 18 – 20)
- Either meet criteria for the DSM-5 specification for adults. OR
- Be determined to be at-risk for developing a SUD
- Adults (ages 21+)
- Meet criteria for at least one diagnosis from the current DSM-5 for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

205.6 Definition of At-Risk for Individuals up to Age 21 (*LA County Provider Manual 2017*)

Youth (ages 12 – 17) and Young Adults (ages 18 – 20) in the specialty SUD system are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Eligibility for EPDST broadens the definition of medical necessity for youth to include individuals who are deemed "at-risk" for SUDs, and also makes the full SUD benefit package available to all individuals up to age 21 without any caps or limitations, assuming medical necessity is established.

Importantly, these federal EPSDT requirements supersede state Medi-Cal requirements, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver does not override EPSDT.

205.7 Medical necessity encompasses all six (6) ASAM dimensions and takes into consideration the extent and biopsychosocial severity of the various dimensions within the full ASAM assessment. Medical necessity must not be restricted to acute care and narrow medical concerns. The six dimensions are:

- Acute Intoxication and/or Withdrawal Potential,
- Biomedical Conditions and Complications,
- Emotional, Behavioral, or Cognitive Conditions and Complications,
- Readiness to Change,
- Relapse, Continued Use, or Continued Problem Potential, and
- Recovery/Living Environment.

205.A DHCS Title 22 Diagnosis Medical Necessity FAQ

205.B DHCS DSM-5 Information Notice 16-051

206 PHYSICAL EXAMINATION REQUIREMENTS

206.1 If a consumer has a physical examination within a twelve month period prior to the consumer's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the consumer's most recent physical examination within thirty (30) calendar days of the consumer's admission to treatment date. This review shall be documented in the individual consumer record progress notes.

- If a Provider is unable to obtain documentation of a consumer's most recent physical examination, the Provider shall describe the efforts made to obtain this documentation in the consumer's individual progress notes.

206.2 As an alternative to the above, the physician or physician extender may perform a physical examination of the consumer within thirty (30) days of the consumer's admission to treatment date.

206.3 If the physician or a physician extender has not reviewed the documentation of the consumer's physical examination or does not perform a physical examination, the LPHA or counselor shall include in the consumer's initial and updated treatment plans the goal of obtaining a physical examination, until this goal is met and the physician has reviewed the physical examination results. The physician 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 and legibly printed name.

(Intergovernmental Agreement, Exhibit A, Attachment 1 A1, Section PP (11)(i)(a)(ii-iii))

207 CONSUMER ADMISSION

Each Provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining consumer's eligibility and the medical necessity for treatment.

207.1 Minimum documentation criteria shall include:

- DSM-5 Diagnosis,
- Use of alcohol/drugs of abuse,
- Physical health status
- Documentation of social and psychological problems.

207.2 If a potential consumer does not meet the admission criteria, the consumer shall be referred to an appropriate service provider as described in Section 202.9.

207.3 If a consumer is admitted to treatment, the consumer shall sign the consent to treatment form.

207.4 The Medical Director or LPHA shall document the basis for the diagnosis in the consumer record.

207.5 All referrals made by the provider staff shall be documented in the consumer record.

207.6 Copies of the following documents shall be provided to the consumer upon admission:

- Consumer rights
- Share of cost if applicable
- Notification of DMC funding accepted as payment in ful
- Consent to treatment

207.7 Information of the following shall be provided to the consumer or posted in a prominent place accessible to all consumers:

- 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.
- Patient's Rights
- Notice of Privacy Practices HIPAA
- Program rules and expectations.
- Pursuant to 42 CFR 438.100, Providers shall be responsible for making available the Member Benefits Brochure to each consumer upon initial contact. The Member Benefits Brochure, provided by the County, contains information to enable consumers to understand how to use effectively utilize and navigate through DMC-ODS.

207.8 Where drug screening by urinalysis is deemed medically appropriate, the Providers shall:

- Establish procedures that protect against the falsification and/or contamination of any urine sample.
- Document urinalysis results in the consumer's file.

207.9 If any person requests services but cannot be admitted immediately by the Provider due to full capacity status, the Provider shall notify the closest County facility and direct the person to the nearest County SAPT Outpatient facility for treatment.

208 CARE COORDINATION

208.1 Services provided to the consumer will be coordinated as follows:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
- With the services, the consumer receives from any other managed care organization.
- With the services, the consumer receives in FFS Medicaid.
- With the services, the consumer receives from community and social support providers.
- Providers shall assist Riverside county residents in filling out any applicable applications for Welfare, Medi-Cal, and/or any other social services needed or requested.

208.2 Provider will work closely with County Care Coordinators, County Clinics and other County Providers to ensure consumers remain engaged, are re-engaged or are transitioned to another level of care efficiently and successfully.

209 PERSONNEL SPECIFICATIONS (NICOLE)

The following requirements shall apply to Provider and Provider staff.

209.1 The professional staff shall be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:

- Physician,
- Nurse Practitioners,
- Physician Assistants,
- Registered Nurses,
- Registered Pharmacists,
- Licensed Clinical Psychologists,
- Licensed Clinical Social Worker,
- Licensed Professional Clinical Counselor,
- Licensed Marriage and Family Therapists, and
- License Eligible Practitioners working under the supervision of Licensed Clinicians.

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

209.3 Professional and non-professional 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.

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

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

209.6 Providers will ensure personnel are competent, trained and qualified to provide any services necessary.

209.7 Providers will maintain records of current certification and NPI registration and fidelity reviews for all staff providing EBP interventions.

209.8 Providers shall maintain proof of participation in all County and State mandated training.

209.9 Providers shall employ and utilize staff who are culturally and ethnically representative of the population being served.

209.10 Providers will ensure all primary staff members are paid personnel. Volunteers and interns may be used on a limited basis.

Providers will ensure consumers of the program are not substituted for paid personnel.

209.11 Providers will ensure a sufficient number of staff members are certified in Cardiopulmonary Resuscitation (CPR) and basic First Aid to provide coverage at all times.

209.12 Providers will ensure that all staff members working with individuals receiving services are fingerprinted (LiveScan), and pass Department of Justice (DOJ), and Federal Bureau of Investigations (FBI) background checks.

209.13 Provider shall be responsible for checking, on a monthly basis, the Office of the Inspector General (OIG) website to validate that none of the Provider's officers, board members, employees, associates, and agents providing services are on the OIG or Medi-Cal list of excluded individuals to provide direct services to County consumers. Providers shall notify, in writing within thirty (30) calendar days, if and when any Provider's personnel are found listed on this site and what action has been taken to remedy the matter.

Additional exclusion databases to check monthly are as follows:

HTTPS://FILES.MEDI-CAL.CA.GOV/PUBSDOCO/SANDILANDING.ASP
HTTPS://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCE/ADMINISTRATIVE-SIMPLIFICATION/NATIONALPROVIDENTSTAND/DATADISSEMINATION.HTML
HTTPS://WWW.SAM.GOV/SAM/
HTTPS://CLASSIC.NTIS.GOV/PRODUCTS/SSA-DMF/#

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

- Application for employment and/or resume,
- Signed employment confirmation statement/duty statement,
- Job description,
- Performance evaluations,
- Health records/status as required by Provider, AOD certification or Title 9.
- Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries),

- Training documentation relative to substance use disorders and treatment.
- Current registration, certification, intern status, or licensure,
- Proof of continuing education required by licensing or certifying agency and program, and
- Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well.

209.15 Job descriptions shall be developed, revised as needed and approved by the Provider'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.

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

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

209.17 If a Provider utilizes the services of volunteers and or interns, procedures shall be implemented which addresses:

- Recruitment,
- Screening,
- Selection,
- Training and orientation,
- Duties and assignments,

- Scope of practice,
- Supervision,
- Evaluation, and
- Protection of consumer confidentiality.

209.18 Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a Provider representative and the physician.

209.A Title 9, Chapter 8

210 SUBSTANCE USE DISORDER MEDICAL DIRECTOR (NICOLE TO VERIFY W/NEW IA)

The substance use disorder Medical Director's responsibilities shall, at a minimum, include all of the following.

210.1 Ensure that medical care provided by physicians and physician extenders meets the applicable standard of care.

210.2 Ensure that physicians do not delegate their duties to non-physician personnel.

210.3 Develop and implement medical policies and standards for the provider.

210.4 Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.

210.5 Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

210.6 Ensure that provider's physicians and LPHAs are adequately trained to diagnose substance use disorders for consumers and determine the medical necessity of treatment for consumers.

210.7 Ensure that physicians are adequately trained to perform other physician duties, as outlined.

210.8 The substance use disorder Medical Director may delegate his/her responsibilities to a physician consistent with the Provider's medical policies and standards. However, the substance use disorder Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

RIVERSIDE COUNTY CONTINUUM OF CARE

RUHS-BH offers a full continuum of care. The appropriate level of care modality is initially determined by completion of the ASAM criteria in conjunction with approved screening tools. After the initial assessment, admissions, and transitioning from modalities is based on successful completion of and referral to another level of service, until discharge. There are times that consumers may need a higher level of care as a result of continued use or in need of increased

support. Consumers will continue to be assessed and if needed, assisted by staff in transitioning to the level of care necessary to increase potential consumer success.

211 OUTPATIENT-ODF (ASAM LEVEL 1.0)

Outpatient counseling services are provided to consumers **(up to 9 hours per week for adults and less than 6 hours per week for adolescents)** when determined by a Medical Director or LHPA to be medically necessary and in accordance with an individualized consumer treatment plan. Services are designed to treat the individual who meets the diagnostic criteria for SUD and presents with the ability and stability to participate in low-intensity, professionally directed SUD treatment. Ultimately, the SUD treatment will assist in achieving permanent change in using behaviors and improve mental functioning for the consumer. Group size is limited to no less than two (2) and no more than twelve (12) consumers.

211.1 Services can be provided by a licensed behavioral health professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone, or by telehealth, and in any appropriated setting in the community.

211.2 Providers will address personal lifestyles, attitudes and behaviors that can affect or prevent accomplishing the goals of treatment.

211.3 Level 1 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. The consumer may be in the pre-contemplation stage of the Stages of Change.

211.4 Level 1 is an excellent way to engage resistant individuals.

211.5 A consumer shall be provided a minimum of two (2) counseling sessions per thirty (30) day period except when the physician determines that:

- Fewer consumer contacts are clinically appropriate.
- The consumer is progressing toward treatment plan goals.

211.6 Outpatient services shall include assessment, treatment planning, individual and group counseling, family therapy, patient education, individual and group counseling, collateral services, crisis intervention services, and discharge planning.

212 INTENSIVE OUTPATIENT TREATMENT-IOT (2.1)

Intensive Outpatient Services are provided to consumers for 9 hours or more of service/week **(adults, generally 9 – 19 hours/week) or for 6 hours or more hours/week (adolescents, generally 6 – 19 hours/week)** to treat multidimensional instability. Services are designed to treat the individual who meets the diagnostic criteria for a SUD with instabilities or complicating factors, which require high-intensity, professionally

directed SUD treatment. Group size is limited to no less than two (2) and no more than twelve (12) consumers.

212.1 Intensive outpatient services can be provided during the day, in evenings, during weekdays, or on weekends. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

212.2 IOT is designed to have the capacity to treat consumers who have more complex co-occurring mental and substance-related conditions.

212.3 Providers will ensure specific populations are offered IOT services when and where applicable.

212.4 A consumer shall be provided a minimum of two (2) counseling sessions per thirty (30) day period except when the physician determines that:

- Fewer consumer contacts are clinically appropriate.
- The consumer is progressing toward treatment plan goals.

Perinatal and Postpartum Services

An IOT program for pregnant and parenting substance abusing women shall have a child-learning laboratory as part of treatment, where women learn hands-on parenting skills. Groups will cover a variety of topics specific to pregnant and parenting mothers. Special speakers are also used to provide information and referrals to other community programs available for women.

212.5 Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.

212.6 Perinatal services shall include Mother/child IOT (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).

212.7 Provision of arrangement for transportation for mother and children to and from medically necessary treatment.

212.8 Provider shall offer education regarding the reduction of harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.

212.9 Provider shall make available coordination of ancillary services such as assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services that are medically necessary to prevent risk to fetus or infant.

212.10 Medical documentation that substantiates the consumer's pregnancy and the last day of pregnancy shall be maintained in the consumer record.

212.11 Provider shall follow Perinatal Services Network Guidelines.

212.12 Intensive outpatient services shall include: assessment, treatment planning, individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning.

212.B Perinatal Services Network Guidelines, 2018-19

213 PARTIAL HOSPITALIZATION (ASAM LEVEL 2.5)

Services feature twenty (20) or more hours of clinically intensive programming per week when determined by a Medical Director or LPHA to be medically necessary and as specified in the consumer's treatment plan. Level 2.5 partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs, which warrant daily monitoring or management but can be appropriately addressed in a structured outpatient setting.

214 RESIDENTIAL TREATMENT

Facilities are short-term residential programs that provide rehabilitation services to consumers with a substance use disorder diagnosis when determined by a Medical Director or LPHA as medically necessary and in accordance with an individualized treatment plan. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build behavioral patterns within a community.

214.1 The contracting Provider must receive prior authorization for residential services before admitting a consumer into a withdrawal management or residential services as described in Placement Section 202.

214.2 Residential services are provided to non-perinatal (male and female), perinatal and adolescents.

214.3 Services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. In the residential treatment environment, an individual's functional cognitive deficits may require treatment that is primarily slower paced, more concrete and repetitive in nature.

214.4 Each consumer 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.

214.5 Providers and residents work collaboratively to define barriers, set priorities, establish goals, create individualized treatment plans, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

214.6 Adults, ages 21 and over, may receive up to two continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one

(1) residential stay in a DHCS licensed facility for a maximum of ninety (90) days per 365-day period.

214.7 An adult consumer may receive one thirty (30) day extension, if that extension is medically necessary, per 365-day period.

214.8 Adolescent consumers, under the age of 21, may receive a thirty (30) day extension if that extension is determined to be medically necessary. Adolescent consumers are limited to one (1) extension per year. Adolescent consumers receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment. Nothing in the DMC-ODS or in this paragraph overrides any EPSDT requirements. EPSDT adolescent consumers may also receive a longer length of stay based on medical necessity.

214.9 Perinatal consumers may receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends.)

214.10 If determined to be medically necessary, perinatal consumers may receive a longer length of stay than those described above.

214.11 See Perinatal and post-partum services (Has this been updated? – Belinda) for more information.

214.A DHCS ASAM Levels Residential Info Notice

214.B DHCS Medically Managed Residential and WM 3.7 & 4.0 Info Notice

214.C DHCS Residential Authorization Info Notice

215 CLINICALLY MANAGED, LOW INTENSITY RESIDENTIAL SERVICES (ASAM LEVEL 3.1)

Level 3.1 is a 24-hour structure with available trained personnel and **at least five (5) hours of clinical service/week.**

215.1 Services are to improve the ability to structure and organize tasks of daily living and recovery.

215.2 Planned clinical program activities (at least five (5) hours/week) are directed to stabilize the consumer's SUD symptoms, increase motivation, and develop recovery skills.

215.3 Counseling and clinical monitoring are to support involvement in productive daily living activities.

215.4 Drug screening and monitoring of medication adherence will be utilized in a therapeutic manner.

215.5 Recovery support services, including support for the affected family shall be made available.

215.6 Addiction pharmacotherapy shall be made available.

216 CLINICALLY MANAGED, POPULATION SPECIFIC HIGH INTENSITY RESIDENTIAL SERVICES (ASAM LEVEL 3.3)

Level 3.3 is a 24-hour structured living environment in combination with high-intensity clinical services for individuals with significant cognitive impairment. The cognitive impairments are so significant that outpatient motivational and/or relapse prevention strategies are not feasible or effective and it is unlikely he/she could benefit from other levels of residential care. The impairments may be permanent or temporary and generally result in problems in interpersonal relationships, emotional coping, and/or comprehension.

216.1 Daily clinical services shall be provided to improve consumer's ability to structure and organize adult daily living tasks and succeed in productive daily activities such as work or school.

216.2 Clinical programming to stabilize consumer's addiction symptoms and develop recovery skills: may include a range of cognitive and/or behavioral therapies administered on an individual and group basis.

216.3 Drug Screening and monitoring of medication adherence shall be utilized in a therapeutic manner.

216.4 Recovery support services, including support for the affected family shall be made available.

217 CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL SERVICES (ASAM LEVEL 3.5)

Level 3.5 is a 24-hour residential care for consumers who require a 24-hour supportive treatment environment in order to develop sufficient recovery skills to avoid relapse or continued AOD use. Consumers typically have multiple challenges in addition to addiction (trauma history, criminal/legal issues, psychological problems, etc.).

217.1 Planned, evidence-based clinical program activities and professional services to stabilize addiction symptoms and develop recovery skills shall be provided.

217.2 Daily organized programming shall be provided to improve consumer's ability to structure and organize tasks of daily living and recovery.

217.3 Counseling and clinical monitoring are to support involvement in productive daily living activities.

217.4 Drug Screening and monitoring of medication adherence shall be utilized in a therapeutic manner.

217.5 Planned community reinforcement designed to foster pro-social values and community living skills shall be offered.

217.6 Recovery support services, including support for the affected family shall be made available.

217.7 Addiction pharmacotherapy shall be made available.

217.8 An assessment shall be conducted to include an initial withdrawal assessment including a medical evaluation or referral within 48-hours of admission. If consumer is experiencing detoxification, the provider will make available daily withdrawal monitoring and ongoing screening for medical and nursing care needs (Adolescent Care).

218 MEDICALLY MANAGED INTENSIVE INPATIENT SERVICES (ASAM LEVEL 3.7)

Level 3.7 is a 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment service in an in consumer setting. These programs operate under a defined set of policies, procedures that are appropriate for consumers whose sub-acute biomedical and emotional, behavioral, or cognitive problems are so severe that they require medical management in an inpatient setting.

218.1 Daily clinical services to assess and address the consumer's individual treatment needs shall be provided. Services may include daily nursing services and medical services as required.

218.2 Providers will make available planned clinical program activities utilizing best-practice interventions to stabilize the consumer's SUD symptoms and/or psychiatric symptoms and develop recovery skills.

218.3 Counseling and clinical monitoring are to support involvement in productive daily living activities.

218.4 Drug Screening and monitoring of medication adherence shall be utilized in a therapeutic manner.

218.5 Recovery support services, including support for the affected family shall be made available.

218.6 Addiction pharmacotherapy shall be made available.

219 MEDICALLY MANAGED INPATIENT SERVICES (ASAM LEVEL 4.0)

Services in a Level 4 program are appropriate for consumers who have severe, unstable mental health and substance use disorders, which at times may be complicated by significant medical issues. These disorders require a range of medical, nursing, and other clinical interventions delivered in a 24-hour, medically managed care setting.

219.1 The Provider will make available all necessary acute care services, specialty consultation, and intensive care with initial withdrawal management and daily nursing observation, evaluation, and monitoring.

219.2 Daily assessment and clinical services shall be provided to address the consumer's individual treatment needs, to include pharmacological, cognitive-behavioral, motivational enhancement, and health education services.

219.3 Daily treatment shall be provided to manage acute biomedical symptoms.

219.4 Drug Screening and management of medication adherence shall be utilized in a therapeutic manner.

219.5 Recovery support services, including support for the affected family shall be made available.

219.6 Addiction pharmacotherapy shall be made available.

219.7 A physician shall be made available as medically necessary.

219.8 Additional medical specialty consultation and lab/toxicology services are available on-site or through consultation.

219.9 Psychiatric services are available on-site or through consultation-available within eight (8) hours by telephone or 24-hours in person.

220 WITHDRAWAL MANAGEMENT

Withdrawal Management (WM) services are provided in a continuum of WM services as per the five levels of WM in the ASAM Criteria when determined by a Medical Director or LPHA as medically necessary and in accordance with an individualized treatment plan. Each consumer shall reside at the facility if receiving a residential service and shall be monitored during the detoxification process. Medically necessary rehabilitative services are provided in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the State of California requirements.

220.A DHCS Medically Managed Residential and WM 3.7 & 4.0 Info Notice

220.B DHCS Additional Withdrawal Management Info Notice

220.C DHCS Residential Authorizations (and WM) Info Notice

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

This level of withdrawal management is an organized outpatient service, which may be delivered in an office setting, healthcare or addiction treatment facility or in a consumer's home by trained clinicians who provide medically supervised evaluation, detoxification,

and referral services according to a predetermined schedule. Providers will ensure the following are available:

221.1 All necessary services for assessment.

221.2 Medication or non-medication withdrawal management.

221.3 Physician or nurse monitoring.

221.4 Clinical support and education.

221.5 Referral for ongoing support or transfer planning.

222 AMBULATORY WITHDRAWAL MANAGEMENT WITH EXTENDED ON-SITE MONITORING ASAM (LEVEL 2.0-WM)

This level of withdrawal management is an organized outpatient service, which may be delivered in an office setting, a health care or addiction treatment facility or in a consumer's home by trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. Providers will ensure the following are available:

222.1 All necessary services for assessment and medication or non-medication withdrawal management.

222.2 Clinical support, best practices and evidenced based therapies, and education designed to enhance the consumer's health.

222.3 Education and understanding of addiction.

222.4 Assessment of progress through withdrawal management.

222.5 Services to families and significant others.

222.6 Referral for ongoing support or transfer planning.

223 CLINICALLY MANAGED RESIDENTIAL WITHDRAWAL MANAGEMENT (ASAM LEVEL 3.2 WM)

Clinically Managed Residential Withdrawal Management (sometimes referred to as "social setting detoxification") is an organized service that may be delivered by an appropriately trained staff member who provides 24-hour supervision, observation, and support for consumers who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than medical and nursing care. This level provides care for consumers whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. Providers will ensure the following are available:

223.1 The clinical components of Level 3.2 WM include all necessary services for assessment and medication or non-medication withdrawal management.

223.2 Clinical support, best-practices therapies, and education designed to enhance the consumer's health education and understanding of addiction.

223.3 Daily assessment of progress through withdrawal management.

223.4 Services to families and significant others.

223.5 Referral for ongoing support or transfer planning.

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

This level of detoxification is provided to consumers whose withdrawal symptoms are sufficiently severe to require 24-hour inpatient care and medical monitoring. Providers will ensure the following are available:

224.1 Cognitive, behavioral, medical, mental health and other therapies designed to enhance the consumer's understanding of addiction and completion of the withdrawal.

224.2 Multidisciplinary individualized assessment and treatment.

224.3 Health Education.

224.4 Services for families and significant others.

224.5 Referral for ongoing support or transfer planning.

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

This level of detoxification is provided to consumers whose withdrawal symptoms are sufficiently severe to require 24-hour inpatient care and medical management. Providers will ensure the following are available.

225.1 Cognitive, behavioral, medical, mental health and other therapies designed to enhance the consumer's understanding of addiction and completion of the withdrawal.

225.2 Multidisciplinary individualized assessment and treatment.

225.3 Health Education.

225.4 Services for families and significant others.

225.5 Referral for ongoing support or transfer planning.

226 OPIOID TREATMENT PROGRAM - OTP - (ASAM LEVEL 1.0)

An Opioid Treatment Program (OTP) is offered at six (6) locations. RUHS-BH and DHCS continue to approve slot increases for the six (6) OTP sites. Currently, not all six sites are at capacity, and all six sites could expand to serve more consumers on an average of 75 per clinic. Providers will ensure that all consumers seeking OTP services are provided with

an appointment within three business days of an OTP service request. Providers will ensure the following are available:

226.1 Assessment

226.2 Individual and Group Counseling

226.3 Consumer Education

226.4 Medication Services that will be offered at OTP sites will be Methadone, Buprenorphine, Naloxone, and Disulfiram.

226.5 Collateral Service

226.6 Crisis Intervention Services

226.7 Individualized Treatment Planning

226.8 Medical Psychotherapy: Type of counseling services consisting of a face- to- face discussion conducted by the Medical Director of the NTP/OTP on a one- on-one basis with the consumer.

226.9 Discharge Services.

226.10 OTP/NTP providers shall provide a minimum of fifty (50) minutes per calendar month of counseling.

226.11 Consumers may be simultaneously participating in OTP services and other ASAM levels of care.

226.A DHCS MAT Rates Info Notice

226.B DHCS MAT Rates Info Notice Attachment 19-20

226.C DHCS MAT FAQ

226.D Title 9, Chapter 4

227 ADDITIONAL MEDICATION ASSISTED TREATMENT (MAT)

RUHS-BH recognizes the expansion of MAT services is crucial, and is actively pursuing both contracted providers and private providers to enroll in DMC to offer these services.

227.1 Providers will have procedures for linkage/integration for consumers requiring medication-assisted treatment.

227.2 Providers must submit MAT protocols to County for approval prior to providing services.

227.3 Provider staff will regularly communicate with physicians of consumers who are prescribed these medications unless the consumer refuses to consent to sign a 42 CFR Part 2 compliant release of information for this purpose.

227.4 These services are expanded services under the DMC-ODS and shall be reimbursed by DHCS under Drug Medi-Cal (DMC).

227.5 Additional Medication Assisted Treatment includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders.

227.6 Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

227.7 RUHS-BH will require Providers to have procedures for linkage and integration of consumers requiring MAT.

227.8 MAT service providers including clinics will offer Naltrexone (tablets or injection), Disulfiram (tablets), Acamprosate Calcium (tablets), Buprenorphine (tablets), and Vivitrol (injection).

Naltrexone Treatment Services

227.9 For each consumer, the provider shall confirm and document that the consumer meets all of the following conditions:

- Has a documented history of opiate or alcohol addiction.
- Is at least 18 years of age.
- Has been opiate or alcohol free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate or alcohol free status of the consumer.
- Is not pregnant and is discharged from the treatment if she becomes pregnant.
- The physician shall certify the consumer's fitness for treatment based upon the consumer's physical examination, medical history, and laboratory results.
- The physician shall advise the consumer of the overdose risk should the consumer return to opiate or alcohol use while take Naltrexone and the ineffectiveness of opiate and alcohol pain relievers while on Naltrexone.
- Residential and outpatient facilities cannot deny a consumer utilizing or needing MAT from program participation.

227.A DHCS MAT Info Notice

227.B DHCS MAT FAQ

228 RECOVERY SERVICES (AFTERCARE)

Recovery Services continuing care is the stage following discharge, when the consumer no longer requires services at the intensity required during primary treatment. Consumers continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle. Aftercare will occur in a variety of settings, such as periodic outpatient aftercare,

relapse/recovery groups, 12-Step and self-help groups, as well as sober living housing. Whether individuals completed primary treatment in a residential or outpatient program, they will develop the skills to maintain sobriety and begin work on remediating various areas of their lives.

Linkages to these recovery services are provided in each RUHS-BH clinic by certified substance abuse counselors, licensed clinicians, and peer support specialists, as well as through contracted providers.

228.1 Components of Recovery Services

- Outpatient Counseling: In the form of individual or group counseling to stabilize the consumer, then reassess if further care is needed.
- Recovery Monitoring: Including recovery coaching and monitoring via telephone/telehealth.
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
- Support for Education and Job Skills: Including linkages to life skills, employment services, job training, and education services.
- Family Support: Including linkages to childcare, parent education, child development support services, and family/marriage education.
- Support Groups: Including linkages to self-help and faith-based support.
- Ancillary Services: Including linkages to housing assistance, transportation, case management, and individual services coordination.

228.2 Access to Recovery Services

- Post-Treatment. Recovery Services are made available to eligible consumers after they complete their course of treatment.
- Relapse Prevention and / or Early Intervention. Services are available to consumers whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.
- Consumer treatment plan. Services should be provided in the context of an individualized consumer treatment plan that includes specific goals. This may include the plan for ongoing recovery and relapse prevention that was developed during discharge planning when treatment was completed.

228.3 Who Can Provide Recovery Services

- Licensed Practitioner of the Healing Arts (LPHA)
- Certified Substance Abuse Counselor
- Peers (when provided as substance abuse assistance services as a component of recovery services)

228.A DHCS information notice on Peer Support

228.B DHCS Recovery Services FAQ

229 EVIDENCED BASED PRACTICES (EBP)

229.1 The County will monitor the implementation and regular training of EBPs towards staff during reviews.

229.2 Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan. Provider should use two EBPs for each modality.

229.3 Motivational Interviewing: A consumer-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 consumers' past successes.

229.4 Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

229.5 Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. 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.

229.6 Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

229.7 Psycho-Education: Psycho-educational groups are designed to educate consumers about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to consumers' lives. to instill self-awareness, suggest options for growth through change, identify community resources that can assist consumers in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

SERVICE DESCRIPTIONS

The following are descriptions of various treatment services available to consumers served within the RUHS-BH system of care. These services are available to consumers receiving outpatient, intensive outpatient, residential, withdrawal management and opioid treatment services. See the sections above pertaining to additional services including screening, assessment, and recovery support services.

230 GROUP COUNSELING

Group counseling sessions are designed to support discussion among consumers, with guidance from the facilitator to support understanding and encourage participation, on

psychosocial issues related to substance use. Group counseling sessions need to utilize one of the multiple Evidence Based Practices curriculums that RUHS-BH offers to consumers.

A consumer who is seventeen years of age or younger cannot participate in group counseling with a consumer that is eighteen (18) years of age or older ***unless*** the counseling occurs at a DMC certified program's school site ***or*** the consumer is receiving Perinatal Services.

230.1 Group counseling sessions are available at all levels of care and are defined as face-to-face contact between up to two (2) registered or certified SUD counselors or LPHAs, and between two (2) and no more than twelve(12) consumers at the same time.

230.2 A separate Progress Note must be written for each consumer and documented in the consumer's chart. Residential shall adhere to their established standard of Option one or Option two described as follows:

Option One:

- Document each service with an individualized progress note. Services requiring a progress note include Intake, Individuals, Group Counseling, Patient Education, Family Therapy, Collateral Services, Crisis Interventions, Treatment Planning, Discharge Services, and Case Management.
- Use a transportation log including; Date of transportation, time out and in, purpose of trip and signature with printed name and date of person logging the transportation.
- Option Two: Develop a group and Patient Education daily note template to include:
- Type of each service, topic, time in and time out.
- Daily summary progress note for listed services relating progress or lack of progress towards individual's specific treatment plan problems, goals, action steps, objectives, and/or referrals.
- Use a transportation log including; Date of transportation, time out and in, purpose of trip and signature with printed name and date of person logging the transportation.
- Document all other services including Intake, Individuals, Collateral Services, Crisis Interventions, Treatment Planning, Discharge Services and Case Management with an individual progress note recorded by the LPHA or counselor who performed the service.

230.3 Group sign-in sheets will be established and maintained for every group counseling session and include 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 signatures(s) must be adjacent to the typed or legibly printed names(s). By signing the sign-in sheet, the LPHA(s) and /or counselor(s) attest that the sig-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.
- A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session.
- The participants shall sign the sign-in sheet at the start of or during the counseling session.

230.4 The frequency of group counseling sessions in combination with other treatment services shall be based on medical necessity and individualized consumer needs rather than a prescribed program required for all consumers.

230.5 In an effort to provide flexible group times, consumers may attend any outpatient modality that is offered as long as the consumer attends the proper hours per week for the modality they are enrolled in. The exception to this would be gender specific or age specific groups.

231 INDIVIDUAL COUNSELING

231.1 Individual counseling sessions are designed to support direct communication and dialogue between the staff and consumer. Sessions will focus on psychosocial issues related to substance use and goals outlined in the consumer's individualized treatment plan.

231.2 Individual counseling sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) registered counselor, certified counselors or LPHA, and one (1) consumer at the same time.

231.3 An individualized progress note, which includes progress or lack of progress, must be written for each session and documented in the consumer's chart.

231.4 Each consumer is required to record his or her attendance at individual sessions. The provider shall implement a sign-in process for individual sessions.

231.5 The frequency of individual counseling sessions, in combination with other treatment services shall be based on medical necessity and individualized consumer needs rather than a prescribed program required for all consumers.

231.A DHCS Face-to-Face Info Notice

232 CRISIS INTERVENTION

232.1 These sessions are immediate and short-term encounters that focus on (1) stabilization and immediate management of the crisis, often by strengthening coping mechanisms and (2) alleviating a consumer's biopsychosocial functioning and well-being after a crisis.

232.2 Crisis interventions are provided when there is a relapse or an unforeseen event or circumstance causing imminent threat of relapse.

232.3 A component of this service includes linkages to ensure ongoing care following the alleviation of the crisis. Crisis Intervention sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) registered counselor, certified counselors or LPHA, and one (1) consumer at the same time. Services may, however, involve a team of care professionals.

232.4 An individualized progress note, which includes progress or lack of progress, must be written for each session and documented in the consumer chart.

232.5 Crisis intervention sessions are not scheduled events, but need to be available to the consumer as needed during the agency's normal operating hours or in alignment with afterhours crisis procedures.

233 FAMILY THERAPY

233.1 Family therapy is a form of psychotherapy that involves both consumer and their family members, and uses specific techniques and evidence-based approaches (e.g. family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit.

233.2 Family therapy sessions are available at all levels of care and are defined as face-to-face contact between one (1) therapist level LPHA, one (1) consumer and family members.

233.3 An individualized progress note, which includes progress or lack of progress, must be written for each session and documented in the consumer's chart.

233.4 The frequency of family therapy sessions, in combination with other treatment services shall be based on medical necessity and individualized consumer needs, rather than a prescribed program required for all consumers.

234 COLLATERAL SERVICES

234.1 Collateral services are sessions between significant persons in the life of the consumer (e.g., personal, not official or professional relationship with consumer) and SUD counselors or LPHAs. The sessions are used to obtained useful information regarding the consumer to support his or her recovery.

234.2 The focus of collateral services is on better addressing the treatment needs of the consumer.

234.3 Collateral services sessions are available at all levels of care and are defined as face-to-face contact between one (1) SUD counselor or LPHA, one (1) consumer and significant persons in the consumer's life. The consumer **does not** need to be present for a collateral service.

234.4 An individualized progress note, which includes progress or lack of progress, must be written for each session and documented in the consumer's chart.

234.5 The frequency of collateral services sessions, in combination with other treatment services shall be based on medical necessity and individualized consumer needs rather than a prescribed program required for all consumers.

235 CASE MANAGEMENT

235.1 Each counselor will be trained to avail needed knowledge, skills, and attitudes, which prepare them to provide more treatment-specific services. Effective practice of case management includes the ability to establish rapport quickly, an awareness of how to maintain appropriate boundaries in the fluid case management relationship, and the willingness to be nonjudgmental towards consumers.

235.2 Examples of case management competencies include, but are not limited to:

- The ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.
- The ability to recognize the importance of family, social networks, and community systems in the treatment recovery process.
- Demonstrate an understanding of the variety of healthcare options available, and the importance of helping the consumer access those benefits.
- Demonstrate an understanding of the diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice.

235.3 Case management is a method to help consumers achieve their goals throughout treatment. Case management will begin as soon as a consumer engages in the RUHS-BH screening process and shall be provided to all consumers.

235.4 Consumers shall be guided through the system of care, linkages will be made to ancillary services, and consumers will be assisted in connecting the next needed ASAM level of care from detoxification through recovery services (aftercare).

235.5 Case management will be utilized as a method to provide thorough discharge planning through implementation of aftercare plans that include access to on-going Recovery Support Services, vocational rehabilitation, sober living housing, and access to childcare and parenting services to enhance the capacity of each consumer to achieve long-term recovery.

235.6 Case management is available at all levels of care and is defined as a face-to-face or telephone contact between one (1) registered counselor, certified counselors or LPHA, and one (1) consumer at the same time.

235.7 A progress note must be written for each case management interaction and documented in the consumer's chart.

235.8 Providers may use case management services as an adjunct to outpatient and intensive outpatient treatment services to improve the consumer's ability to navigate their active treatment episode.

235.A DHCS Case Management FAQ

236 DRUG TESTING PROCESS

Drug testing should be viewed and used as a therapeutic tool. A punitive approach to drug testing generally does not facilitate a productive relationship with consumers and should be avoided. Consequences to drug testing should also be communicated in a therapeutic manner.

236.1 Alcohol and drug testing is the examination of biological specimens (e.g., urine, blood, hair) to detect the presence of specific drugs and determine prior drug use. Drug testing is best utilized when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) should ideally vary as well.

236.2 If body fluids testing (urinalysis) is performed, the consumer's emission of the urine must be collected and observed by an employee with the same gender to protect against the falsification and/or contamination of the urine sample.

236.3 Drug testing is a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions.

236.4 The frequency of alcohol and drug testing should be based on the consumer'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 as happening higher in frequency.

236.5 Alcohol and drug testing is allowable at all levels of care.

236.6 Documentation must be completed for all alcohol and drug tests in consumer's chart.

236.7 Positive Drug Tests: Decisions about effective responses to positive drug tests and relapses should take into account:

- The chronic nature of addiction.
- That relapse is a manifestation of the condition for which people are seeking SUD treatment.
- That medications or other factors may at times lead to false or inappropriately positive drug test results.

237 RELAPSE PROCEDURE

237.1 Recovery and psychosocial crisis cover a variety of situations that can arise while a consumer is in treatment. Examples include, but are not limited as described below:

- Slip/using alcohol or other drugs while in treatment.
- Suicidal and the individual is feeling impulsive or wanting to use alcohol or other drugs.
- Loss or death, disrupting the person's recovery and precipitating cravings to use or other impulsive behavior.
- Disagreements, anger, frustration with fellow consumers or therapist.

237.2 The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

- Counselors or LPHAs should set up a face-to-face appointment as soon as possible. If an appointment is not possible in a timely fashion, counselors or LPHAs should follow the next steps via telephone.
- Counselors or LPHAs should convey an attitude of acceptance. Counselors or LPHAs should listen and seek to understand the consumer's point of view rather than lecture or enforce "program rules." Counselors or LPHAs should avoid authoritarian or dismissive perspectives and be mindful of any counter transference or reactivity towards the consumer.
- Counselors or LPHAs should assess the consumer's safety for current intoxication/withdrawal or potential. Counselors or LPHAs should also assess for any imminent risk of impulsive behavior and/or harm to self, others, or property. The six ASAM assessment dimensions shall be utilized to screen for severe problems and identify any new issues in all biopsychosocial areas.
- If no immediate needs are present, counselors or LPHAs shall discuss the circumstances surrounding the crisis and develop a sequence of events including precipitants leading up to the crisis. If the crisis is a slip, counselors

or LPHAs will utilize the ASAM six dimensions as a guide to assess causes. If the crisis appears to be willfully defiant, towards treatment plan goals, counselors or LPHAs shall explore the consumer's understanding of the treatment plan, level of agreement on the strategies in the treatment plan and possible reasons why he or she did not follow through.

- Counselors or LPHAs will modify the treatment plan with consumer input to address any new or updated problems that arose from the ASAM multidimensional assessment.
- Counselors or LPHAs will reassess the treatment contract and what the consumer wants out of treatment, if there is resistance or ambivalence towards modification of the treatment plan. If it becomes clear that the consumer is mandated and "doing time" rather than "doing treatment and change," counselors or LPHAs will explore what ASAM Dimension four (4), Readiness to Change motivational strategies may be effective in re-engaging the consumer into treatment.
- Counselors or LPHAs should determine if the modified strategies can be accomplished in the current level of care, or a more or less intensive level of care in the continuum of services or different services such as Co-Occurring Disorder (COD) enhanced services are warranted. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.
- If, on completion of step six (6), the consumer recognizes the problems, and understands the need to change the treatment plan, but still chooses not to accept treatment, then discharge may be appropriate. Such a consumer may also demonstrate his/her lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in gambling behavior while in treatment. If such behavior is a willful disruption to the treatment milieu and not an overwhelming ASAM Dimension five (5) issue, then discharge or criminal justice sanctions are appropriate to promote a recovery-oriented environment.
- If the consumer is invested in treatment as evidenced by a willingness to change or update his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a consumer for an acute reoccurrence of signs and symptoms breaks continuity of care at a crisis time when the consumer needs support to continue treatment. For example, if the consumer is not acutely intoxicated and has alcohol on his/her breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change his/her treatment plan. Concerns about "triggering' others in the

group are handled no differently from if a consumer was sharing trauma issues, sobbing and this triggered identification and tearfulness in other group members. Such a consumer with Posttraumatic Stress Disorder would not be excluded from group or asked to leave for triggering others. Group members and/or other consumers in a residential setting are best helped to deal with such "triggering" with the support of peers and a trained clinician. To protect fellow consumers from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills. In addition, it jeopardizes the safety of the consumer at the very time he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.

- Document the crisis and modified treatment plan or discharge the medical record.

Mee-Lee, David (2017), Improving Skills and Systems to Implement The ASAM Criteria.

238 CHARTING AND DOCUMENTATION (QI TEAM)

Clinical documentation refers to anything in the consumer's EHR that describes the care provided to that consumer and the reasoning for any services delivered. All progress notes are to be observational and narrative in content as they tell the story of the consumer that is being served.

Clinical documentation is a critical component of quality care delivery and serves multiple purposes including but not limited to helping to ensure comprehensive and quality care, ensures an efficient way to organize and communicate with other providers, protects against risk and minimizes liability, complies with legal, regulatory and institutional requirements and helps to facilitate quality improvement and application of utilization management. The Treatment Timeline provides guidance when charting should occur.

238.1 The Provider shall establish, maintain, and update as necessary, an individual consumer record for each consumer admitted to treatment and receiving services.

238.2 Each consumer's individual record shall include documentation of personal information.

238.3 Documentation of personal information shall include all of the following:

Information specifying the consumer's identifier (i.e., name, number).
Date of consumer's birth, the consumer's sex, race and/or ethnic background, the consumer's address and telephone number, the consumer's next of kin or emergency contact.

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

- Date of the original treatment service was provided
- SUD Screening;
- Intake and admission data, including, if applicable, a physical examination;
- Treatment plans;
- Progress notes;
- Continuing services justifications;
- Laboratory test orders and results;
- Referrals;
- Counseling notes;
- Discharge plan;
- Discharge summary;
- Contractor authorizations for residential services;
- Monthly Medi-Cal eligibility print-outs; and
- Any other information relating to the treatment services rendered to the consumer.

Treatment Plan

238.5 The initial treatment plan serves as a guide and must be individualized and based on the information obtained during the intake and assessment process. The initial treatment plan must be completed within:

- 30 days of admission for Outpatient /IOT.
- 28 days of admission for OTP/NTP.
- 10 days of admission for Residential.
- Day 1 for Withdrawal Management level of care.

238.6 For each consumer 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.

238.7 The LPHA or counselor shall attempt to engage the consumer to meaningfully participate in the preparation of the initial or updated treatment plan. The initial and subsequent treatment plans shall include:

- A statement of problems identified through the SUD Screening, other assessment tool(s) or intake documentation.
- Goals to be reached which address each problem.
- Action steps that will be taken by the Provider and/or consumer to accomplish identified goals.
- Target dates for accomplishment of actions steps and goals.
- A description of services, including the type of counseling, to be provided and the frequency thereof.
- Assignment of a primary therapist and counselor.
- The consumer's DSM-5 diagnosis language as documented by the Medical Director or LPHA.
- The treatment plan shall be consumer driven.
- If a consumer has not had a physical examination within the 12-month prior to the consumer's admission to treatment date, a goal that the consumer have a physical examination should be present on the treatment plan.
- If documentation of a consumer's physical examination, which was performed during the prior twelve months, indicates a consumer has a significant medical illness, a goal that the consumer obtains appropriate treatment for the illness shall be included on the treatment plan.

238.8 The Provider shall ensure that the LPHA or counselor types or legibly prints their name, signs and dates the initial treatment plan within thirty (30) calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.

238.9 The consumer shall review, approve, type or legibly print their name, sign and date the initial treatment plan within thirty (30) calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.

- If the consumer refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the consumer to participate in treatment in a progress note.
- For outpatient clinics, the consumer's progress shall be reviewed and documented within 30 calendar days after signing the treatment plan and not later than every 30-calendar days thereafter.

238.10 If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review it to determine whether services are a medically necessary and appropriate for the consumer.

- 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 fifteen (15) days of the counselor's signature. The signature shall be adjacent to the typed or legibly printed name.

238.11 The LPHA or counselor shall complete, type or legibly print their name, sign and date updated treatment plans 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 reflect the current treatment needs of the consumer.

For OTP providers, updated plans are revised at least every (3) months from the date of admission or when a change in problem or focus of treatment occurs. The signature shall be adjacent to the typed or legibly printed name. The updated treatment plan shall reflect the current treatment needs of the consumer.

- For OTP providers, the supervising counselor shall review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans 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, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and shall record the following:

1. Countersignature to signify concurrence with the findings; and
2. Amendments to the plan where medically deemed appropriate.

238.12 The consumer shall be encouraged to review, approve, type or legibly print their name and, sign and date the updated treatment plan. The signature shall be adjacent to the typed or legibly printed name.

- If the consumer refuses to sign the updated treatment plan, the Provider shall document the reason for refusal and any strategies used to engage the consumer to participate in treatment.

238.13 After the counselor and consumer complete the updated treatment plan, the Medical Director or LPHA shall review each plan to determine whether continuing services are a medically necessary and appropriate for the consumer.

- If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, he or she shall type or legibly print their name, sign and date the updated treatment plan, within fifteen (15)

calendar days of the counselor's signature. The signature shall be adjacent to the typed or legibly printed name.

Progress Notes

238.14 Progress notes and individual narrative summaries shall contain the following:

- The topic of the session or purpose of the service.
- A description of the consumer's progress or lack of progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
- Information on the consumer's attendance shall be documented including the date, start/end times of each individual and group counseling session or treatment service.
- Documentation shall identify if services were provided in-person, by telephone, or by telehealth.
- If services were provided in the community, documentation shall identify the location and how the provider ensured confidentiality was upheld.

LPHA/counselor must type or legibly print their name, sign and date (to include electronic signatures) within seven (7) days of the provided service date. The signature shall be adjacent to the typed or legibly printed name.

238.15 Progress notes for outpatient, Naltrexone, and recovery treatment services requires a minimum of one progress note for each consumer participating in structured activities including counseling sessions.

- The LPHA or counselor must type or legibly print their name, sign and date (to include electronic signatures) within seven (7) calendar days of the provided service. The signature shall be adjacent to the typed or legibly printed name.
- The staff providing the service within seven (7) calendar days of the service being provided must document all individual services.

238.16 Progress notes for residential services require at a minimum, all notes be written in Data Assessment Plan (DAP) format. The physician, LPHA, or counselor is to type or legibly print their name, sign and date (to include electronic signatures) the progress note. Each note shall be recorded within seven (7) calendar days of the session. The signature shall be adjacent to the typed or legibly printed name.

- The LPHA or counselor shall document individual services within seven (7) calendar days of the service being provided.
- At a minimum, the LPHA or counselor shall document group services weekly.
- Residential Provider Option One: Document each service with an individualized progress note.

- Progress notes shall be legible and completed as follows:
- For each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each consumer who participated in the counseling session or treatment service.
- The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.
- Progress notes are individual narrative summaries and shall include all of the following:
- The topic of the session or purpose of the service.
- A description of the consumer's progress or lack of progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
- Information on the consumer's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
- Identify if services were provided in-person, by telephone, or by telehealth.
- If services were provided in the community, identify the location and how the provider ensured confidentiality.
- Relate what (if any) evidenced based practice was utilized.
- Residential Provider Option Two: Develop a group and Patient Education daily note.
- Daily Progress Notes are to be legible and completed as follows:
    1. The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within seven calendar days of the session. The signature shall be adjacent to the typed or legibly printed name.
    2. Progress notes are individual narrative summaries and shall include all of the following:
        - A description of the consumer's progress or lack of progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
        - A record of the consumer's attendance at each counseling session including the date, start and end times and topic of the counseling session.
        - Identify if services were provided in-person, by telephone, or by telehealth.

- If services were provided in the community, identify the location and how the provider ensured confidentiality.
- Relate what (if any) evidenced based practice was utilized.

238.17 Progress notes for case management services shall be documented by the LPHA or counselor who provided the treatment service as follows:

- Consumer's name.
- The purpose of the service.
- A description of how the service relates to the consumer's treatment plan problems, goals, action steps, objectives, and/or referrals.
- Contain the date, start and end times of each service.
- Identify if services were provided in-person, by telephone, or by telehealth.
- If services were provided in the community, the note shall identify the location and how the provider ensured confidentiality was upheld.

238.18 For physician consultation services, additional MAT, and withdrawal management, the Medical Director or LPHA working within their scope of practice, which provided the treatment service, shall ensure documentation is present in a progress note in the consumer's file.

- The Medical Director of LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.

Sign-In Sheets

238.19 Group Sign-in Sheet Requirements:

- A sign-in sheet is required for every group counseling session.
- The typed or legibly printed name and signature of the LPHA(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete. LPHA or counselor will sign and date the sign-in sheet on the same day of the session.
- Must include date, topic, and start and end time of the counseling session.
- A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

238.20 Individual Sign-in Sheet Requirements:

- Effective March 13, 2017, each consumer is to record their attendance at individual sessions.
- At a minimum, confirmation of attendance in one-on-one services will be available for review as requested by County Monitors.

238.A 22 CCR § 51476(a)

239 CONTINUING SERVICES

239.1 For case management, intensive outpatient treatment, Naltrexone treatment, and outpatient services each consumer, no sooner than five (5) months and no later than six (6) months after the consumer's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the consumer's progress and eligibility to continue to receive treatment services, and recommend whether the consumer should or should not continue to receive treatment services at the same level of care.

239.2 For each consumer, no sooner than five (5) months and no later than six (6) months after the consumer's admission to treatment date or the date of completion of the most recent justification for continuing service, the Medical Director or LPHA shall determine medical necessity for continued services for the consumer. The determination of medical necessity shall be documented by the Medical Director or LPHA in the consumer's individual record and shall include documentation that all of the following have been considered:

- The consumer's personal, medical and substance use history.
- Documentation of the consumer's most recent physical examination.
- The consumer's progress notes and treatment plan goals.
- The LPHA's or counselors recommendation pursuant to the first bullet point above.
- The consumer's prognosis.
- The Medical Director or LPHA shall type or legibly print their name, sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.

239.3 If the Medical Director or LPHA determines that continuing treatment services for the consumer is not medically necessary, the Provider shall discharge the consumer from the current level of care and arrange for the consumer to an appropriate level of treatment services. For more information on re-assessment see Section 204.

239.4 For OTP/NTP, annually the Medical Director or LPHA shall reevaluate and document in the consumer record the facts justifying the decision to continue treatment. The justification shall include:

- A summary of the progress or lack of progress on each goal identified on the most recent treatment plan.
- A statement that failure to continue treatment would lead to a return to opiate addiction.

240 DISCHARGE AND TRANSITION

Discharge or transition planning is available at all levels of care and is the process of preparing the consumer for referral into another level of care. This ensures consumer continuum of care, post-treatment return, reentry into the community, and/or other linkages necessary for greater success with long-term recovery.

240.1 Consumers should always be referred to recovery services at the very least when transitioning through RUHS-BH systems of care or its providers.

240.2 Discharge planning is openly discussed between staff and consumer at the onset of treatment services to ensure sufficient time to plan for the consumer's transition to additional levels of care if determined medically necessary.

240.3 A discharge plan is a planned discharge that takes place while the consumer is still in treatment and must be completed within thirty (30) days prior to the final face-to-face service.

- If a consumer is transferred to a higher or lower level of care based on the 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.
- During the LPHA's or counselor's last face-to-face treatment with the consumer, the LPHA or counselor and the consumer shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the consumer and documented in the consumer record. The signatures shall be adjacent to the typed or legibly printed name.

240.4 A discharge plan must, at minimum, include a description of each relapse triggers, a specific plan to assist the consumer to avoid relapse when confronted with each trigger, and a support plan.

240.5 A discharge summary is to be completed for all consumers regardless of level of care or successful/unsuccessful completion.

240.6 For a consumer with whom a provider has lost contact or who does not attend treatment for more than thirty (30) days, Providers must discharge the consumer

and complete a discharge summary within thirty (30) calendar days of the date of the Provider's last face-to-face treatment contact with the consumer.

240.7 The discharge summary must include:

- The duration of the consumer's treatment, as determined by dates of admission to and discharge from treatment.
- The reason for discharge.
- A narrative summary of the treatment episode. and
- The consumer's prognosis.

240.8 Discharge of a consumer from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, a Notice of Adverse Benefit Determination, (NOABD) shall be sent for an involuntary discharge.

Riverside University HEALTH SYSTEM
Behavioral Health
Substance Abuse Prevention and Treatment Program

Approved for clinical practices, content and supporting documentation:

Chang 12/30/19

Matthew Chang, Medical Director **Date**
Riverside University Health System-Behavioral Health

M Khan MD 12/24/19

M-Shahid Atique Khan, MD **Date**

Rhyan Miller 12/19/19

Rhyan Miller, Deputy Director **Date**
Forensics and Substance Abuse Prevention

QUALITY ASSURANCE AND MONITORING

Quality assurance and monitoring will adhere to the larger framework established by RUHS-BH Agency, and DHCS AOD, DMC-ODS, and EQRO oversight. The following documentation contains guidelines to follow within each of these overseeing bodies and requirements.

300 ADVERSE INCIDENTS

300.1 In the event an adverse incident occurs involving consumers, Providers will report incidents through the established process found in County Policy #248.

301 CULTURAL COMPETENCY AND ACCESS

301.1 The Providers shall promote the delivery of services in a culturally competent manner to all consumers, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation of gender identity.

301.2 Providers are responsible to make available culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations.

301.3 The Providers shall provide physical access, reasonable accommodations, and accessible equipment for Medicaid consumers with physical or mental health challenges.

301.4 To ensure equal access to quality care by diverse populations, each Provider shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards and comply with 42 CFR 438.206(c)(2).

301.5 The Providers shall make interpretation services available free of charge to each consumer. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the County identifies as prevalent.

301.6 The Providers shall notify consumers that oral interpretation is available for any language and written translation is available in prevalent languages. Riverside County's threshold language is Spanish.

301.7 The Providers shall notify consumers that auxiliary aids and services are available upon request and at no cost for consumers with disabilities and how to access the services.

301.8 The Providers shall provide all written materials for potential consumers and consumers consistent with the following:

- Use easily understood language and format.

- Use a font size no smaller than 12 point.
- Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of consumers or potential consumers with disabilities of limited English proficiency.
- Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

302 CONTRACTING

Contracts with contracted Providers are issued once a year. The term of the agreement is Fiscal year July 1 XXXX through June 30, XXXX. New contracted Providers may be added through a competitive bid process as described in Section 4, "Contracting with RUHS-BH SAPT."

302.1 Bulletins: Periodically, bulletins will be issued by SAPT Administration during a contract fiscal year. Changes are mandatory and are monitored for compliance by QI monitoring.

Provider may contact SAPT Administration for a complete library of bulletins.

303 HIPAA AND 42 CFR PART (2) COMPLIANCE

Annual training is mandatory for Providers. Resources are available and listed below.

303.1 County policies pertaining to Personal Identifiable Information (PII) are available to review and comply with.

303.A HIPAA – Confidentiality-Sensitive Information Manual DRAFT

303.B County Policies pertaining to Personal Identifiable Information (PII) #239, #239 Attachment, #298, #299

303.C 42 CFR Part 2 Confidentiality Forms

304 MONITORING

304.1 Providers are monitored by DHCS for AOD compliance, DMC compliance and by the PSPP unit.

304.2 The Providers will make available, for the purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid consumers.

304.3 DHCS, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the Provider will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

304.4 If DHCS, CMS or the HHS Inspector General determines that there is reasonable possibility of fraud or similar risk, DHCS, CMS or the HHS Inspector General may inspect, evaluate and audit the Provider at any time.

304.5 The County shall monitor the Provider's performance on a triannual basis and subject Providers at a minimum, to an annual onsite review, consistent with statutes, regulations and service delivery requirements under the DMC-ODS Waiver.

304.6 The County will identify deficiencies or areas for improvement, Providers shall take corrective actions and the County will ensure the implementation of these corrective actions.

304.7 Corrective Action Plans (CAP) will be required from Providers for State and County Monitoring findings.

304.8 New Providers shall receive technical assistance the first year under contract with County.

305 NON-DISCRIMINATION IN EMPLOYMENT

Providers shall not unlawfully discriminate against any person as defined under the laws of the United States and the State of California. Refer to Section Five: References for applicable laws.

306 NON-DISCRIMINATION OF PROVIDERS

During the procurement process for SAPT Contracted Providers, RUHS-BH will adhere to the criteria outlined in the DMC-ODS 1115 Waiver Intergovernmental Agreement:

306.1 RUHS-BH cannot limit consumer access in any way when selecting Contracted Providers. Standards for access include:

- Timeliness
- Geographic distribution of care
- Threshold language and cultural competence
- Physical access for disabled consumers
- Coordination of physical and mental health services
- Access to Medication Assisted Treatment services

306.2 RUHS-BH will apply policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.

306.3 RUHS-BH will not discriminate against persons who require high-risk or specialized services.

306.4 RUHS-BH will select only providers that have a license and/or certification issued by the state that is in good standing (documentation of license/certification required)

306.5 RUHS-BH will select only providers that, prior to the furnishing of services, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations, have been screened in accordance with 42 CFR 455.450(c) as a "high" categorical risk prior to furnishing services, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104.

306.6 RUHS-BH will select only providers that have a Medical Director who, prior to the delivery of services under RUHS-BH contract, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director under RUHS-BH contract, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107

306.7 RUHS-BH will not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of their certification.

306.8 It is the policy of the RUHS-BH to maintain a provider selection and retention criteria. The selection procedure for Mental Health Plan (MHP) contracted providers does not discriminate against particular provides that serve high-risk populations or specialize in conditions that require costly treatments. The MHP may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

306.9 RUHS-BH will not select providers who are under investigation for Medi-Cal fraud, RUHS-BH will ask provider to attest to not being under investigation during the procurement process.

307 CONSUMER GRIEVANCES AND APPEALS

Forms may be requested from QI-Outpatient.

306.A Consumer/Consumer Problem Resolution Process

306.B DHCS Information Notice Grievances IN 18-010E

308 CONSUMER RIGHTS

Providers will adhere to Consumer Rights as outlined by 42 CFR 438.100.

308.1 Consumers have the right to be treated with respect and with due consideration for his or her dignity and privacy.

308.2 Consumers have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the consumer's condition and ability to understand. (The information requirements for services that are not covered under the Agreement because of moral or religious objections are set forth in 42 CFR §438.10(g)(2)(ii)(A) and (B).)

308.3 Consumers have the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

308.4 Consumers have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

308.5 Consumers have the right if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request, and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

308.6 Each consumer is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Provider treats the consumer. Documents may be requested from SAPT Administration.

308.A SU Consumer Protection

308.B Consumer Rights Flyer

308.C DHCS Consumer Protections FAQ

309 CONSUMER SATISFACTION

309.1 Quarterly Treatment Perception Surveys will be conducted for all consumers in County Clinics and Provider facilities. RUHS-BH Research and Evaluation department will send surveys to all facilities and manage data collection and submittal to UCLA.

309.2 Pursuant to 42 CFR 438.3(I), Providers will allow each consumer to choose his or her health professional to the extent possible and appropriate.

309.A DHCS Treatment Perceptions Survey Info Notice

309.B DHCS Treat Perceptions Survey Info Notice

310 PROVIDER CONSUMER COMMUNICATIONS

310.1 The Providers may advise or advocate on behalf of the consumer who is their consumer regarding:

- The consumer's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

- Any information the consumer needs to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The consumer's right to participate in decisions regarding his or health care, including the right to refuse treatment.
- To express preferences about future treatment decisions.

311 PROVIDER GRIEVANCE AND APPEALS

311.1 Service denials and appeals may occur through the course of Providers billing for services. Services may be denied for various reasons. Steps for County processing and Provider feedback and appeals are available by request from SAPT Administration or QI.

311.A Service Denial Letter

311.B Provider Denied Service Report (Example)

311.C QI Provider Appeal Form

311.D SU Waiver Denial and Appeal Flow Chart

312 QUALITY IMPROVEMENT PLAN

312.A QI FY 19-20 Plan

312.B DHCS Quality Management FAQ

313 TRAINING

Providers will ensure personnel attend required State and County trainings at onset of contracting with County and throughout contractual period.

313.1 Required clinical trainings are State CalOMS, DMC Waivered County Compliance, ASAM Multi-dimensional Assessment (ASAM B) and From Assessment to Service Planning and Level of Care (ASAM C) and two evidenced based practice trainings. It is strongly recommended clinicians attend SUD Adult and/or Adolescent Screening Tune-up training.

- MDs and LPHAs shall provide proof of at least five (5) continuing education credits in addiction medicine annually. Documentation shall be filed in personnel file.
- Certified counselors shall maintain documentation of all continuing education credits for recertification in their personnel files.

313.2 With respect to other trainings, Providers shall provide proof of completion in personnel files of 42 CFR Part (2) and HIPAA (every two years), Human Trafficking, and Cultural Competency (annually).

313.3 Periodic, ongoing training is provided by the County throughout the year. Some training may be mandatory to satisfy monitoring deficiencies.

313.4 Annual Cost Report Training shall be attended by Provider's fiscal personnel.

313.A CalOMS Web Training

313.B CIBHS ASAM and Waiver Trainings

314 CREDENTIALING

314.1 Providers are responsible for adhering to DHCS credentialing requirements through primary sources. QI shall verify Provider policy of the following information from each network provider, as applicable:

- Work history;
- Hospital and clinic privileges in good standing;
- History of any suspension or curtailment of hospital and clinic privileges;
- Current Drug Enforcement Administration identification number;
- National Provider Identifier number;
- Current malpractice insurance in an adequate amount, as required for the particular provider type;
- History of liability claims against the provider;
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

314.2 Attestation – County shall obtain from all network providers who deliver covered services, a signed and dated statement attesting to the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
- A history of loss of license or felony conviction;
- A history of loss or limitation of privileges or disciplinary activity;
- A lack of present illegal drug use; and

- The application's accuracy and completeness.

314.3 County shall verify and document at a minimum every three years that each contracted provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. The County shall require each contracted provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing shall include documentation that the County has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

314.4 Providers are responsible for adhering to DHCS credentialing requirements through primary sources. QI shall verify documentation of the following information from each network provider, as applicable:

- The appropriate license and/or board certification or registration, as required for the particular provider type;
- Evidence of graduation or completion of any required education, as required for the particular provider type;
- National Provider Identifier number;
- Current malpractice insurance in an adequate amount, as required for the particular provider type
- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
- Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

315 NOTICE OF ADVERSE BENEFIT DETERMINATION

315.1 Adverse Benefit Determination is defined to mean any of the following actions taken by a Plan:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;

- The failure to act within the required timeframes for standard resolution of grievances and appeals; or
- The denial of a beneficiary's request to dispute financial liability.

315.2 Providers shall follow steps and criteria as outlined in DHCS Information Notice 18-010E. Additionally, all documentation shall be submitted to QI-Outpatient department within 24 hours of determination and notification to consumer.

315.A NOABD FAQ

315.B NOABD Instructions

315.C DHCS Information Notice Grievances IN 18-010E

315.D NOABD Denial Notice Template

315.E NOABD Payment Denial Notice Template

315.F NOABD Delivery System Notice Template

315.G NOABD Modification Notice Template

315.H NOABD Termination Notice Template

315.I NOABD Timely Access Notice Template

315.J NOABD Financial Liability Notice Template

315.K NOABD Your Rights

315.L NOABD Adverse Benefit Determination Upheld Template

315.M NAR Your Rights

315.N NAR Adverse Benefit Determination Overturned Template

315.O Beneficiary Non-Discrimination Notice (May be requested from QI)

315.P Language assistance tag lines (May be requested from QI)

315.Q NOABD Authorization Delay Notice Template

315.R NOABD Grievance and Appeal Timely Resolution Notice

316 PROVIDER ADEQUACY REPORTING

316.1 Provider shall submit to RUHS-BH documentation verifying it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards developed by DHCS. Documentation shall be submitted no less frequently than the following:

- At the time it enters into this Contract with the COUNTY;

- On A monthly basis; and
- At any time there has been a significant change, as defined by RUHS-BH, in the CONTRACTOR's operations that would affect the adequacy capacity of services, including the following:

    1. A decrease of twenty-five percent (25%) or more in services or providers available to beneficiaries;
    2. Changes in benefits;
    3. Changes in geographic service area; and
    4. Details regarding the change and CONTRACTOR's plans to ensure beneficiaries continue to have access to adequate services and providers

4. SAPT ADMINISTRATIVE OVERSIGHT

400 AUTHORIZATION TO ADMIT CONSUMERS INTO PROVIDER FACILITIES

The SU CARES staff is responsible for all residential placements and coordinating intake date with Contract Providers. Once placement is approved, the SU CARES department will fax a placement authorization and applicable documentation to the Contract Provider. Upon intake, the Contract Provider shall complete the admissions process and submit admission documentation to SAPT Administration.

For transitions to a lower level of care and outpatient services, placement is not required to be processed by the SU CARES department. Contract Providers will ensure placement criteria is met, enroll the consumer in appropriate level of care, and submit admission documentation to SAPT Administration.

400.1 Per County Contract Exhibit A, Contract Providers are to submit admission documentation for individuals admitted prior to 1:00 p.m. on holidays or weekends to SAPT Administration office prior to 1:00 p.m. the next working day via fax or secure file transfer. Contract Provider's documentation will be reviewed for accuracy and validity. Admissions placed and approved by the SU CARES will be submitted on the DAS SAPT 6027 Placement Referral form. Admissions completed by the Contract Provider (transitions and outpatient services) shall be submitted on the SAPT Contractor Admission- Service Authorization Request Admissions must be accompanied by proof of Drug Medi-Cal eligibility (as applicable). All admissions for the month must be received from the Contract Provider no later than the 5th of the following month.

Corrections to admission documents that are incomplete or invalid will be requested via email from SAPT Administration clerical staff. Emails will be sent to Contract Provider line staff. Corrections are due within twelve (12) hours of a sent email.

400.2 SAPT Administration clerical staff shall complete a service authorization in the EHR for all admissions. The service authorization is unique to specific consumer, date(s) of episode, program and level of care. Each service authorization indicates consumer length of stay and approved amount of billing units per episode. Also, refer to sections 404.1 through 404.4.

400.3 Unit authorizations vary by modality:

- Withdrawal management ten (10) days.
- Withdrawal management for Co-Occurring fourteen (14) days.
- Residential treatment adults ninety (90) days, adolescents thirty (30) days.
- ODF and IOT six (6) months.

- OTP 365 days.
- MAT varies by provider.

400.4 Extension requests are reviewed by SAPT Administration and approved based on medical necessity. Contract Providers are required to submit extension requests to SAPT Administration as soon as need is established. Extension requests are required to be submitted prior to rendering services exceeding initial authorization. Approved extensions will be entered in the EHR. Refer to section 400.6 for denial process.

400.5 Residential Services for adults may be authorized for up to ninety (90) days in one continuous period and Residential Services for adolescents may be authorized for up to thirty (30) days in one continuous period. Reimbursement will be limited to two (2) non-continuous regimens in any one-year period (365 days). One extension of up to thirty (30) days beyond the maximum length of stay may be authorized for one (1) continuous length of stay in a one (1) year period (365 days) for both adults and adolescents. In keeping with the EPSDT mandate, consumers under the age of 21 are eligible to receive services needed to correct and ameliorate health conditions that care coverable under section 1905(a) Medicaid authority. Refer to DHCS Information Notice 16-042 regarding EPSDT residential requirements. Perinatal consumers shall receive a length of stay for the duration of their pregnancy, plus thirty (30) days post-partum. Adolescent consumers shall receive a longer length of stay if medically necessary.

400.6 Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope, that is less than requested, shall be made by an individual who has appropriate expertise in addressing the consumer's medical and behavioral health issues. SAPT Administration shall notify Contracted Provider, and give the consumer written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The consumer's notice shall meet the requirements of 42 CFR §438.404.

400.A DHCS Information Notice 16-042 Residential Treatment Services and Residential Authorizations

401 BILLING

Contract Providers will treat and bill the majority of consumers under DMC-ODS guidelines. Billing staff shall be expected to understand the rules and regulations to bill for treatment services through RUHS-BH SAPT.

401.1 DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in Riverside County. Determination of who may receive the DMC-ODS benefit shall be performed in accordance with

DMC-ODS Special Terms and Conditions (STC) 128(d), Article II.E.4. Providers shall not charge DMC consumers for covered services under the DMC-ODS Waiver.

401.2 Contract Providers are responsible for ensuring that any of its staff members or personnel in which they employ, is licensed or certified to practice and is in possession of a valid, current license or certificate to practice or to provide mental health or other required services, to consumers. Contract Providers who receive Medi-Cal funds are required to validate and submit a signed statement to RUHS-BH with their monthly invoice to confirm that their staffs are not on either the OIG Exclusion List and/or the Medi-Cal list of Suspended or Ineligible Providers list. In addition, Contract Providers providing Medi-Cal billable services must have, and provide in writing to SAPT Administration, pursuant Section XLVI, NOTICES, of Contract Agreement, a valid rendering site and/or individual provider NPI and taxonomy code that corresponds with the work they are performing. Any updates or changes must be made by the Contract Provider to the National Plan & Provider Enumeration System (NPPES) within thirty (30) days. Contract Providers shall establish their own procedures to ensure adherence to these requirements.

401.3 Contract Providers will be required to obtain access to verify Medi-Cal eligibility via the state system. Contract Providers must verify Medi-Cal eligibility determination of an individual. When Contract Providers conduct the initial eligibility verification, it shall be reviewed and approved by SAPT Administration prior to payment for services. Contract Providers shall verify Medi-Cal eligibility on all consumers at time of admission, and every month thereafter while the consumer remains in treatment.

401.4 In addition to verifying Medi-Cal Eligibility, Contract Providers shall review the Aid Code indicated on all eligibility verifications to ensure the Aid Code is DMC reimbursable.

401.5 County Residence Requirement: Contract Providers shall adhere to providing services to consumers who reside in Riverside County. DMC eligibility documentation must also reflect Riverside County as the County of Responsibility. Consumers who live in other counties and have out of county DMC shall be referred back to their respective county of residence.

401.6 Contract Providers shall utilize RUHS-BH developed service codes for billing submissions. Service codes are detailed in the SAPT Procedure Code Manual. During the RUHS-BH claiming process, the designated service codes are translated to the required Healthcare Common Procedure Coding System (HCPCS) codes including appropriate modifiers and unit designation, aligning with DHCS MHSUDS Information Notice 17-045 and DHCS DMC Billing Manual.

401.7 As indicated in the SAPT Procedure Code Manual, certain consumer categories will be assigned specific service codes. These categories include Youth, Perinatal, and Perinatal-Youth:

Youth service codes will be utilized for eligible EPSDT consumers up to the age of 21. In keeping with the ESPDT mandate, consumers under the age of 21 are eligible to receive services needed to correct and ameliorate health conditions that care coverable under section 1905(a) Medicaid authority. EPSDT regulatory guidelines take precedence over DMC-ODS.

Perinatal service codes will be utilized for pregnant or post-partum consumers receiving treatment in a Perinatal-Certified DMC Provider. Medical documentation that substantiates the consumer's pregnancy and the last day of pregnancy shall be maintained in the consumer's record. Contract Providers are required to submit notification to SAPT Administration that proof of pregnancy is on file. Post-partum covers the first day after the termination of pregnancy; sixty (60) days post-partum and the end of the month the sixty (60) days falls in.

Perinatal-Youth service codes will be utilized for those consumers that meet both the Youth and Perinatal category.

401.8 As part of the DMC-ODS Waiver State-County contract, the State will permit a consumer to receive more than one (1) service per calendar day by various providers. There will be no requirement to use the Multiple Billing Override (MBO) code for multiple services on the same date. Services will be allowed to have a multiple billing in the same day when the combination of services does not have a conflict.

401.9 Upon contract execution, Contract Providers are trained by SAPT Administration in RUHS-BH's EHR system. All billing service entry is submitted through the EHR system. In addition to instructions provided in the Contract Provider EHR User Guide, there are specific rules for submitting service line entry for group services. These guidelines ensure the group prorating formula is captured accurately, consistent with guidelines set by DHCS DMC Billing Manual.

401.10 Contract Providers must submit final billing entries by the fifth calendar day of every month for prior month services. Contract Providers shall submit PVD 2003 ELMR Invoice Summary Report, Letterhead, and Program Integrity Form (PIF) to ELMR_PIF@rcmhd.org .

401.11 Other Healthcare Coverage: Pursuant to California Code of Regulations (CCR), Title 22, Section 51005(a) and Title 42 CFR 433.138, if a consumer has Other Healthcare Coverage (OHC), then the Contract Provider shall bill that OHC prior to billing DMC to receive payment from the OHC, or a notice of denial from the OHC indicating that: a) The recipient's OHC coverage has been exhausted, or b) The specific service is not a benefit of the OHC.

401.12 Each consumer is required to utilize their OHC prior to Medi-Cal when the same service is available under the recipient's private health coverage. Providers are not allowed to deny Medi-Cal services based upon potential third party liability. If the recipient elects to seek services not covered by Medi-Cal, Medi-Cal is not liable for the cost of those services. To establish Medi-Cal's liability for a covered Medi-Cal service, the Provider must obtain an acceptable denial letter from the OHC entity.

401.13 If the Contract Providers submit a claim to an OHC and receives partial payment of the claim, the Contract Providers shall submit a copy of Explanations of Benefits (EOB) to SAPT Administration. RUHS-BH will submit any claim to DMC and the Contractor is eligible to receive payment up to the maximum DMC rate for the service, less the amount of the payment made by the OHC. Contract Providers are required to submit documentation of OHC denials to SAPT Administration.

401.14 OTP Contract Providers are excluded from the OHC regulation.

401.15 Residential Services: Room and board units shall not be a covered expenditure under the DMC-ODS. Room and board units will be billed under SAPT Block Grant as identified on the Provider's Agreement Schedule I.

401.16 Share of Cost: Some Medi-Cal recipients must pay, or agree to be obligated to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called the Share of Cost (SOC). Consumers are not eligible to receive Medi-Cal benefits until their monthly SOC dollar amount has been certified. SOC is certified once the verification system shows the consumer has paid, or has become obligated to pay for the entire monthly dollar SOC amount.

401.17 Obligated payments mean the Contract Providers will allow the consumer to pay for the services at a later date or through an installment plan. Obligated payments may be used to clear SOC. RUHS-BH is not responsible for obligated payments. This agreement is with the Contract Provider and the consumer.

401.18 Providers should perform a SOC clearance transaction immediately upon receiving payment or accepting obligation from the consumer for the service rendered. Delays in performing the SOC clearance transaction may prevent the consumer from receiving other medically needed services. SOC clearance transactions are completed via the state website. Once SOC is cleared, Contract Providers are to submit printouts/copies of SOC transactions to SAPT Administration.

401.19 ACH Steps County of Riverside offers Automated Clearing House (ACH) Deposits for Providers. See County of Riverside ACH Enrollment Form.

- Complete the ACH form and mail it to the address provided on the form.
- Vendor Number: If the Provider does not have a vendor number, e-mail Cheryl (ChWilson@ruhealth.org) to request one.
- ACH Coordinator: If it does not apply or the Provider does not have this information, type or write in "Not Applicable".
- Ensure that the appropriate person with signature authority signs the form.
- A business card for the person with signature authority must be attached to the form.
- Attach a "voided" blank check to the form; Auditor Controller's Office has the correct banking institutional information.
- Processing should take approximately four (4) weeks to complete. If the Provider has any issues, contact the Auditor Controller's Office at the email address or phone number listed on the form. It is a message only phone number. A representative will return the call.
- Once the ACH Deposit is completed, and if the Provider is banking information changes, the Provider must submit a new ACH Enrollment Form and select the "Change" box.
- Should the Auditor Controller's Office suspect fraudulent activity, it will stop ACH Deposits for the financial safety of both the Provider and the County of Riverside and revert to issuing warrants by mail.

Contact SAPT Administration for copies of current forms.

401.A	ACH Enrollment Form
401.B	Aid Codes
401.C	SAPT Provider User Guide
401.D	DHCS Billing FAQ.....
401.E	DHCS DMC Billing Manual:
401.F	DHCS DMC- ODS FAQ .....
401.G	DHCS Information Notice No 17-036 County of Responsibility Transition
401.H	DHCS Information Notice No 17-045 Drug Medi-Cal Organized Delivery System Healthcare Common Procedure Coding System and Modifiers
401.I	DHCS Information Notice No 17-039 Same Day Billing
401.J	DMC OHC Requirement and OTP
401.K	County of Residence Eligibility Guide

401.L PIF Letterhead Template

401.M Other Health Care Documents: ADP Bulletin 11-01

401.N Other Health Care Providers Contact Information

401.O ODF and IOT Group Billing Instructions

401.P Procedure Code Manual – Post Waiver

401.Q Program Integrity Form

401.R Understanding Aid Code Master Chart

402 CERTIFICATION REQUIREMENTS

SAPT requires Contracted Providers and County clinics to obtain both AOD and DMC certifications from DHCS. It is the responsibility of the Contracted Provider to provide updated certifications to SAPT and at no time should certifications lapse.

402.1 Renewable AOD certifications will designate the modalities approved at the location under RUHS-BH contract. Residential providers will also have identified ASAM levels of service, Withdrawal Management, and/or Incidental Medical Services (IMS) approvals.

402.2 DMC certifications and DHCS supplemental certification letters shall contain, at a minimum, a four-(4) digit DMC number, an NPI number, a California Outcomes Measurement System (CalOMS) number, Effective date, Service Location address, modalities and special populations identified.

402.3 Both AOD and DMC certifications shall be posted in a public space.

402.4 Providers shall notify the County immediately upon notification from DHCS that its license, registration, certification or approval to operate an SUD program or a covered service is revoked, suspended, modified, or not renewed by DHCS.

402.5 All DMC certified Providers shall be subject to continuing certification requirements at least once every five (5) years.

402.6 DHCS may allow the Providers to continue delivering covered services to consumers at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.

402.7 DHCS shall conduct unannounced certification and recertification on-site visits at clinics pursuant to W&I Code, Section 14043.7.

402.A AOD Facility Licensing

402.B DMC Provider Enrollment Certification

403 CONTRACTING WITH RUHS-BH SAPT

Providers are selected through a competitive bidding process pursuant to policies set forth by the County of Riverside Purchasing and Fleet Department. Proposals are reviewed, evaluated and scored. Quality of proposal response, modalities of service, location and need are a few factors considered. Selected providers are required to maintain an AOD and DMC certification as described in section 402.

403.1 It is the policy of the RUHS-BH to maintain a provider selection and retention criteria. The selection procedure for RUHS-BH contracted providers does not discriminate against particular provides that serve high-risk populations or specialize in conditions that require costly treatments. RUHS-BH may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

403.2 Provider shall not knowingly have any prohibited type of relationship with the following:

- An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 C.F.R. § 438.610(a)(1)].
- An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in this section [42 C.F.R. § 438.610(a)(2)]

403.3 Provider shall not have a prohibited type of relationship by employing or contracting with providers or other individuals and entities excluded from participation in Federal health care programs (as defined in section 1128B(f) of the Social Security Act) under either Section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act [42 C.F.R. §§ 438.214(d)(1), 438.610(b); 42 U.S.C. § 1320c-5].

403.4 CONTRACTOR shall not have any types of relationships prohibited by this section with an excluded, debarred, or suspended individual, provider, or entity as follows:

- A director, officer, agent, managing employee, or partner of the CONTRACTOR [42 U.S.C. § 1320a-7(b)(8)(A)(ii); 42 C.F.R. § 438.610(c)(1)].
- A subcontractor of the CONTRACTOR, as governed by 42 C.F.R. § 438.230. [42 C.F.R. § 438.610(c)(2)].
- A person with beneficial ownership of 5 percent (5%) or more of the CONTRACTOR's equity [(42 C.F.R. § 438.610(c)(3)].
- An individual convicted of crimes described in section 1128(b)(8)(B) of the Act [42 C.F.R. § 438.808(b)(2)].

- A network provider or person with an employment, consulting, or other arrangement with the CONTRACTOR for the provision of items and services that are significant and material to the CONTRACTOR's obligations under this Contract [42 C.F.R. § 438.610(c)(4)].

403.5 CONTRACTOR shall not employ or contract with, directly or indirectly, such individuals or entities for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services, or the establishment of policies or provision of operational support for such services [42 C.F.R. § 438.808(b)(3)].

403.6 County also requires a monthly signed acknowledgement from contracted providers when submitting their monthly billing that they performed their due diligence in verifying compliance with the above.

403.7 County monitors excluded parties reports annually.

403.8 Additional information is requested at the onset of initial contract and subsequent contract renewals.

403.9 SAPT monitoring will conduct an initial review of a new Provider and regular onsite technical assistance visits throughout the first year. Renewed Providers are monitored as described in Section IV- "Program Supervision, Monitoring and Review" of the Provider Agreement, as well as the Exhibit A of each contract. Training occurs after contract execution.

403.10 Access to RUHS-BH requires that Providers submit a completed CARF, Provider enrollment documents for each practitioner, VPN request and SFTP application.

403.11 Provider practitioners are required to submit copies of valid certifications and printouts of individual NPI numbers before practitioners provide any service. Individual practitioner's NPI will reflect the address of employing Provider. It is the responsibility of Provider to ensure timely updates of active practitioners by contacting SAPT Administration. See 401.2 for more information.

403.12 SAPT Administration shall track all practitioners using the Practitioner Required Information form.

403.13 DMC eligibility access will be required to bill for DMC recipients. Application to access State website is also required. PIN is assigned when DMC certification is issued by DHCS.

403.14 Providers who are not selected for a contract, full or partial after completing the competitive bid process, may protest the decision through Riverside County Purchasing.

403.15 Providers shall comply with the regulations and guidelines listed in Section 5- Resources.

Documentation may be requested through SAPT Administration.

403.A ADA Checklist

403.B Competitive Bid Appeal Process

403.C Medi-Cal Website

403.D CARF Template

403.E New Provider Information Form and Document Checklist

403.F NPI Registry

403.G Practitioner Enrollment Request Form

403.H SFTP Application

403.I VPN Request Agreement

403.J VPN Request Form

404 DATA ENTRY- CONTRACT PROVIDER AND SAPT ADMINISTRATION

404.1 SAPT Administration and Contract Providers are both involved in the data entry process on each consumer's record. Data is entered into the RUHS-BH EHR System via VPN and EHR account login. Every Contract Provider is required to submit, at minimum, one (1) VPN request to obtain access to the RUHS-BH EHR System. Contract Providers obtain an EHR account during the initial contract process, as detailed in section 403.

404.2 SAPT Administration clerical staff shall complete preliminary admissions data entry. Data entry includes consumer demographic information, financial eligibility, and assigned Contractor program and location. Admissions are assigned to Provider caseload in the EHR, which gives the Contract Providers access to enter consumer data into the EHR. Residential episodes are to be entered into the EHR by SAPT Administration within twenty-four (24) hours of receiving admission documentation from Contract Providers.

404.3 Daily, assigned SAPT Administration clerical staff shall send email notifications to the Contract Provider's line staff indicating admissions have been entered into the EHR. Email includes medical record number, last name, authorization number, program ID, level of care, and the consumer's admission date.

404.4 Once the consumer is available on Provider caseload in the EHR, Contract Providers are required to enter the following data as completed:

- Diagnosis.
- CalOMS Admission.
- ASAM Data Collection.

- CalOMS Discharge.
- CalOMS Annual Update (as applicable).

404.5 Two (2) reports are available to Contract Providers to assist with maintaining updated and current data on the Provider caseload:

- PVD Provider Open Caseload Report: All open consumers assigned to specific provider, sorted by Program ID.
- PVD 2010 CalOMS and Diagnosis Data Entry Validation: Report generates a list of any consumers assigned to a caseload that are missing CalOMS Admission form and/or Diagnosis entry.

  Documentation may be requested through SAPT Administration.

  404.A Annual Updates after Initial Instructions- Data Entry

  404.B ASAM Data Collection Instructions

  404.C Contract Provider Report Access

  404.D DAS Discharge Data Entry Instructions

405 PROVIDER ADDING/CHANGE NOTIFICATIONS

County Administration and AOD and DMC Certified Providers are responsible for maintaining accurate records with DHCS. Administration will update any State Analyst and report through DHCSMPF@dhcs.ca.gov to update the Master Provider File (MPF) when changes occur with Contracted Providers. Providers will assist County with adhering to these requirements.

405.1 Providers will notify the County when the Provider applies for any new or additional services by location.

405.2 Providers will notify the County if there is any change in status to its AOD or DMC certification status by the State.

405.3 Providers shall notify the County after any change in ownership or executive management.

405.4 Providers shall notify the County if there is any change in Medical Director or their DMC approved status.

406 REPORTS MANAGED BY SAPT ADMINISTRATION

SAPT Administration manages quality assurance for billing, contractual compliance and adherence to state certification and CalOMS requirements. Reports are run weekly, monthly and annually, to verify Contract Providers are meeting expectations in the above-mentioned areas.

406.1 CalOMS treatment data is due to DHCS by the 15th of each month. CalOMS Compile Error Reports reveal errors that must be corrected prior to submission. SAPT Administration reviews errors and then sends email(s) to Contract Provider's line staff and Supervisors detailing incorrect or missing CalOMS data. Outstanding data is due within three (3) days of email request. Compliance with CalOMS reporting is mandatory.

406.2 The DAS 1000 Open Caseload Report is run every other week to identify consumers who have not received a service in thirty (30) days. SAPT Administration sends reports to Contract Providers monthly via email.

406.3 The Drug and Alcohol Treatment Access Report (DATAR) tracks capacity and waitlists for each location. It is a State requirement for all facilities to submit statistics monthly. An email reminder is sent to all providers the fifth of every month from SAPT Administration. If the fifth falls on a weekend, notification will be sent the Friday prior. If DATAR is not completed by the specified deadline, Contract Providers will appear on the DHCS County Non- Compliance Report. Any Provider appearing on this report will be notified via email. Providers are required to submit late DATAR submissions within one (1) day of any non-compliance email.

406.4 The Patient Accounts Department sends the Void and Replace Report to SAPT Administration monthly. This report identifies all denied Medi-Cal services and the reason for denial. SAPT Administration reviews reports, corrects any internal errors, and will contact Contract Providers requesting supporting documentation on services that may be eligible for rebilling.

406.5 Annual updates are required for those Provider participants in treatment for twelve (12) months or more, continuously in one provider and one service modality with no break in services exceeding thirty (30) days. The Provider must collect the CalOMS Treatment data approximately one (1) year from the day the individual was admitted to that specific provider and service modality. Annual updates are required for all treatment program participants. New admissions entered on or after January 1, 2006 will require an annual update on the admission anniversary date in 2007 and each year thereafter that the consumer is in the same program and modality continuously. First and all subsequent annual updates should be collected no later than the anniversary date of the admission. Annual update information can be collected earlier than twelve (12) months, as early as sixty (60) days prior to the individual's admission date anniversary as well.

SAPT Administration generates the Annual Update Due Report. This report identifies consumers that are due, past due for annual updates, or may need review for discharge. Updates or past due discharges from Provider staff are due within one (1) week of report generation.

Documentation may be requested through SAPT Administration.

406.A Contract Provider Report Access

407 STATE REPORTING COMPLIANCE

All certified facilities are required to adhere to mandated reporting by DHCS. “Any Provider that receives any public funding for SUD treatment services and all Opioid Treatment Program (OTP) Providers must report CalOMS Treatment data for all of their consumers receiving treatment, whether those individual consumer services are funded by public funds or not.

Providers will collect consumer data at admission and at discharge or administrative discharge from the same treatment program. Data will also be collected annually as an annual update for consumers in treatment for over twelve (12) months” (CalOMS Treatment Data Dictionary, 2014).

Additionally, “Treatment Providers that receive state or federal funding through the State or the County, as well as all licensed Opioid Treatment Programs (OTP), must send DATAR information to DHCS each month” (Department of Healthcare Services).

407.1 CalOMS Annual Update reporting. All Providers and County clinics are required to adhere to CalOMS guidelines pertaining to proactively extending consumers who will be in a treatment episode for twelve (12) months or longer.

407.2 Open Caseload reporting. All Providers and County clinics are required to adhere to CalOMS guidelines pertaining to discharging consumers who have not participated in a service within thirty (30) days.

407.3 DATAR Reporting and Compliance. Facility must log in to DATAR website and submit a DATAR capacity report to the State by the tenth (10) of every month. The report tracks capacity and waitlist information. Every site must be reported. Contact SAPT Administration for log-in user ID assistance for DATAR training and system log-in.

407.A CalOMS Collection Guide

407.B CalOMS Data Dictionary

407.C DATAR Log-in

407.D DATAR State Instruction

408 TERMINATING CONTRACT WITH COUNTY

408.1 In the event of contract termination as described in County Agreement Section XXIX Termination Provisions, County will notify current consumer’s treated by Provider within fifteen (15) days of written notice of termination of options for continuing treatment.

408.2 The County will notify DHCS (SUDCountyReports@dhcs.ca.gov) of Provider termination and basis for termination of the Provider within two (2) business days of termination notification.

408.3 The County is the owner of all patient care/client records. In the event that the Agreement is terminated, the Provider is required to prepare and box the client medical records so that the County, according to the procedures developed by the County, can archive them. The County is responsible for taking possession of the records and storing them according to regulatory requirements. The County is required to supply the Provider with a copy of any medical record that is requested by the Provider, as required by regulations, at no cost to the Provider, and in a timely manner.

408.4 At the time of termination, the window of time relevant to 408.3 above shall be client records within seven (7) years following discharge of the client, with the exception of un-emancipated minors, which shall be kept at least seven (7) years after such minor has reached the age of eighteen (18) years.

409 TRAINING AND INFORMATION UPDATES-ADMINISTRATION

409.1 Administrative training for RUHS-BH's EHR, including billing and CalOMS data entry (CARF form required), will be immediately scheduled after contract execution.

409.2 Administration will train Providers on checking DMC eligibility fundamentals and understanding Aide Codes.

409.3 Periodic, ongoing training is provided by the County throughout the year.

409.4 Contracted Provider executives and/or managers are required to attend County Provider meetings held every other month on the second Thursday of the month from 12:00 p.m. -2:00 p.m. and lunch will be served. Topics may include updates from the Program Administrator about Statewide changes, industry topics and from SAPT personnel pertaining to compliance, administrative changes and an interactive question and answer period.

409.A Aid Code Manual

409.B CalOMS Web Training

409.D Medi-Cal Eligibility Website

5. RESOURCES

500 LAWS AND REGULATIONS

This Practices and Procedures document, along with other federal, state and local regulations govern the delivery of SUD treatment services in Riverside County. Below is an extensive listing of laws and regulations that are to be followed. For a comprehensive and detailed listing, please refer to the DHCS and Riverside County Agreement:

Federal

500.1 42 Code of Federal Regulation (CFR) Part 2 of Substance Use Disorder Consumer Records

500.2 42 CFR Part 428 Managed Care

500.3 Health Insurance Portability and Accountability Act (HIPAA)

500.4 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.

500.5 Title IX of the Education Amendments of 1972 (Regarding education programs and activities).

500.6 Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of [ability to pay], race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.

500.7 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.

500.8 Age Discrimination in Employment Act (29 CFR Part 1625).

500.9 Title I of the Americans with Disabilities Act (29 CFR Part 1630).

500.10 Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.

500.11 Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.

500.12 The Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.

500.13 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.

500.14 Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.

500.15 The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

500.16 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.

500.17 The Americans with Disabilities Act of 1990 as amended.

500.18 Section 1557 of the Consumer Protection and Affordable Care Act.

500.19 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.

State

500.20 California Code of Regulations (CCR) Title 9 Counselor Certification

500.21 Title 9, Division 4, Chapter 8, commencing with Section 10800.

500.22 CCR Title 22 Drug Medi-Cal

500.23 Sobky v. Smoley (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994),

500.24 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.).

500.25 California non-discrimination act. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135**.**

Agency - DHCS

500.26 Drug Medi-Cal Special Terms and Conditions (Note: Refer to pages 96-128 and 384-415 for the DMC-ODS system. (Updated June 7, 2018))

500.27 Department of Health Care Services (DHCS) Perinatal Services Network Guidelines, 2018-19

500.28 DHCS Youth Treatment Guidelines, 2002

500.29 DHCS Alcohol and/or Other Drug Program Certification Standards, 2017

500.30 Minimum Quality Drug Treatment Standards SABG

County

500.30 Riverside County DMC-ODS Implementation Plan

500.31 Riverside County Organized Delivery System Contract for Substance Use Disorder (SUD) services.

500.32 Individual Provider Agreement's with County.

500.33 Riverside SAPT bulletins. (May be requested from SAPT Administration)

501 SAPT LICENSED AND CERTIFIED PROGRAMS

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

501.1 Title 21, CFR Part 1300, et seq.. Title 42, CFR, Part 8

501.2 Title 22, Sections 51490.1(a)

501.3 Title 9, Division 4, Chapter 4, Subchapter 1, Sections 50000, et seq. References and

501.4 Title 22, Division 3, Chapter 3, Sections 55000 et. seq.

502 NETWORK COVERAGE

County shall provide adequate coverage for network services. Documentation may be requested through SAPT Administration.

502.A Substance Abuse Network Coverage Map.

502.B Provider Directory and Modalities.

502.C County Clinic Locations.

503 TERMINOLOGY

503.1 Abuse: 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 consumer practices that result in unnecessary cost to the Medicaid program.

503.2 Adolescents: means consumers between the ages of twelve and under the age of twenty-one.

503.3 Administrative Costs: means the Provider's direct costs, as recorded in the Provider's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost do not include the cost of treatment or other direct services to the consumer. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Provider's overhead per approved indirect cost rate proposal pursuant to OMB Omni-Circular and the State Controller's Office Handbook of Cost Plan Procedures.

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

503.5 Authorization: is the approval process for DMC-ODS Services prior to providing Detoxification or Residential services.

503.6 Available Capacity: means the total number of units of service (bed days, hours, slots, etc.) that a Provider actually makes available.

503.7 Consumer: means a person who. a) has been determined eligible for Medi-Cal. b) is not institutionalized. c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. and d) meets the admission criteria to receive DMC covered services.

503.8 Consumer Handbook: is the state developed model enrollee handbook.

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

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

503.11 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.

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

503.13 Complaint: means requesting to have a problem solved or have a decision changed because you are not satisfied. A complaint is sometimes called a grievance or an appeal.

503.14 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.

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

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

503.17 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.

503.18 Discharge Services: means the process to prepare the consumer 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.

503.19 DMC-ODS Services: means those DMC services authorized by Title XIX or Title XXI of the Social Security Act. Title 22 Section 51341.1. W&I Code, Section 14124.24. and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver special terms and conditions.

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

503.21 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.

503.22 Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered consumers 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.

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

503.24 Emergency Medical Condition: means a medical condition manifesting itself by acute symptoms of sufficient 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.

503.25 Emergency Services: mans covered inpatient and outpatient services that are as follows:

Furnished by a provider that is qualified to furnish these services under this Title.

Needed to evaluate or stabilize an emergency medical condition.

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

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

503.28 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.

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

503.30 Fair Hearing: means the state hearing provided to consumers 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).

503.31 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 as the final settlement.

503.32 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.

503.33 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 an enrollee's right to dispute an extension of time proposed by the County to make an authorization decision.

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

503.35 Group Counseling: means contacts in which one or more therapists or counselors treat two or more consumers at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A consumer 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 consumer 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.

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

503.37 Individual Counseling: means contact between a consumer 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.

503.38 Intake: means the process of determining a consumer meets the medical necessity criteria and a consumer 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. And 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.

503.39 Intensive Outpatient Treatment: means (ASAM Level 2.1) structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 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.

503.40 Licensed Practitioners of the Healing Arts (LPHA) includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, 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.

503.41 Medical Necessity and Medical 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.

503.42 Medical Necessity Criteria: means adult consumers must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent treatment criteria. Consumers under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, consumers under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

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

503.44 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.

503.45 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.

503.46 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.

503.47 Network: means the group of entities that have contracted with the County to provide services under the DMC-ODS Waiver.

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

503.49 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.

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

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

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

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

503.54 Consumer Education: means providing research based education on addiction, treatment, recovery and associated health risks.

503.55 Participating Provider: means a provider that is engaged in the continuum of services under this Agreement.

503.56 Perinatal DMC Services: means covered services as well as mother/child habilitative and rehabilitatitve 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).

503.57 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.

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

503.59 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.

503.60 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 Waiver.

503.61 Preauthorization: means approval by County that a covered service is medically necessary.

503.62 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.

503.63 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.

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

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

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

503.67 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.

503.68 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.

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

503.70 Recovery Services: are available after the consumer has completed a course of treatment. Recovery services emphasize the consumer'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 consumers.

503.71 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 consumer to his best possible function level.

503.72 Relapse: means a single instance of a consumer's substance use or a consumer's return to a pattern of substance use.

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

503.74 Residential Treatment Services: means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to consumers. Each consumer 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 consumer for outpatient treatment.

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

503.76 Service Authorization Request: means a consumer's request for the provision of a service.

503.77 Short-Term Resident: means any consumer 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.

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

503.79 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 consumer/consumer services.

503.80 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 the County to provide any of the administrative functions related to fulfilling the County's DMC-ODS Waiver obligations.

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

503.82 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.

503.83 Support Groups: means linkages to self-help and support, spiritual and faith-based support.

503.84 Support Plan: means a list of individuals and/or organizations that can provide support and assistance to a consumer to maintain sobriety.

503.85 Telehealth Between Provider and Consumer: means office or outpatient visits via interactive audio and video telecommunication systems.

503.86 Telehealth between Providers: means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

503.87 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.

503.88 Threshold Language: means a language that has been identified as the primary language, indicated on the Medi-Cal Eligibility System (MEDS), of 3000 consumers or five percent of the consumer population whichever is lower, in an identified geographic area. Riverside County's threshold language is Spanish.

503.89 Transportation Services: means provision of or arrangement for transportation to and from medically necessary treatment.

503.90 Unit of Service Description:

- For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a consumer in 15-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 visit or in 15-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 in 15-minute increments.
- For residential services, providing 24-hour daily service, per consumer, per bed rate.
- For withdrawal management per consumer per visit/daily unit of service.

503.91 Urgent Care: means a condition perceived by a consumer as serious, but not life threatening. A condition that disrupts normal activities of daily necessary, treatment within 24-72 hours.

503.92 Utilization: means the total actual units of service used by consumers and participants.

503.93 Withdrawal Management: means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS consumers.

Document may be requested from QI Outpatient.

503.A Riverside County Acronyms