Riverside University HEALTH SYSTEM

Behavioral Health

Substance Abuse Prevention and Treatment Program

Practices Guidelines

&

Procedure Manual

Contracted Providers

V.2
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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 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 and 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.

No State or Federal funds shall be used by the Provider for sectarian worship, instruction, and/or proselytization. No State funds shall be used by the provider to provide direct, immediate, or substantial support to any religious activity.

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

104.B Youth Treatment Guidelines

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.

2. 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 ASAM 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, 2017 through January 31, 2018, consumers shall receive an intake assessment within 14 calendar days by Provider after initial screening or request for service. 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 ASAM 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 ASAM screening and predetermination level of care will be entered into the Provider's Electronic Health Record (HER) at that time and the consumer shall be linked to an appointment before the call 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 FAX to RUHS-BH SAPT Administration 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

201.B County of Residence Guideline

201.C Adolescent ASAM

201.D Adolescent ASAM Level of Care Guidelines

201.E Adult ASAM

201.F Adult ASAM Level of Care Guidelines

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 Placement may be conducted by either the Provider or the SU CARES team.

202.6 When a predetermination of placement is conducted and the ASAM level of care is made, the Provider's MD and/or LPHA must then complete a full assessment to determine a diagnosis and confirm medical necessity.

202.7 When applicable, a medical 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 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. Additionally, they will fill out the SAPT Placement Referral form.

202.10 Providers are required to provide written notice to the 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.

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 Reports daily through email (sareferral@rcmhd.org) 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.

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 Medical Psychiatric Clearance Form

202.B SAPT Placement Referral Form

202.C DHCS Information Notice 16-042

202.D Bed Availability Report

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 MD or LPHA shall type or legibly print their name, and sign and date the documentation.

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 be 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 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 with the consumer to establish whether the consumer meets medical necessity criteria or not.

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 30 calendar days of each consumer's admission to treatment date.

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

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 SUP07-2016 Bulletin Medical Necessity Statement

205.C 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.

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, and
- 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:

Share of cost if applicable, notification of DMC funding accepted as payment in full and consent to treatment.

207.7 Access information of the following shall be provided to the consumer or posted in a prominent place visible 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.
- Program rules and expectations.

Pursuant to 42 CFR 438.100, Providers shall be responsible for distributing the Consumer Brochure to each consumer upon initial contact. The Consumer 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 which 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.

207.A Consumer Brochure

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

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 quarterly 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.

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

209.B SUP02-2015 Bulletin County Contract Exhibit A Staffing

209.C SUP09-2016 Bulletin Substance Use Disorder MD

210 SUBSTANCE USE DISORDER MEDICAL DIRECTOR

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.

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.

211.2 Providers will address personal lifestyles, attitudes and behaviors that can impact 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.

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.

212.1 Intensive outpatient services can be provided during the day, in evenings, during weekdays, or on weekends.

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 shall 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 child care 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.A DHCS Intensive Outpatient Treatment FAQ

212.B Perinatal Services Network Guidelines

213 PARTIAL HOSPITALIZATION (ASAM LEVEL 2.5)

Services feature twenty (20) or more hours of clinically intensive programming per week 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.

210.A DHCS Partial Hospitalization FAQ

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. 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 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

214.D DHCS Perinatal FAQ

214.E DHCS Residential FAQ

214.F SUP11-2016 Bulletin 90 Day Res Stay Option

214.G SAPT12-2017 Bulletin Residential Levels 3.1 3.3 3.5

214.H SAPT16-2017 Bulletin Leave of Absence from Residential Facilities

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 will be made available.

215.6 Addiction pharmacotherapy will 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 will 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 will be utilized in a therapeutic manner.

216.4 Recovery support services, including support for the affected family will 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 will be provided.

217.2 Daily organized programming will 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 will be utilized in a therapeutic manner.

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

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

217.7 Addiction pharmacotherapy will be made available.

217.8 An assessment will 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 will 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 will be utilized in a therapeutic manner.

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

218.6 Addiction pharmacotherapy will 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 will 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 will be provided to manage acute biomedical symptoms.

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

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

219.6 Addiction pharmacotherapy will be made available.

219.7 A physician will 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 will 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

220.D DHCS Withdrawal Management FAQ

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 three locations. Over the last two years RUHS-BH and DHCS have approved slot increases for the three OTP sites. Currently all three sites are not at capacity, and all three sites could expand to serve more consumers on an average of 75 per clinic. The Riverside OTP provider feels they could expand by

150 slots and that would still be 250 under licensed capacity. Providers will ensure the following are available:

226.1 Intake

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.A DHCS MAT Rates Info Notice

226.B DHCS MAT Rates Info Notice Attachment

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 will 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.

227.A DHCS MAT Info Notice

227.B DHCS MAT FAQ

227.C Release of Information

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 Recovery Services Screening Tool

228.B DHCS information notice on Peer Support

228.C Peer Support Info Notice Guide

228.D 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 can 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) to or more consumers at the same time.

230.2 A separate Progress Note must be written for each consumer and documented in the consumer's chart.

230.3 Group sign-in sheets must include signatures and printed names of consumers and group facilitators, date, start/end times, location, and group topic.

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.

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 A progress note must be written for each session and documented in the consumer's chart.

231.4 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 A progress note 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 A progress note 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 A progress note 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 will be provided to all consumers.

235.4 Consumers will 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

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:

- ASAM;
- 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.

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 ASAM, 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 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.

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.

- 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.

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.

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.

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

- 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.

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 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.

238.15 Progress note updates shall be documented for each individual and group counseling session and 7the counselor or LPHA shall record a progress note for each consumer in the session.

- 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.

238.16 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.
- All individual services must be documented by the staff providing the service within seven (7) calendar days of the service being provided.

238.17 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.

- Individual services shall be documented by the LPHA or counselor.
- At a minimum, group services shall be documented weekly by the LPHA or counselor.

238.18 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.

238.19 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.

Sign-In Sheets

238.20 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.
- 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.

238.21 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)

238.B SAPT13-2017 Individual Services Bulletin

238.C Treatment Timeline

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.

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 treatment 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.

240.4 A discharge plan must, at minimum, include a list of triggers, specific coping skills to address each trigger and a support plan.

- The counselor and the consumer must document their names legibly, sign and date the discharge plan.
- A copy of the discharge plan must be provided to the consumer and must become part of the consumer record.

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: 1) the duration of the consumer's treatment, as determined by dates of admission to and discharge from treatment. 2) the reason for discharge. 3) a narrative summary of the treatment episode. and 4) the consumer's prognosis.

3. 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 during a contract fiscal year.

Changes are mandatory and are monitored for compliance by SAPT monitoring.

302.A SUP02-2015 County Contract Exhibit A-Staffing

302.B SUP07-2016 Medical Necessity Statement

302.C SUP8-2016 6 Mo Justification for Continuing Services

302.D SUP09-2016 Substance Use Disorder Medical Director

302.E SUP10-2016 YT Service Code Change

302.F SUP11-2016 90 Day Res Stay Option

302.G SAPT12-2017 Residential Levels 3.1 3.3 3.5

302.H SAPT13-2017 Individual Services

302.I SAPT14-2017 CAP Certification

302.J SAPT15-2017 Pregnant 12-17 Outpatient Guideline

302.K SAPT16-2017 Leave of Absence from Residential Facilities

302.L SAPT17-2017ASAM LOC Data Collection

302.M SAPT18-2017 Waiver Intake and Assessments

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 quarterly 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.A SAPT14-2017 CAP Certification.

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 CONSUMER GRIEVANCES AND APPEALS

306.A Beneficiary/Consumer Problem Resolution Process

307 CONSUMER RIGHTS

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

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

307.2 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).)

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

307.4 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.

307.5 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.

307.6 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.

307.A SU Consumer Protection

307.B Consumer Rights Flyer

307.C DHCS Consumer Protections FAQ

308 CONSUMER SATISFACTION

308.1 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.

308.2 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.

308.A DHCS Treatment Perceptions Survey Info Notice

308.B DHCS Treat Perceptions Survey Info Notice

309 PROVIDER CONSUMER COMMUNICATIONS

309.1 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.

310 PROVIDER GRIEVANCE AND APPEALS

310.1 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.

310.A Service Denial Letter

310.B Provider Denied Service Report (Example)

310.C QI Provider Appeal Form

310.D SU Waiver Denial and Appeal Flow Chart

311 QUALITY IMPROVEMENT PLAN

311.A QI FY 16-17 Plan

311.B DHCS Quality Management FAQ

312 TRAINING

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

312.1 Required clinical training is State CalOMS. County DMC, ASAM A and B.

312.2 With respect to other annual trainings, Providers shall provide proof of completion in personnel files of 42 CFR Part (2), Human Trafficking, and Cultural Competency.

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

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

312.A CalOMS Web Training

312.B CIBHS ASAM and Waiver Trainings

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 Contractor Admission- Service Authorization Request Example

400.B DAS 6027 SAPT Placement Referral Form

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

400.D. Extension Form- Contract Provider Example

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 XXXIII, 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 5th 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 Veronica at VESanchez@rcmhd.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’s 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 back to issuing warrants by mail.

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

403.2 SAPT monitoring will conduct an initial review of a new Provider and regular onsite 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.

403.3 Access to RUHS-BH requires that Providers submit a completed Enrollment Form, enrollment documents for each Provider, VPN Forms request and SFTP application.

403.4 Provider practitioners are required to submit copies of valid certifications and print-outs of individual NPI numbers before any service is provided by practitioners. 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.

403.5 SAPT Administration shall track all practitioners using the Practitioner Required Enrollment form.

403.5 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.

403.6 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.

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

403.A ADA Checklist

403.B Competitive Bid Appeal Process

403.C Medi-Cal Website

403.D Practitioner Enrollment Form

403.E Provider Information Form and Document Checklist

403.F NPI Registry

403.G VPN Account Form

403.H SFTP Application

403.I VPN Request Agreement

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.

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 5th of every month from SAPT Administration. If the 5th 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 or 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.

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 they can be archived by the County, according to the procedures developed by the County. 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 State-wide 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 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 https://govt.westlaw.com/calregs/Document/I12C91B008DA411E4A0F094BBA3CAFB62?originationContext=Search+Result&listSource=Search&viewType=FullText&navigationPath=Search/v3/search/results/navigation/i0ad60024000001576cde19f6a3bcd7bd?startIndex%3d1%26Nav%3dREGULATION_PUBLICVIEW%26contextData%3d%28sc.Default%29&rank=1&list=REGULATION_PUBLICVIEW&transitionType=SearchItem&contextData=%28sc.Search%29&t_T1=22&t_T2=51341.1&t_S1=CA+ADC+s

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 89-122 and 335-363 for the DMC-ODS system. (Updated June 1, 2017))

500.27 Department of Health Care Services (DHCS) Perinatal Services Network Guidelines, 2016

500.28 DHCS Youth Treatment Guidelines, 2002

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

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.

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) https://govt.westlaw.com/calregs/Document/I575CFB0E6ECC483EB4752C561C8DF544?originationContext=Search+Result&listSource=Search&viewType=FullText&navigationPath=Search%2fv3%2fsearch%2fresults%2fnavigation%2fi0ad720f50000015ecf4df3d0d1615e20%3fstartIndex%3d1%26Nav%3dREGULATION_PUBLICVIEW%26contextData%3d(sc.Default)&rank=1&list=REGULATION_PUBLICVIEW&transitionType=SearchItem&contextData=(sc.Search)&t_T1=22&t_T2=51490.1&t_S1=CA+ADC+s

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.

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 Postservice Postpayment (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.

503.A Riverside County Acronyms

Attachments

Eligibility for SUDS Services by County of Residence

This document does not address medical necessity for services.

Clients CURRENTLY Living in Riverside County

Private Health Coverage	→	refer to private health insurer
Criminal Justice involved	→	admit with sliding scale fee as long as not privately insured
Undocumented	→	admit with sliding scale fee
Uninsured	→	admit with sliding scale fee
Medi-Cal	→	Verify eligibility at admission

Clients NOT Currently Living in Riverside County

Private Health Coverage	→	refer to private health insurer
Undocumented or Homeless	→	refer to home county or if willing, Case Manage toward changing Medi-Cal as described below
Uninsured	→	refer to home county
Medi-Cal	→	determine in which county the individual resides and in which county the individual's Medi-Cal is active: ✓ Refer back to home county or; ✓ Provide limited DMC services as described below or; ✓ Case Manage toward changing Medi-Cal to as described below

Medi-Cal Active in a County with Standard DMC Program (Non-ODS Pilot)

Non-County residents who are EPSDT can receive the following DMC services based on the standard DMC program

- ✓ Outpatient Treatment (Group Treatment Modality)
- ✓ Intensive Outpatient
- ✓ Perinatal Residential
- ✓ Opioid Treatment Program (Methadone maintenance or detox)

For all other services, individual shall be referred back to his/her home county for service

OR

Client can request Medi-Cal coverage to be transferred to Riverside and must be advised that a transfer in coverage:

- ✓ Will interrupt all other services the client and his/her family members currently receive via Medi-Cal, such as physical health, mental health, etc.

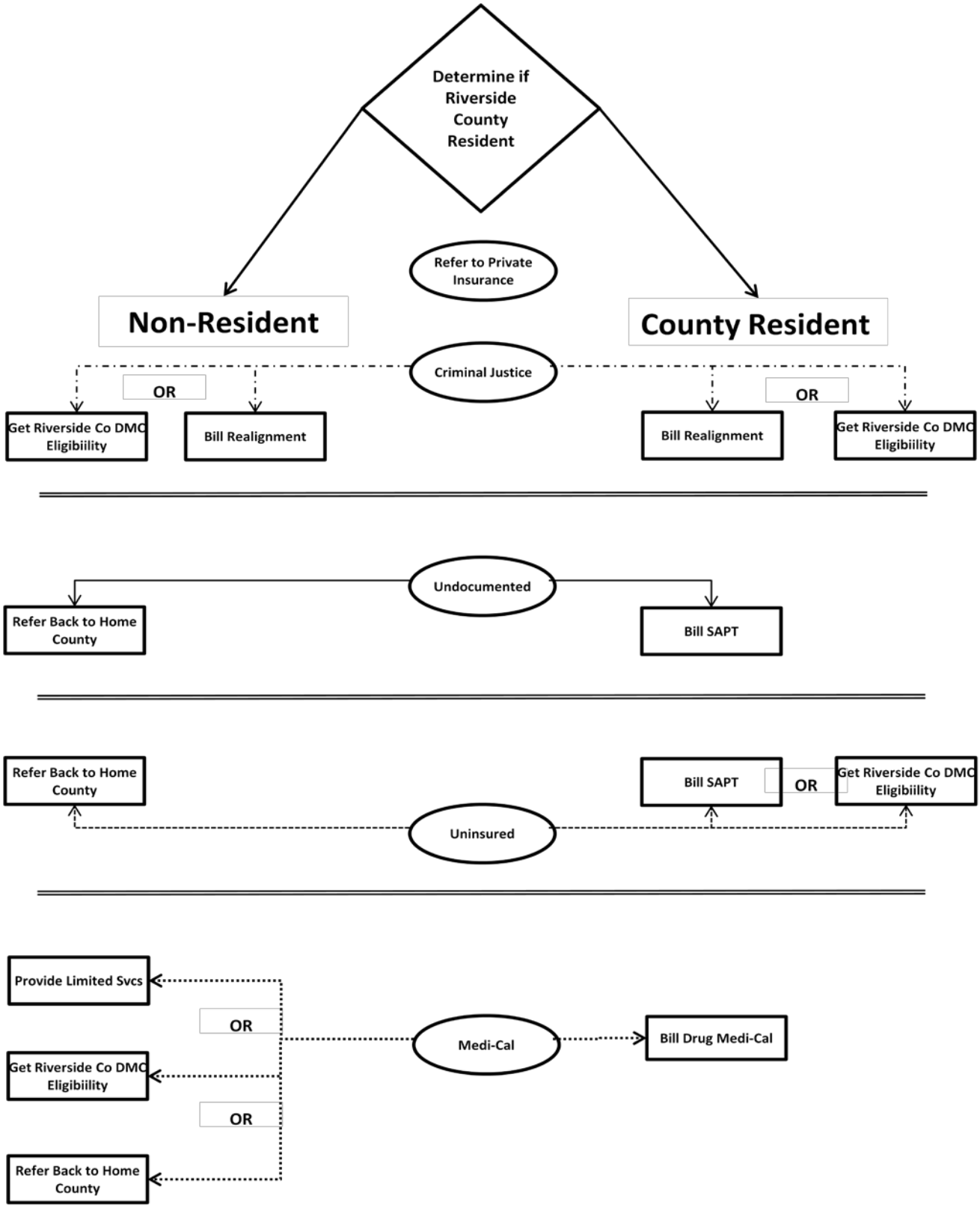
Medi-Cal Active in a DMC ODS Pilot County

Individual shall be referred back to home county where Medi-Cal is active

OR

Client can request Medi-Cal coverage to be transferred to Riverside and must be advised that a transfer in coverage:

- ✓ Will interrupt all other services the client and his/her family members currently receive via Medi-Cal, such as physical health, mental health, etc.



County Client Referral Numbers

Alameda	800-491-9099	San Bernadino	909-421-4601
Imperial	760-482-2138	San Diego	855-463-5408
Los Angeles	800-564-6600		
Orange	800-832-1200		
Oxnard/Ventura			
Santa Barbara	805-981-6830		

Riverside University HEALTH SYSTEM Behavioral Health

Treatment Program completes form . This form drives authorizations for service/billing entry.

Substance Abuse Prevention and Treatment Program
Contractor Admission – Service Authorization Request

FAX ... tion 951-683-4904

Initial is used for IOT or ODF consumers without a transfer of care within the last [30] days.

☐ Initial Request (IOT **or** ODF)

Transition is used if consumer is transitioning to next level of care within your agency.
*Consumers transitioning from Detox to Residential should coordinate with assigned Case Manager.

☐ Transit (Detox to Residential **or**

☐ Recovery Services (No ASAM Designation

Consumer must have successfully completed treatment in order to transition to Recovery Services within your own agency.

Form must be completed in it's entirety

C_____ (First)_____ **Gender:**_____
(Male,Female,Other)

Date of Birth: ____/____/_____

Social Security Number: _____-____-_____
(Make every attempt to obtain client's SSN)

Client ID: _____
(if known)

Admission Date: ___/___/_____

Program: MUST include Program Name and Program ID (RU)
_____
(Program Name & ID)

Admitting Practitioner: _____ Practitioner is required to be registered in ELMR

Client's Middle Name: _____ **Suffix:** _____

Client's Address: (Street)_____
(Street Number, Name, and Type)

Client's Address: (Zip Code) _____
*(**DMC Billing**: If Homeless, use Facility Address & Zip Code)*

Address must be provided. If client is 'Homeless' use facility address

Client's Primary Phone: ____-____-_____

Primary Language: _____

Marital Status:

☐ Single/Never Married ☐ Now Married
☐ Registered Domestic Partner ☐ Widowed
☐ Divorced/Annulled ☐ Separated

Maiden Name_____

The ASAM level indicated, assigned and any reason for discrepancy in this section must match ASAM completed by clinician.

ASAM Level Indicated

- ☐ **0.5** Early Intervention
- ☐ **1.0** Outpatient
- ☐ **2.1** Intensive Outpatient
- ☐ **2.5** Partial Hospitalization
- ☐ **3.1** Clinically Managed Low-Intensity Residential
- ☐ **3.3** Clinically Managed Population Specific High-Intensity Residential
- ☐ **3.5** Clinically Managed High-Intensity Residential
- ☐ **3.7** Medically Monitored High-Intensity Inpatient
- ☐ **4.0** Medically Managed Intensive Inpatient
- ☐ **OTP Level 1** Opioid Treatment Program
- ☐ **1.WM** Ambulatory Withdrawal Management (W/O Extended Onsite Monitoring)
- ☐ **2.WM** Ambulatory Withdrawal Management (with Extended On-Site Monitoring)
- ☐ **3.2WM** Residential/Inpatient Withdrawal Management Monitoring
- ☐ **3.7WM** Medically Monitored Inpatient Withdrawal Management
- ☐ **4.WM** Medically Managed Intensive Inpatient Withdrawal Management

ASAM Level Assigned

- ☐ **0.5** Early Intervention
- ☐ **1.0** Outpatient
- ☐ **2.1** Intensive Outpatient
- ☐ **2.5** Partial Hospitalization
- ☐ **3.1** Clinically Managed Low-Intensity Residential
- ☐ **3.3** Clinically Managed Population Specific High-Intensity Residential
- ☐ **3.5** Clinically Managed High-Intensity Residential
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- ☐ **3.7WM** Medically Monitored Inpatient Withdrawal Management
- ☐ **4.WM** Medically Managed Intensive Inpatient Withdrawal Management

Reason for Discrepancy

- ☐ Not Applicable
- ☐ Language
- ☐ Living environment
- ☐ Service not available
- ☐ Safety sensitive occupation
- ☐ Cognitive / Mental Health condition consideration
- ☐ Family responsibility
- ☐ Transportation
- ☐ Service available, but no payment source
- ☐ Geographic accessibility
- ☐ Physical Health
- ☐ Consumer on waiting list for more appropriate level
- ☐ Consumer preference (explain below)
- ☐ Other (specify below)

Comments:
_____
_____
_____

Additional Consumer Category: ☐ Perinatal **Proof of Pregnancy on File?:** ☐ Yes ☐ No (if yes, submit copy with request)

Requesting MAT?: ☐ Yes ☐ No

If YES- Along with submitting copy of proof to RUHS- BH, ensure copy of proof is filed in consumer chart.

Financial Eligibility:

Select appropriate financial guarantor. Sumbit copy of eligibility verification with request.

☐ **505 – ADP CalWORKs:** Worker ___ Location _____

☐ **Private Insurance:** Name _____ olicy # _____

☐ **501 – ADP Medi-Cal:** CIN _____ Code _____ SOC? ($) _____ OHC? _____

☐ **502 – ADP NNA**

CONFIDENTIAL PATIENT INFORMATION

Riverside University HEALTH SYSTEM Behavioral Health

ADOLESCENT ASAM (ages 12 – 17)

Based on the American Society of Addiction Medicine (ASAM)
Criteria Multidimensional Assessment; 3rd Edition

Date: _____ **Start time:** _____ **Stop time:** _____ **Total time:** _____

☐ **Initial Screening and Placement** ☐ **Update** ☐ **Transitional Placement**

Demographic Information

Name:			**Client # (P#):**
Address:			**Phone Number:** **Okay to leave voicemail?** ☐ Yes ☐ No
DOB:	**Age:**	**Race:**	**Preferred Language:**

Self Identified Gender: ☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman ☐ Gender Queer/Gender non-conforming ☐ Another Gender identity ☐ Unknown/Prefer not to answer

Insurance Type: ☐None ☐Drug Medi-Cal ☐Medicare ☐Medi-Cal ☐Private ☐Other (specify):

Referred by (specify):

How can we help you today?

Dimension 1: Substance Use, Withdrawal Potential

Adolescent: (To be completed by clinician with adolescent)

1. **Do you drink any alcohol (more than a few sips)?** ☐ Yes ☐ No (Do not count sips of alcohol taken during family or religious events.)
2. **Do you use weed or spice?** ☐ Yes ☐ No
3. **Do you use anything else to get high?** ☐ Yes ☐ No ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff") If yes, Explain:
4. **Do you ever have blackouts while using alcohol or drugs?** ☐ Yes ☐ No
5. **How do you feel physically/emotionally when you stop using?**

6. **When was the last time you used?**	**What was it?**	**How much?**	**Route of administration:**

7. **Have you ever overdosed or been hospitalized due to your drug/alcohol use?** ☐ Yes ☐ No If so, when:

Please circle one of the following levels of severity

Severity Rating - Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential)

0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
No signs of withdrawal/intoxication present	Mild/moderate intoxication, interferes with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

Comments:

Consumer Name: _____

Consumer ID: _____

Dimension 2: Biomedical Condition and Complications

Adolescent: (To be completed by clinician with adolescent)

8. Do you have any current physical health problems (seizures)? ☐ Yes ☐ No If yes, explain:

9. If female, are you pregnant? ☐ Yes ☐ No ☐ N/A	**If yes, how many weeks/months?**

10. Are you currently prescribed any medication for a medical issue? ☐ Yes ☐ No If yes, specify name:

Please circle one of the following levels of severity

Severity Rating - Dimension 2 (Biomedical Condition and Complications)

0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Fully functional/ able to cope with medical concerns.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with medical concerns.	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present.	Serious medical problems neglected. Severe medical problems present but stable. Poor ability to cope with physical problems.	Incapacitated with severe medical problems.

Comments:

Dimension 3: Emotional, Behavioral, or Cognitive Condition and Complications

Adolescent: (To be completed by clinician with adolescent)

11. Have you ever heard voices? ☐ Yes ☐ No

12. Have you ever had trouble controlling your anger? ☐ Yes ☐ No If yes, describe (give example):

13. Have you ever wanted to harm yourself or others (cutting)? ☐ Yes ☐ No If yes, explain:

14. Have you ever talked to a therapist or counselor? ☐ Yes ☐ No	**15. Are you currently prescribed any medication for mental or behavioral needs?** ☐ Yes ☐ No If yes, specify name:

Please circle one of the following levels of severity

Severity Rating - Dimension 3 (Emotional, Behavioral, or Cognitive Condition and Complications [EBC])

0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
No impulsive or dangerousness, no evidence of emotional issues.	Suspect diagnosis of EBC complications. May require intervention. No immediate threat to self/others.	Confirmed EBC complications. No immediate threat to self/others.	Severe EBC. Unstable without 24-hr supervision to prevent risk of harm to self or others.	Very severe EBC. Requires acute level of care and exhibits life-threatening symptoms (posing imminent danger to self/others).

***If consumer scores a 3 or 4 in severity, consider referral to Behavioral Health Clinic**

Consumer Name: _____

Consumer ID: _____

Comments:

Dimension 4: Readiness to Change

Adolescent: (To be completed by clinician with adolescent)

16. On a scale of 0 (low) to 4 (very) how important is it to you to stop drinking or using? **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐

17. Does your family or friends ever tell you that you should cut down on your drinking or drug use? ☐ Yes ☐ No

Please circle one of the following levels of severity

Severity Rating - Dimension 4 (Readiness to Change)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/Unable to follow through with treatment recommendations.
Comments:				

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Adolescent: (To be completed by clinician with adolescent)

18. Do you ever use alcohol or drugs while you are by yourself, or alone? ☐ Yes ☐ No

19. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? ☐ Yes ☐ No

20. How often do you want to or feel like using or drinking?

21. What is the longest time you have went without using drugs and/or alcohol?

Please circle one of the following levels of severity

Severity Rating - Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Low/no potential for relapse.	Minimal relapse potential.	Impaired recognition of risk for relapse.	Little recognition of risk for relapse.	Substance use/behavior, places self/others in danger.
Comments:				

Consumer Name: _____

Consumer ID: _____

Dimension 6: Recovery/Living Environment/Social Network

Adolescent: (To be completed by clinician with adolescent)

22. Have you ever gotten into trouble while you were using alcohol or drugs? ☐ Yes ☐ No

If yes, explain:

23. Do you feel supported in your current living environment? ☐ Yes ☐ No	**24. Where do you live?**

25. Does anyone else at home use drugs or alcohol? ☐ Yes ☐ No If yes, explain:

26. Do your close friends use drugs and/or alcohol? ☐ Yes ☐ No

Please circle one of the following levels of severity

Severity Rating - Dimension 6 (Recovery/Living Environment/Social Network)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Environment is supportive.	Environment is supportive. May require clinical intervention.	Supportive friends and family but environment requires clinical support.	Environment unsupportive to recovery process, difficulty in participating even with clinical support.	Environment toxic/hostile to recovery. Unable to participate and the environment may pose a threat to safety.

Comments:

Dimension 1: Substance Use, Withdrawal Potential

Parent/Caregiver: (To be completed by clinician with parent or caregiver)

27. Do you know if your child is drinking alcohol or using drugs? ☐ Yes ☐ No If yes, describe:

28. Do you know if your child is using anything else to get high? ☐ Yes ☐ No

("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")

If yes, Explain:

29. Has your child ever been hospitalized or experienced blackouts due to drug/alcohol use? ☐ Yes ☐ No

Please circle one of the following levels of severity

Severity Rating - Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
No signs of withdrawal/intoxication present	Mild/moderate intoxication, interferes with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

Consumer Name: _____

Consumer ID: _____

Comments:

Dimension 2: Biomedical Condition and Complications

Parent/Caregiver: (To be completed by clinician with parent or caregiver)

30. Does your child have any current physical health problems (seizures)? ☐ Yes ☐ No If yes, explain:

31. If female, is your child pregnant? ☐ Yes ☐ No ☐ N/A | **If yes, how many weeks/months?**

32. With the health concerns, are there any medications that are prescribed by a physician? ☐ Yes ☐ No

If yes, specify name:

Please circle one of the following levels of severity

Severity Rating - Dimension 2 (Biomedical Condition and Complications)

0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Fully functional/ able to cope with medical concerns.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with medical concerns.	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present.	Serious medical problems neglected. Severe medical problems present but stable. Poor ability to cope with physical problems.	Incapacitated with severe medical problems.

Comments:

Dimension 3: Emotional, Behavioral, or Cognitive Condition and Complications

Parent/Caregiver: (To be completed by clinician with parent or caregiver)

33. Have you ever taken your child to a therapist or counselor? ☐ Yes ☐ No

34. Has your child ever harmed themselves or someone else (cutting, acted violent toward others)**?** ☐ Yes ☐ No

If yes, explain:

35. Has your child ever received services in an inpatient or outpatient setting for mental or behavioral health needs? ☐ Yes ☐ No

36. Is he or she currently taking medications? ☐ Yes ☐ No If so, list:

Please circle one of the following levels of severity

Severity Rating - Dimension 3 (Emotional, Behavioral, or Cognitive Condition and Complications [EBC])

0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
No impulsive or dangerousness, no evidence of emotional issues.	Suspect diagnosis of EBC complications. May require intervention. No immediate threat to self/others.	Confirmed EBC complications. No immediate threat to self/others.	Severe EBC. Unstable without 24-hr supervision to prevent risk of harm to self or others.	Very severe EBC. Requires acute level of care and exhibits life-threatening symptoms (posing imminent danger to self/others).

Consumer Name: _____

Consumer ID: _____

***If consumer scores a 3 or 4 in severity, consider referral to Behavioral Health Clinic**
Comments:

Dimension 4: Readiness to Change

Parent/Caregiver: (To be completed by clinician with parent or caregiver)

37. On a scale of 0 (low) to 4 (very) how ready is your child to stop drinking or using? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

Please circle one of the following levels of severity

Severity Rating - Dimension 4 (Readiness to Change)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/Unable to follow through with treatment recommendations.
Comments:				

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Parent/Caregiver: (To be completed by clinician with parent or caregiver)

38. As far as you know, has your child ever used alcohol or drugs while they are alone or by themselves? ☐ Yes ☐ No

39. Do you feel your child could stop using or drinking without help? ☐ Yes ☐ No

Please circle one of the following levels of severity

Severity Rating - Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Low/no potential for relapse.	Minimal relapse potential.	Impaired recognition of risk for relapse.	Little recognition of risk for relapse.	Substance use/behavior, places self/others in danger.
Comments:				

Dimension 6: Recovery/Living Environment/Social Network

Parent/Caregiver: (To be completed by clinician with parent or caregiver)

Consumer Name: _____

Consumer ID: _____

40. Has your child ever gotten into trouble while they were using alcohol or drugs? ☐ Yes ☐ No

If yes, explain:

41. Do you have any problems with transportation? ☐ Yes ☐ No

42. Do you have a stable living environment? ☐ Yes ☐ No

43. Do your child's friends use drugs and/or alcohol? ☐ Yes ☐ No

Please circle one of the following levels of severity

Severity Rating - Dimension 6 (Recovery/Living Environment/Social Network)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Environment is supportive.	Environment is supportive. May require clinical intervention.	Supportive friends and family but environment requires clinical support.	Environment unsupportive to recovery process, difficulty in participating even with clinical support.	Environment toxic/hostile to recovery. Unable to participate and the environment may pose a threat to safety.
Comments:				

Adolescent Summary of Multidimensional Assessment					
Dimension	**Severity Rating (Based on rating above)**				
Dimension 1 Substance Use, Acute Intoxication, Withdrawal Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 2 Biomedical Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 4 Readiness to Change	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 5 Relapse, continued Use, or Continued Problem Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 6 Recovery/Living Environment	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe

Consumer Name: _____

Consumer ID: _____

Parent/Caregiver Summary of Multidimensional Assessment					
Dimension	**Severity Rating (Based on rating above)**				
Dimension 1 Substance Use, Acute Intoxication, Withdrawal Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 2 Biomedical Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 4 Readiness to Change	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 5 Relapse, continued Use, or Continued Problem Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 6 Recovery/Living Environment	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe

Consumer Name: _____

Consumer ID: _____

PLACEMENT SUMMARY

Level of Care/Service Indicated by ASAM: The following ASAM level of care offers the most appropriate level of care/service intensity given the consumer's functioning/severity:

Prevention:	☐ *0.5*				
Outpatient:	☐ *1.0*	☐ *IOT: 2.1*		*Partial Hospitalization:*	☐ *2.5*
Residential:	☐ *3.1*	☐ *3.5*			
Medical Inpatient:	☐ *3.7*	☐ *4.0*			
Withdrawal Management:	☐ *1-WM*	☐ *2-WM*	☐ *3.2-WM*	☐ *3.7-WM*	☐ *4-WM*

Not Applicable (Referred to Recovery Services) ☐

Level of Care/Service Provided: If the most appropriate level of care/service intensity was not utilized, enter the most appropriate ASAM level of care that is available then select the reason for this discrepancy (if any):

Prevention:	☐ *0.5*				
Outpatient:	☐ *1.0*	☐ *IOT: 2.1*		*Partial Hospitalization:*	☐ *2.5*
Residential:	☐ *3.1*	☐ *3.5*			
Medical Inpatient:	☐ *3.7*	☐ *4.0*			
Withdrawal Management:	☐ *1-WM*	☐ *2-WM*	☐ *3.2-WM*	☐ *3.7-WM*	☐ *4-WM*

Not Applicable (Referred to Recovery Services) ☐

Reason for Discrepancy: If there is a difference between the level of care indicated by the ASAM and the level of care actually provided then select the reason for discrepancy.

☐ *Not applicable*	☐ *Service not available*	☐ *Service available, but no payment source*
☐ *Transportation*	☐ *Geographic accessibility*	☐ *Cognitive/Mental Health condition consideration*
☐ *Family responsibility*	☐ *Language*	☐ *Consumer on waiting list for more appropriate level*
☐ *Physical Health*	☐ *Living environment*	

☐ *Consumer preference, explain:* _____

_____

☐ *Other (specify):* _____

_____

If special consumer requests or needs were taken into consideration of placement, please indicate below:

_____

_____

Designated Treatment Provider Name and Location:

_____

_____

Staff/Clinician Name **Signature** **Date**

Consumer Name: _____

Consumer ID: _____

ADOLESCENT ASAM TOOL – INSTRUCTIONS

INDICATE TYPE OF ASAM

- Initial Screening and Placement is the consumer's first contact and/or when the consumer is no longer active in an open episode.
- Update is to be completed at a minimum of every 30 days for Residential/Inpatient providers, or at a minimum of every 90 days for other modalities (including Prevention, Outpatient, Intensive Outpatient, Partial Hospitalization, and Opioid Treatment Program (OTP).
- Transition is when consumer is moving from one level of care to another, or for discharge, one time in the last 14 days of an open episode.

DEMOGRAPHIC INFORMATION

- Enter the consumer's name in the order of last name, first name and middle name.
- Enter the date the ASAM was performed.
- Enter the consumer's phone number and check yes or no, indicating if it is okay to leave a voicemail.
- Enter the consumer's address (if homeless, then write "homeless")
- Enter the consumer's date of birth.
- Enter the consumer's age.
- Enter the consumer's self identified gender.
- Enter the consumer's race.
- Enter the consumer's preferred language.
- Enter the consumer's medical record or 'P' number.
- Check off or specify the consumer's insurance type and indicate what type of plan they have.
- Enter who and/or which agency referred the consumer for assessment.
- Enter explanation for why consumer is currently seeking services and a brief substance use history.

ADOLESCENT SECTION

DIMENSION 1: SUBSTANCE USE, AND/OR WITHDRAWAL POTENTIAL

- For questions 1-4, the interviewer asks the consumer the following questions, to which the consumer would respond yes or no. The interviewer is then to ask the consumer to further describe their yes or no response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 1: Substance Use, and/or Withdrawal Potential.
- Question 1: Record any alcohol that the consumer has used in the past 30 days.
- Question 2: Record any weed or spice used in the past 30 days.
- Question 3: Check yes or no. If yes, record answer in space provided.
- Question 4: Check yes or no. If yes, describe the response in the space provided.
- Question 5: Record emotional or physical symptoms the consumer has experienced when they have stopped using.
- Question 6: Record last use, drug, amount, and route of administration.
- Question 7: Check yes or no. If yes, record dates and substance used in box provided.
- Enter additional comments (if any) relevant to Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential, based on the consumer's current risk level (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very

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Severe). This is done by reading the descriptions for each severity level and considering the information that was gathered in questions 1-7. The interviewer then chooses the rating that best describes the consumer's current level of risk for substance use, acute intoxication, and risks associated with withdrawal.

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

- For questions 8-10, the interviewer asks the consumer the following questions, to which the consumer would respond yes or no. The interviewer is then to ask the consumer to further describe their yes or no response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 2: Biomedical Conditions and Complications.
- Questions 8-10: Check yes or no. Further describe the response in the space provided.
- Enter additional comments relevant to Dimension 2: Biomedical Conditions and Complications, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 2: Biomedical Conditions and Complications, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 8-10. The interviewer then chooses the rating that best describes the consumer's current level of risk for physical health problems and how they may impact the consumer's treatment placement.

DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

- For questions 11-15, the interviewer asks the consumer the following questions, to which the consumer would respond yes or no. The interviewer is then to ask the consumer to further describe their yes or no response and document it in the space provided.
- Questions 11-14: Check yes or no. Further describe the response in the space provided.
- Question 11: Check yes or no. Further describe the response in the space provided.
- Question 12: Check yes or no. If yes, describe how the consumer expresses their anger.
- Question 13: Check yes or no. If yes, describe the response in the space provided and consider transport to emergency room or call 911.
- Question 14: Check yes or no. If yes, provide dates and names in the space provided.
- Question 15: Check yes or no. If yes, describe name and dosage in space provided.
- Enter additional comments relevant to Dimension 3: Emotional, Behavioral, or Cognitive Conditions, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 11-15. The interviewer then chooses the rating that best describes the consumer's current level of risk for mental health problems and how they may impact the consumer's treatment placement. *If a consumer scores a 3 or 4 in severity, consider referral to a Behavioral Health Clinic.

DIMENSION 4: READINESS TO CHANGE

- For questions 16-17, the interviewer asks the consumer the following questions. The interviewer is then to ask the consumer to further describe their response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 4: Readiness to Change.
- Question 16: Indicate response to scaling question, 0 being low importance and 4 being high. If the consumer answers lower than 4, ask what it would take to get to the next level up. Ex: "I see you answered a

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1 on the importance scale. What would it take to get to a 2?"

- Question 17: Check yes or no. Describe response in the space provided.
- Enter additional comments relevant to Dimension 4: Readiness to Change, in the space provided, that may impact placement of the consumer
- Choose a severity rating of 0-4 for Dimension 4: Readiness to Change, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 16-17. The interviewer then chooses the rating that best describes the consumer's current level of risk for readiness to change and engage in treatment, and how that may impact the consumer's treatment placement.

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

- For questions 18-21, the interviewer asks the consumer the following questions. The interviewer is then to ask the consumer to further describe their response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 5: Relapse, Continued Use or Continued Problem Potential.
- Question 18: Check yes, or no. Describe the response in the space provided.
- Question 19: Check yes, or no. Describe the response in the space provided.
- Question 20: Describe the response in the space provided.
- Question 21: Describe the response in the space provided.
- Enter additional comments relevant to Dimension 5: Relapse, Continued Use or Continued Problem Potential, in the space provided, that may impact placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 5: Relapse, Continued Use or Continued Problem Potential, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 18-21. The interviewer then chooses the rating that best describes the consumer's current level of risk for readiness to change and engage in treatment, and how that may impact the consumer's treatment placement.

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT/SOCIAL NETWORK

- For questions 22-26, the interviewer asks the consumer the following questions, to which the consumer would respond yes or no. The interviewer is then to ask the consumer to further describe their yes or no response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 6: Recovery/Living Environment.
- Question 22: Check yes or no. Further describe response in space provided.
- Question 23: Check yes or no. Further describe response in space provided.
- Question 24: Describe the consumer's response to their living arrangements.
- Question 25: Check yes or no. Further describe response in space provided.
- Question 26: Check yes or no. Further describe response in space provided.
- Enter additional comments relevant to Dimension 6: Recovery/Living Environment, in the space provided, that may impact treatment or placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 6: Recovery/Living Environment, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 22-26. The interviewer then chooses the rating that best describes the consumer's current level of risk for readiness to change and engage in treatment, and how that may impact the consumer's treatment placement.

Consumer Name: _____

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PARENT/CAREGIVER SECTION

DIMENSION 1: SUBSTANCE USE, AND/OR WITHDRAWAL POTENTIAL

- For questions 27-29, the interviewer asks the parent/caregiver the following questions, to which the parent/caregiver would respond yes or no. The interviewer is then to ask the parent/caregiver to further describe their yes or no response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 1: Substance Use, and/or Withdrawal Potential.
- Question 27: Record any alcohol and/or drugs that the parent/caregiver has said the consumer have used in the past 30 days.
- Question 28: Check yes or no. If yes, record answer in space provided.
- Question 29: Check yes or no. If yes, record answer in space provided.
- Enter additional comments (if any) relevant to Dimension 1: Substance Use, and/or Withdrawal Potential, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential, based on the consumer's current risk level (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level and considering the information that was gathered in questions 27-29. The interviewer then chooses the rating that best describes the consumer's current level of risk for substance use, acute intoxication, and risks associated with withdrawal.

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

- For questions 30-32, the interviewer asks the parent/caregiver the following questions, to which the parent/caregiver would respond yes or no. The interviewer is then to ask the parent/caregiver to further describe their yes or no response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 2: Biomedical Conditions and Complications.
- Questions 30-32: Check yes or no. Further describe the response in the space provided.
- Enter additional comments relevant to Dimension 2: Biomedical Conditions and Complications, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 2: Biomedical Conditions and Complications, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 30-32. The interviewer then chooses the rating that best describes the consumer's current level of risk for physical health problems and how they may impact the consumer's treatment placement.

DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

- For questions 33-36, the interviewer asks parent/caregiver the following questions, to which the parent/caregiver would respond yes or no. The interviewer is then to ask the parent/caregiver to further describe their yes or no response and document it in the space provided.
- Questions 33-36: Check yes or no. Further describe the response in the space provided.
- Enter additional comments relevant to Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 3: Emotional, Behavioral, or Cognitive Conditions or Complications, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 33-36. The interviewer then chooses the rating that best describes the

Consumer Name: _____

Consumer ID: _____

consumer's current level of risk for mental health problems and how they may impact the consumer's treatment placement. *If a consumer scores a 3 or 4 in severity, consider referral to a Behavioral Health Clinic.

DIMENSION 4: READINESS TO CHANGE

- For question 37, the interviewer asks the parent/caregiver the scaling question. The interviewer is then to ask the parent/caregiver to further describe their response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 4: Readiness to Change.
- Question 37: Indicate response to scaling question, 0 being low and 4 being high.
- Enter additional comments relevant to Dimension 4: Readiness to Change, in the space provided, that may impact placement of the consumer
- Choose a severity rating of 0-4 for Dimension 4: Readiness to Change, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in question 37. The interviewer then chooses the rating that best describes the consumer's current level of risk for readiness to change and engage in treatment, and how that may impact the consumer's treatment placement.

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

- For questions 38-39, the interviewer asks the parent/caregiver the following questions. The interviewer is then to ask the parent/caregiver to further describe their response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 5: Relapse, Continued Use or Continued Problem Potential.
- Question 38: Check yes or no. Further describe response in space provided.
- Question 39: Check yes or no. Further describe response in space provided.
- Enter additional comments relevant to Dimension 5: Relapse, Continued Use or Continued Problem Potential, in the space provided, that may impact placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 5: Relapse, Continued Use or Continued Problem Potential, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 38-39. The interviewer then chooses the rating that best describes the consumer's current level of risk for readiness to change and engage in treatment, and how that may impact the consumer's treatment placement.

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT/SOCIAL NETWORK

- For questions 40-43, the interviewer asks the parent/caregiver the following questions. The interviewer is then to ask the parent/caregiver to further describe their response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 6: Recovery/Living Environment/Social Network.
- Question 40: Check yes or no. Further describe response in space provided.
- Question 41: Check yes or no. Further describe response in space provided.
- Question 42: Check yes or no. Further describe response in space provided.
- Question 43: Check yes or no. Further describe response in space provided.
- Enter additional comments relevant to Dimension 6: Recovery/Living Environment, in the space provided, that may impact treatment or placement of the consumer.
- Choose the severity rating of 0-4 for Dimension 6: Recovery/Living Environment, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 40-43.

Consumer Name: _____

Consumer ID: _____

The interviewer then chooses the rating that best describes the consumer's current level of risk due to their recovery and living environment and how that may impact the consumer's treatment placement.

SUMMARY OF MULTIDIMENSIONAL ASSESSMENT

- The intent of the 'Summary of Multidimensional Assessment' section of the assessment is to consolidate the information gathered from all 6 ASAM dimensions onto one page to help the interviewer synthesize this information to develop an individualized case formulation and ultimately select the most appropriate ASAM level of care.
- For Dimensions 1-6, check off the severity rating that you chose in the previous section.

PLACEMENT SUMMARY INFORMATION

- Enter the Level of Care as indicated by the ASAM. *Use the key below for definition of the numbers and corresponding description of each level of care.
- Enter the Level of Care that is being provided. *Use the key below for definition of the numbers and corresponding description of each level of care.
- There may be exceptions in which the Level of Care chosen for the consumer and Level of Care that the consumer is placed differ. This may be due to lack of availability, or consumer preference. If there is a discrepancy between the Level of Care chosen by the interviewer and the Level of Care that is to be provided, please check off the appropriate reason for the discrepancy and briefly explain why.
- Describe if any special consumer requests or needs were taken into consideration of placement.
- Provide the information and location for the designated treatment provider for the consumer.
- Enter the interviewer's (counselor) name, signature and date of the multidimensional screening.

*ASAM LEVELS OF CARE FOR ADOLESCENTS

- 0.5: Early Intervention
- 1.0: Outpatient Services
- 2.1: Intensive Outpatient Services
- 2.5: Partial Hospitalization Services
- 3.1: Clinically Managed Low-Intensity Residential Services
- 3.5: Clinically Managed High-Intensity Residential Services (Non-population-Specific)
- 3.7: Medically Monitored Intensive Inpatient Services
- 4.0: Medically Managed Intensive Inpatient Services
- 1-WM: Ambulatory Withdrawal Management (Without extended onsite monitoring)
- 2-WM: Ambulatory Withdrawal Management (With extended onsite monitoring)
- 3.2-WM: Residential Withdrawal Management (Clinically Managed)
- 3.7-WM: Inpatient Withdrawal Management (Medically Monitored)
- 4-WM: Inpatient Withdrawal Management (Medically Managed and Intensive Services)
- N/A: Not Applicable – no Substance Use Prevention or Treatment Services will be provided

Consumer Name: _____

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ADOLESCENT SUBSTANCE USE DISORDER (SUD) LEVEL OF CARE (LOC) AND ASAM DIMENSIONS

Level Of Care (LOC)	ASAM Level	Dimension 1 Acute Intoxication / Withdrawal	Dimension 2 Biomedical	Dimension 3 Emotional, Behavioral, Cognitive	Dimension 4 Readiness to Change	Dimension 5 Relapse / Continued Use	Dimension 6 Recovery / Living Environment
Early Intervention	0.5	No withdrawal risk	None or very stable	None or very stable. Any D3 issues are being addressed through concurrent mental health services and do not interfere with early intervention addiction treatment services	Willing to explore how current alcohol, tobacco, medications, other drug use and/or high-risk behaviors may affect achievement of personal goals	Needs an understanding of, or skills to change, current alcohol, tobacco, other drug, or medication use patterns, and/or high-risk behaviors	Adolescent's risk of initiation of or progression in substance use and/or high-risk behaviors is increased by substance use or values about use. High-risk behaviors of family, peers, or others in the adolescent's social support system
Outpatient	1	No withdrawal risk	None; very stable; receives concurrent medical monitoring	Not at risk of harm; or minimal interference with addiction/ mental health recovery efforts; or minimal to mild social impairment; or minimal difficulties with daily living activities but with significant risk of deterioration; or minimal imminent risk	Willing to engage in treatment; contemplating change; needs motivating strategies	Can maintain abstinence/ control use/ pursue recovery with minimal support	Supportive family and environment
Intensive Outpatient	2.1	Minimal withdrawal; at risk of withdrawal	None; stable	Low risk of harm; or mild interference with addiction/ mental health recovery efforts; or mild to moderate social impairment but can perform responsibilities; or mild to moderate difficulties with daily living activities and requires frequent monitoring/ interventions; or history and current situation predict need for frequent monitoring/ interventions	Requires close monitoring many times a week; no interest in getting help	Significant risk of relapse; or problems and deterioration in functioning level; or poor prevention skills; needs close monitoring	Environment impedes recovery; requires close monitoring and support
Partial Hospitalization	2.5	Mild withdrawal; at risk of withdrawal	None or severe enough to distract from treatment at another level; such problems require medical monitoring either directly at 2.5 or through referral	Low risk of harm and is safe overnight; or moderate interference with addiction/ mental health recovery efforts; or mild to moderate social impairment but can perform responsibilities; or moderate difficulties with daily living activities and requires near-daily monitoring/ interventions; or history and current situation predict need for near-daily monitoring/ interventions	Lack of perspective or impulse control require close monitoring many times a week; interventions at lower level have failed but willingness to engage in treatment and explore awareness and readiness to change	High risk of relapse; or problems and deterioration in functioning level and poor prevention skills; needs near-daily monitoring	Environment not supportive of recovery without near-daily monitoring or frequent relief from home environment
Low Intensity Residential	3.1	Withdrawal is concurrently managed at another LOC	Stable, or receiving concurrent medical monitoring, or physical health is at risk due to continued use	Needs stable living environment; or needing limited 24-hour supervision to support treatment engagement; or moderate social impairment needing limited 24-hour supervision to perform responsibilities; or moderate difficulties with daily living activities needing limited 24-hour supervision and frequent prompting; or history and current situation predict instability without limited 24-hours supervision	Open to recovery but needs limited 24-hour supervision	Imminent danger of relapse without 24-hr structure; or understands consequences of continued use but is at risk; or has emerging recovery skills but needs supervision; concurrent treatment at level 1 or 2	Dangerous home environment but safe with 24-hr support (i.e., neglect, abuse, using family member, logistical impediments, mobility limitations, lack of transportation)
High Intensity Residential Non-Population Specific	3.5	At risk of or experiencing mild to severe withdrawal (depending on substance) or intoxication; at risk of withdrawal	None; stable; receiving concurrent medical monitoring as necessary	Moderate but stable risk of harm needing medium-intensity 24-hour monitoring; moderate to severe interference with addiction/ mental health recovery efforts needing medium-intensity residential treatment; moderate to severe social impairment; moderate to severe difficulties with daily living activities needing 24-hour supervision and medium-intensity assistance; history and current situation predict destabilization without medium-intensity residential treatment	Needs intensive motivating strategies in 24-hour structured program to promote readiness to change; lack of 24-hr structure could pose imminent risk to self and/or public safety	Imminent risk to relapse or harm to self and/or others; lacks use/ behavior control and avoid impairment without 24-hour structured program; or unable to overcome triggers/ cravings; or poor treatment response	Dangerous environment; requires residential treatment for recovery/ protection
Intensive Inpatient Services Medically Monitored	3.7	High risk of or experiencing moderate to severe withdrawal (depending on substance) or intoxication	Requires 24-hour medical monitoring but not intensive treatment	Moderate risk of harm needing high-intensity 24-hour monitoring or secure placement; severe interference with addiction/ mental health recovery efforts needing high-intensity residential treatment; severe social impairment; severe difficulties with daily living activities needing 24-hour supervision and high-intensity assistance; history and current situation predict destabilization without high-intensity residential treatment	Needs motivating strategies in 24-hour medically monitored program; requires secure placement; needs high-intensity case management	Unable to interrupt high-severity or high-frequency pattern of use and/ or behaviors, and avoid dangerous consequences without high-intensity 24-hour interventions	Dangerous environment; requires residential treatment for recovery/ protection
Intensive Inpatient Services Medically Managed	4.0	Severe withdrawal; requires intensive active medical management	Requires 24-hour medical and nursing care, and full resources of licensed hospital	Severe risk of harm; very severe interference with addiction/ mental health recovery efforts; very severe, dangerous social impairment needing frequent medical and nursing interventions; very severe difficulties with daily living activities needing frequent medical and nursing interventions; history and current situation predict destabilization without inpatient medical management	Problem in this dimension does not qualify patient for Level 4 services. If patient's only severity is in Dimension 4, 5 and/or 6 without high severity in Dimension 1, 2 and/or 3, then patient does not qualify for Level 4		

Ambulatory Withdrawal Management: Without Extended On-Site Monitoring	1-WM	Mild Withdrawal with daily outpatient supervision.	Minimal risk of severe withdrawal that is manageable at this LOC, at least mild withdrawal symptoms or withdrawal is imminent.
Ambulatory Withdrawal Management: With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	Moderate risk of of severe withdrawal outside the program setting; no severe physical or phsychiatric complications; safely responds to several hours of monitoring, medications, and treatment; signs and symptoms of withdrawal or withdrawal is imminent.
Residential Withdrawal Management: Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelyhood of continuing treatment and recovery.	Not at risk of severe withdrawal; moderate withdrawal safely managed at this LOC; signs and symptoms of withdrawal or withdrawal is imminent.
Inpatient Withdrawal Management: Medically Monitored	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	Severe withdrawal syndrome that is manageable at this LOC; signs and symptoms of withdrawal or withdrawal is imminent.
Inpatient Withdrawal Management: Medically Managed & Intensive Services	4-WM	Severe unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimine and manage medical instability.	Signs and symptoms of severe withdrawal; severe withdrawal is imminent; requires primary medical and nursing care services, and 24-hour observation, monitoring, and treatment.

Riverside University HEALTH SYSTEM Behavioral Health

ADULT ASAM

Based on the American Society of Addiction Medicine (ASAM)
Criteria Multidimensional Assessment; 3rd Edition

Date: _____ Start time: _____ Stop time: _____ Total time: _____

☐ **Initial Screening and Placement** ☐ **Update** ☐ **Transitional Placement**

Demographic Information

Name:				**Client # (P #):**
Address:				**Phone Number:** **Okay to leave voicemail?** ☐ Yes ☐ No
DOB:	**Age:**	**Race:**	**Occupation:**	**Preferred Language:**

Self Identified Gender: ☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman ☐ Gender Queer/Gender non-conforming ☐ Another Gender identity ☐ Unknown/Prefer not to answer

Insurance Type: ☐None ☐Drug Medi-Cal ☐Medicare ☐Medi-Cal ☐Private ☐Other (specify):

Referred by (specify):

Brief explanation of why consumer is seeking services including a history of how substance use has affected their life in the last 12 months:

Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential

1. In the past 30 days, have you used:

Alcohol: ☐ Yes ☐ No
Time from last use? _____
Amount last used? _____
Route of administration? _____

Marijuana ☐ Yes ☐ No
Time from last use? _____
Amount last used? _____
Route of administration? _____

Cocaine/Crack: ☐ Yes ☐ No
Time from last use? _____
Amount last used? _____
Route of administration? _____

Heroin: ☐ Yes ☐ No
Time from last use? _____
Amount last used? _____
Route of administration? _____

If consumer is using heroin, consider referral to Opioid Treatment Program or provider of Medication-Assisted Treatment

Methamphetamine: ☐ Yes ☐ No
Time from last use? _____
Amount last used? _____
Route of administration? _____

Other: ☐ Yes ☐ No
If yes, specify name: _____
Time from last use? _____
Amount last used? _____
Route of administration? _____

Consumer Name: _____

Consumer ID: _____

2. In the past 30 days, have you used or misused any prescription medication? (with or without prescription): ☐ Yes ☐ No

Specify type:

☐Opioid Pain Medication

Specify Name: _____ Time from last use: _____

Amount last used: _____

Route of administration: _____

☐Benzodiazepines/Sleeping/Anxiety Medication

Specify Name: _____ Time from last use: _____

Amount last used: _____

Route of administration: _____

☐Stimulants

Specify Name: _____ Time from last use: _____

Amount last used: _____

Route of administration: _____

☐Other

Specify Name: _____ Time from last use: _____

Amount last used: _____

Route of administration: _____

If consumer is misusing opioid medications, consider referral to Opioid Treatment Program or provider of Medication-Assisted Treatment

3. Is there evidence or suspicion of intoxication (withdrawal potential) or current withdrawal? ☐ Yes ☐ No

If yes, answer the following:

a. When you have been in withdrawal from alcohol or any of the drugs listed above, what happened for you? _____

_____

b. Are you currently experiencing any withdrawal signs such as: tremors, tingling, excessive sweating, heart racing, numbness, anxiety, vomiting, or diarrhea? ☐ Yes ☐ No

c. Have you ever had life threatening symptoms or been hospitalized during withdrawal? ☐ Yes ☐ No

d. Are you currently having similar withdrawal symptoms? ☐ Yes ☐ No

e. Do you have a history of seizures? ☐ Yes ☐ No

f. Have you had head injury? ☐ Yes ☐ No If yes, when: _____ Did you lose consciousness? ☐ Yes ☐ No

4. Have you ever been to treatment for your alcohol/drug problems before, including DUI, and PC1000? ☐ Yes ☐ No

Consumer Name: _____

Consumer ID: _____

Please circle one of the following levels of severity

Severity Rating- Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
No signs of withdrawal/ intoxication present	Mild/moderate intoxication, interferes with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.
Comments:				

Dimension 2: Biomedical Condition and Complications

5. Do you have any active medical problems or disabilities that you are aware of? ☐ Yes ☐ No

If yes, do any of the medical problems require immediate attention? ☐ Yes ☐ No

Briefly explain: _____

If yes, are you currently using any medications for a physical health issue? ☐ Yes ☐ No ☐ Unsure

Briefly explain:

6. Are any of these issues directly related to alcohol and/or drug use? ☐ Yes ☐ No ☐ N/A

Briefly Explain:

7. If female: Are you pregnant? ☐ Yes ☐ No ☐ N/A

If yes, how many weeks? _____

8. In the past 30 days, have you been to an urgent care, emergency room, or hospitalized for any medical concerns? ☐ Yes ☐ No

If yes, briefly explain what you were treated for:

9. (Question to be answered by interviewer): Does the consumer report any medical symptoms that would be considered life-threatening or require immediate attention/treatment? ☐ Yes ☐ No **If yes, consider immediate referral to emergency room and/or call 911*

Please circle one of the following levels of severity

Severity Rating- Dimension 2 (Biomedical Condition and Complications)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Fully functional / able to cope with discomfort or pain.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present, or serious biomedical problems are neglected.	Serious medical problems neglected during outpatient treatment. Severe medical problems present but stable. Poor ability to cope with physical problems.	Incapacitated with severe medical problems.
Comments:				

Consumer Name: _____

Consumer ID: _____

Dimension 3: Emotional, Behavioral, or Cognitive Condition and Complications

10. Are you currently receiving supportive therapy for mental health needs? ☐ Yes ☐ No

If yes, briefly explain:

11. In the past 30 days, have you received outpatient mental health services or been hospitalized for psychological or emotional reasons? ☐ Yes ☐ No

If yes, briefly explain:

12. Do you have a history of memory loss and/or head trauma such as concussion? ☐ Yes ☐ No

If yes, briefly explain:

*If consumer has cognitive or mental health condition that requires a slower pace of treatment and a residential level of care, consider referral to ASAM level 3.3 residential care.

13. In the last 30 days have you acted physically aggressive towards people or property? ☐ Yes ☐ No

If yes, briefly explain:

14. In the past 30 days, have you had thoughts about wanting to hurt yourself and/or someone else or wanting to die? ☐ Yes ☐ No

If yes, do you currently have any thoughts of hurting yourself? (if yes, follow protocol for ambulance transport to ETS) ☐ Yes ☐ No

* Have you acted on these feelings to hurt yourself? ☐ Yes ☐ No

Please describe:

15. In the past 30 days, have you <u>taken</u> prescribed medication for mental health needs? ☐ Yes ☐ No

If yes, which ones and who is prescribing them:

Specify name(s) and dosage: _____

16. Has your mental health condition interfered with:

☐ Social functioning ☐ Ability for self care ☐ Addiction recovery efforts ☐ Ability to work ☐ N/A

17. Has the course of your mental health condition been (check as many as applicable):

☐ Stable w/ meds ☐ Stable w/out meds ☐ Unstable ☐ N/A

18. Is there reason to believe that any current emotional, behavioral, and/or cognitive problems are related directly to your use of alcohol and/or drugs? (no pre-morbid history) ☐ Yes ☐ No

<u>Please circle one of the following levels of severity</u>

Severity Rating- Dimension 3 (Emotional, Behavioral, or Cognitive Condition and Complications [EBC])				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
No impulsive behaviors, good social functioning and self-care, no interference with recovery.	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting.	Severe EBC. Requires acute level of care. Exhibits severe and acute life-threatening symptoms (posing imminent danger to self/others).

***If consumer scores a 3 or 4 in severity, consider referral to Behavioral Health Clinic**

Consumer Name: _____

Consumer ID: _____

Comments:

Dimension 4: Readiness to Change

19. Do you ever feel uncomfortable or guilty about your alcohol or other drug use? ☐ Yes ☐ No

20. Have you continued to use alcohol or drugs despite experiencing problems at work or with your relationships? ☐ Yes ☐ No

21. Can you get through the week without using drugs and/or alcohol? ☐ Yes ☐ No

22. Have you been mandated to have an assessment and/or treatment? ☐ Yes ☐ No

23. How important is it to you now to get help for:

Alcohol concerns:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Considerably	☐ Extremely	☐ N/A
Drug concerns:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Considerably	☐ Extremely	☐ N/A
Mental Health issues:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Considerably	☐ Extremely	☐ N/A

24. On a scale of 1 (low) **to 5** (very) **how interested are you in stopping alcohol and/or drug use?** **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐

Please circle one of the following levels of severity

Severity Rating- Dimension 4 (Readiness to Change)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

Comments:

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

25. What high risk situations are created by your use of alcohol and/or drugs (driving under the influence, caring for minor children, working with machinery, heavy equipment, etc.)?

List: _____

_____

26. On a scale of 1 to 5 what degree of cravings or urges to use alcohol and/or drugs in the last 30 days have you had?

☐ **1** (None) ☐ **2** (Slight urge) ☐ **3** (Moderate urge) ☐ **4** (Considerate urge) ☐ **5** (Extreme urge)

27. In the past 30 days, how frequent are these cravings or urges to use alcohol and/or drugs?

☐ hourly ☐ daily ☐ weekly ☐ none

Consumer Name: _____

Consumer ID: _____

28. Do you have any coping skills that have helped to prevent continual use of alcohol and/or drugs?	☐ Yes ☐ No
29. Are you likely to continue to use or relapse without immediate care?	☐ Yes ☐ No
30. In the last 30 days, how many days of continuous abstinence have you had from drugs and/or alcohol? _____	
31. Is Consumer requesting NTP services?	☐ Yes ☐ No ☐ N/A
If yes, a. Have you been to NTP before?	☐ Yes ☐ No
b. Does Consumer have two year history of addiction to Opioid?	☐ Yes ☐ No
c. Does Consumer have two treatment failures for Opioid use?	☐ Yes ☐ No
d. Does Consumer have one year of episodic or continual use prior admission?	☐ Yes ☐ No
32. Are you interested in medications used in conjunction with treatment for alcohol or opioids?	☐ Yes ☐ No

Please circle one of the following levels of severity

Severity Rating- Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Low/no potential for relapse. Good coping & relapse prevention skills.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition of risk for relapse, poor skills to cope with relapse.	No coping skills for relapse/ addiction problems. Substance use/behavior, places self/others in danger.
Comments:				

Dimension 6: Recovery/Living Environment	
33. What are your current living arrangements? ☐ Homeless ☐ No stable arrangements ☐ Stable housing	
34. Are your current relational/environmental resources supportive of your recovery efforts? Explain:	☐ Yes ☐ No
35. Do you currently live with others that use alcohol and/or drugs? If yes, how do you cope with that situation?	☐ Yes ☐ No
36. Do you have children or others that you are responsible for providing care on a daily basis?	☐ Yes ☐ No
37. Are you currently employed, enrolled in school, or a job training program?	☐ Yes ☐ No ☐ Decline to state
38. Do you currently have transportation?	☐ Yes ☐ No

Consumer Name: _____

Consumer ID: _____

39. Are you currently involved with the legal system (on probation, parole, or awaiting trial/sentencing)? ☐ Yes ☐ No

If yes, specify: ☐Parole ☐Probation ☐Awaiting trial/sentence ☐DPSS/CPS ☐Court Mandated Treatment

☐Other

40. Have you been convicted of a felony? ☐ Yes ☐ No

If yes, do any of these charges include homicide, manslaughter, a sex crime, or arson? ☐ Yes ☐ No

Specify: _____

Please circle one of the following levels of severity

Severity Rating- Dimension 6 (Recovery/Living Environment)				
0 None	**1** Mild	**2** Moderate	**3** Severe	**4** Very Severe
Environment supportive of recovery process.	Environment is supportive. May require clinical intervention.	Environment unsupportive to recovery process but able to participate with clinical support.	Environment unsupportive to recovery process, difficulty in participating even with clinical support.	Environment toxic/hostile to recovery. Unable to participate and the environment may pose a threat to safety.
Comments:				

Summary of Multidimensional Assessment					
Dimension	**Severity Rating (Based on rating above)**				
Dimension 1 Substance Use, Acute Intoxication, Withdrawal Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 2 Biomedical Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 4 Readiness to Change	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 5 Relapse, Continued Use, or Continued Problem Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
Dimension 6 Recovery/Living Environment	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe

Consumer Name: _____

Consumer ID: _____

PLACEMENT SUMMARY

Level of Care/Service Indicated by ASAM: The following ASAM level of care offers the most appropriate level of care/service intensity given the consumer's functioning/severity:

Prevention:	☐ *0.5*				
Outpatient:	☐ *OTP (NTP)*	☐ *1.0*	☐ *IOT: 2.1*	*Partial Hosp.*	☐ *2.5*
Residential:	☐ *3.1*	☐ *3.3*	☐ *3.5*		
Medical Inpatient:	☐ *3.7*	☐ *4.0*			
Withdrawal Management:	☐ *1-WM*	☐ *2-WM*	☐ *3.2-WM*	☐ *3.7-WM*	☐ *4-WM*

Not Applicable (Referred to Recovery Services) ☐

Level of Care/Service Provided: If the most appropriate level of care/service intensity was not utilized, enter the most appropriate ASAM level of care that is available then select the reason for this discrepancy (if any):

Prevention:	☐ *0.5*				
Outpatient:	☐ *OTP (NTP)*	☐ *1.0*	☐ *IOT: 2.1*	*Partial Hosp.*	☐ *2.5*
Residential:	☐ *3.1*	☐ *3.3*	☐ *3.5*		
Medical Inpatient:	☐ *3.7*	☐ *4.0*			
Withdrawal Management:	☐ *1-WM*	☐ *2-WM*	☐ *3.2-WM*	☐ *3.7-WM*	☐ *4-WM*

Not Applicable (Referred to Recovery Services) ☐

Reason for Discrepancy: If there is a difference between the level of care indicated by the ASAM and the level of care actually provided then select the reason for discrepancy.

☐ *Not applicable*	☐ *Service not available*	☐ *Family responsibility*	☐ *Geographic accessibility*
☐ *Language*	☐ *Safety sensitive occupation*	☐ *Transportation*	☐ *Physical Health*
☐ *Living environment*	☐ *Cognitive/Mental Health condition consideration*	☐ *Service available, but no payment source*	☐ *Consumer on waiting list for more appropriate level*

☐ *Consumer preference, explain:* _____

_____

☐ *Other (specify):* _____

_____

If special consumer requests or needs were taken into consideration of placement, please indicate below:

_____

_____

Designated Treatment Provider Name and Location:

_____

_____

_____

Staff/Clinician Name **Signature** **Date**

Consumer Name: _____

Consumer ID: _____

ADULT ASAM TOOL – INSTRUCTIONS

INDICATE TYPE OF ASAM

- Initial Screening and Placement is the consumer's first contact and/or when the consumer is no longer active in an open episode.
- Update is to be completed at a minimum of every 30 days for Residential/Inpatient providers, or at a minimum of every 90 days for other modalities (including Prevention, Outpatient, Intensive Outpatient, Partial Hospitalization, and Opioid Treatment Program (OTP).
- Transition is when consumer is moving from one level of care to another, or for discharge, one time in the last 14 days of an open episode.

DEMOGRAPHIC INFORMATION

- Enter the consumer's name in the order of last name, first name and middle name.
- Enter the date the ASAM screening was performed.
- Enter the consumer's phone number and check yes or no, indicating if it is okay to leave a voicemail.
- Enter the consumer's address.
- Enter the consumer's date of birth.
- Enter the consumer's age.
- Enter the consumer's self identified gender.
- Enter the consumer's race.
- Enter the consumer's occupation.
- Enter the consumer's preferred language.
- Enter the consumer's medical record or 'P' number.
- Check off or specify the consumer's insurance type and indicate what type of plan they have.
- Enter who and/or which agency referred the consumer for assessment.
- Enter explanation for why consumer is currently seeking services and a brief substance use history.

DIMENSION 1: SUBSTANCE USE, ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- For questions 1-4, the interviewer asks the consumer the following questions, to which the consumer would respond yes or no. The interviewer is then to ask the consumer to further describe their yes or no response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential.
- Question 1: Record any alcohol and/or drugs that the consumer has used in the past 30 days. If the consumer is using opioids or alcohol, consider a referral to an Opioid Treatment Program or to a provider who offers Medication-Assisted Treatment, as appropriate.
- Question 2: Record any Opioid pain medication, benzodiazepines, stimulants or other prescription medication used or misused in the past 30 days. If the consumer is using opioids or alcohol, consider a referral to an Opioid Treatment Program or to a provider who offers Medication Assisted Treatment, as appropriate.
- Questions 3: Check yes or no. If yes, continue to answer a – f, indicating when for f as necessary.
- Question 4: Check yes or no.
- Enter additional comments (if any) relevant to Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential, based on the consumer's current risk level (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very

Consumer Name: _____

Consumer ID: _____

Severe). This is done by reading the descriptions for each severity level and considering the information that was gathered in questions 1-7. The interviewer then chooses the rating that best describes the consumer's current level of risk for substance use, acute intoxication, and risks associated with withdrawal.

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

- For questions 5-8, the interviewer asks the consumer the following questions, to which the consumer would respond yes or no. The interviewer is then to ask the consumer to further describe their yes or no response and document it in the space provided. Question 9 is to be answered by the interviewer. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 2: Biomedical Conditions and Complications.
- Questions 5-8: Check yes or no. Further describe the response in the space provided.
- Question 9 to be answered by interviewer: Check yes or no. If yes, consider an immediate referral to the emergency room or call 911.
- Enter additional comments relevant to Dimension 2: Biomedical Conditions and Complications, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 2: Biomedical Conditions and Complications, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 8-10. The interviewer then chooses the rating that best describes the consumer's current level of risk for physical health problems and how they may impact the consumer's treatment placement.

DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

- For questions 10-18, the interviewer asks the consumer the following questions, to which the consumer would respond yes or no. The interviewer is then to ask the consumer to further describe their yes or no response and document it in the space provided.
- Questions 10-12: Check yes or no. Further describe the response in the space provided.
- If the consumer has a cognitive or mental health condition that requires a slower pace of treatment and residential care, consider a referral to ASAM level 3.3 residential care.
- Question 13: Check yes or no. Further describe the response in the space provided.
- Question 14: Check yes or no. If yes, continue to next question.
  Check yes or no. If yes, consider transport to emergency room or call 911.
  *Check yes or no. Further describe your responses in the space provided.
- Question 15: Check yes or no. If yes, describe name and dosage in space provided.
- Question 16: Check all that apply or N/A if none.
- Question 17: Check one that applies or N/A if none.
- Question 18: Check yes or no.
- Enter additional comments relevant to Dimension 2: Biomedical Conditions and Complications, in the space provided, that may impact the placement of the consumer.
- Choose a severity rating of 0-4 for Dimension 3: Emotional, Behavioral, or Cognitive Conditions or Complications, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 10-18. The interviewer then chooses the rating that best describes the consumer's current level of risk for mental health problems and how they may impact the consumer's treatment placement. *If a consumer scores a 3 or 4 in severity, consider referral to a Behavioral Health Clinic.

DIMENSION 4: READINESS TO CHANGE

Consumer Name: _____

Consumer ID: _____

- For questions 19-24, the interviewer asks the consumer the following questions. The interviewer is then to ask the consumer to further describe their response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 4: Readiness to Change.
- Question 19: Check yes or no.
- Question 20: Check yes or no.
- Question 21: Check yes or no.
- Question 22: Check yes or no.
- Question 23: Check off only one of the responses given for alcohol, drugs, and mental health issues separately.
- Question 24: Indicate response to scaling question, 1 being low and 5 being high.
- Enter additional comments relevant to Dimension 4: Readiness to Change, in the space provided, that may impact placement of the consumer
- Choose a severity rating of 0-4 for Dimension 4: Readiness to Change, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 19-24. The interviewer then chooses the rating that best describes the consumer's current level of risk for readiness to change and engage in treatment, and how that may impact the consumer's treatment placement.

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

- For questions 25-32, the interviewer asks the consumer the following questions. The interviewer is then to ask the consumer to further describe their response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating for Dimension 5: Relapse, Continued Use or Continued Problem Potential.
- Question 25: Describe the response in the space provided.
- Question 26: Indicate response to scaling question, 1 being none and 5 being extreme urge.
- Question 27: Check one box.
- Question 28: Check yes or no.
- Question 29: Check yes or no.
- Question 30: Enter number of days in space provided.
- Question 31: Check yes, no, or N/A.
  If yes, check yes or no to a – b. A yes answer to a alone or b, c, and d indicates consumer is eligible for Narcotic Treatment Program services. Consider referral to methadone.
- Question 32: Check yes or no. If yes, consider referral to Medication Assisted Treatment (MAT).
- Choose a severity rating of 0-4 for Dimension 5: Relapse, Continued Use or Continued Problem Potential, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 20-23. The interviewer then chooses the rating that best describes the consumer's current level of risk for relapse, continued use or continued problems and how that may impact the consumer's treatment placement.
- Enter additional comments relevant to Dimension 5: Relapse, Continued Use or Continued Problem Potential, in the space provided, that may impact placement of the consumer.

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT

- For questions 33-40, the interviewer asks the consumer the following questions. The interviewer is then to ask the consumer to further describe their response and document it in the space provided. The intent is to gather as much relevant information on each topic in order to best determine the consumer's severity rating

Consumer Name: _____

Consumer ID: _____

for Dimension 6: Recovery/Living Environment.

- Question 33: Check off only one of the responses.
- Question 34: Check yes or no. Further describe response in space provided.
- Question 35: Check yes or no. Further describe response in space provided.
- Question 36: Check one box.
- Question 37: Check yes, no, or decline to state.

- Question 38: Check yes or no.
- Question 39: Check yes or no. If yes, check box(es) indicating involvement.
- Question 40: Check yes or no. If yes, check yes or no. Further explain yes response in space provided.
- Choose the severity rating of 0-4 for Dimension 6: Recovery/Living Environment, based on the consumer's current risk level. (0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; 4 = Very Severe). This is done by reading the descriptions for each severity level, and considering the information that was gathered in questions 24-27. The interviewer then chooses the rating that best describes the consumer's current level of risk due to their recovery and living environment and how that may impact the consumer's treatment placement.
  - **Note: homelessness does not automatically mean the consumer is eligible for residential treatment. The risk of all 6 Dimensions must be fully taken into account when deciding level of care placement.*
- Enter additional comments relevant to Dimension 6: Recovery/Living Environment, in the space provided, that may impact treatment or placement of the consumer.

SUMMARY OF MULTIDIMENSIONAL ASSESSMENT

- The intent of the 'Summary of Multidimensional Assessment' section of the assessment is to consolidate the information gathered from all 6 ASAM dimensions onto one page to help the interviewer synthesize this information to develop an individualized case formulation and ultimately select the most appropriate ASAM level of care.
- For Dimensions 1-6, check off the severity rating that you chose in the previous section.

PLACEMENT SUMMARY INFORMATION

- Enter the Level of Care as indicated by the ASAM. *Use the key below for definition of the numbers and corresponding description of each level of care.
- Enter the Level of Care that is being provided. *Use the key below for definition of the numbers and corresponding description of each level of care.
- There may be exceptions in which the Level of Care chosen for the consumer and Level of Care that the consumer is placed differ. This may be due to lack of availability, or consumer preference. If there is a discrepancy between the Level of Care chosen by the interviewer and the Level of Care that is to be provided, please check off the appropriate reason for the discrepancy and briefly explain why.
- Describe if any special consumer requests or needs were taken into consideration of placement.
- Provide the information and location for the designated treatment provider for the consumer.
- Enter the interviewer's (counselor) name, signature and date of the multidimensional screening.

*ASAM LEVELS OF CARE

- 0.5: Early Intervention
- OTP (NTP): Opioid Treatment Services
- 1.0: Outpatient Services

Consumer Name: _____

Consumer ID: _____

- 2.1: Intensive Outpatient Services
- 2.5: Partial Hospitalization Services
- 3.1: Clinically Managed Low-Intensity Residential Services
- 3.3: Clinically Managed High-Intensity Residential Services (Population-Specific)
- 3.5: Clinically Managed High-Intensity Residential Services (Non-population-Specific)
- 3.7: Medically Monitored Intensive Inpatient Services
- 4.0: Medically Managed Intensive Inpatient Services
- 1-WM: Ambulatory Withdrawal Management (Without extended onsite monitoring)
- 2-WM: Ambulatory Withdrawal Management (With extended onsite monitoring)
- 3.2-WM: Residential Withdrawal Management (Clinically Managed)
- 3.7-WM: Inpatient Withdrawal Management (Clinically Managed)
- 4-WM: Inpatient Withdrawal Management (Medically Managed and Intensive Services)
- N/A: Not Applicable – no Substance Use Prevention or Treatment Services will be provided

Consumer Name: _____

Consumer ID: _____

ADULT SUBSTANCE USE DISORDER (SUD) LEVEL OF CARE (LOC) AND ASAM DIMENSIONS

Level Of Care (LOC)	ASAM Level	Dimension 1 Acute Intoxication/ Withdrawal	Dimension 2 Biomedical	Dimension 3 Emotional, Behavioral, Cognitive	Dimension 4 Readiness to Change	Dimension 5 Relapse/ Continued Use	Dimension 6 Recovery/ Living Environment
Early Intervention	0.5	No withdrawal risk	None; very stable	No psychiatric conditions; very stable	Willing to explore current use and/ or risky behaviors	Needs an understanding or skills to change current use/ risky behaviors	Social support/ environment increase risk of conflict over use
Outpatient	1	Not experiencing significant withdrawal; minimal risk; manageable at Level 1-WM	None or very stable; receiving concurrent medical monitoring	Very stable psychiatric conditions; no impulsice behaviors, receiving concurrent mental health monitoring	Ready for recovery but needs motivating strategies	Able to maintain abstinence, control use and pursue recovery	Recovery environment is supportive; client has skills to cope
Intensive Outpatient	2.1	Minimal risk of severe withdrawal; manageable at Level 2-WM	Biomedical conditions not distracting from treatment	Mild severity with potential distraction; receiving concurrent mental health treatment	Ambivalent to treatment; lack of insight to substance use disorder or mental health problem; requires structured program many times a week to progress through stages of change	Intensification of symptoms indicate likelihood of relapse or continued use without monitoring/ support many times a week	Recovery environment is not supportive but can cope with structure
Partial Hospitalization	2.5	Moderate risk of severe withdrawal	Biomedical conditions not sufficiently distracting from treatment	Mild to moderate severity with potential distraction	Significant ambivalence to treatment; lack of insight to substance use disorder or mental health problem; requires structured program almost every day to progress through stages of change	Intensification of symptoms indicate high likelihood of relapse or continued use without close monitoring/ support almost every day	Recovery environment is not supportive but can cope with structure and when provided relief from home environment
Low Intensity Residential	3.1	None/ minimal/ stable withdrawal risk; concurrently receiving Level 1-WM or Level 2-WM	Stable/ receiving concurrent medical monitoring	None/ minimal; not distracting recovery.	Open to recovery but needs structured environment to improve	Understands relapse; needs structure	Dangerous environment but safe with 24-hour structure
High Intensity Residential Population Specific	3.3	Minimal risk of severe withdrawal; if withdrawal present, manageable at Level 3.2-WM	Stable/ receiving concurrent medical monitoring	Mild/ moderate severity; needs structure; treatment designed to address cognitive defects.	Little awareness; needs interventions available only at this LOC to stay in treatment	Little awareness; needs interventions available only at this LOC to prevent continued use	Dangerous environment; needs 24- hour structure to learn to cope
High Intensity Residential Non-Population Specific	3.5	Minimal risk of severe withdrawal; if withdrawal present, manageable at Level 3.2-WM	None/ stable/ receiving concurrent medical monitoring	Repeated inability to control impulses; unstable; requires 24-hour setting for stabilization	Marked difficulty/ opposition to treatment with dangerous consequences	No recognition of skills needed to prevent continued use; with imminent dangerous consequences	Dangerous environment; lacks coping skills outside of 24-hour highly structured setting
Intensive Inpatient Services Medically Monitored	3.7	High risk of withdrawal but manageable at Level 3.7-WM	Requires 24-hour medical monitoring but not intensive treatment	Moderate severity; needs 24-hour structured setting; for co-occurring mental disorder, requires concurrent mental health services	Low interest in treatment/ poor impulse control despite negative consequences; needs coping/ motivating strategies safely available only in 24-hour structured setting	No self-control; with imminently dangerous consequences	Dangerous environment; lacks skills to cope outside of a highly structured 24-hour setting
Intensive Inpatient Services Medically Managed	4.0	High risk of withdrawal; require Level 4-WM and the full resources of a licensed hospital	Requires 24-hour medical and nursing care with full resources of a licensed hospital	Severe and unstable problems requiring 24-hour psychiatric care with concurrent addiction treatment	Problems in these dimensions do not qualify client for this LOC; must have severity in Dimensions 1-3	Problems in these dimensions do not qualify client for this LOC; must have severity in Dimensions 1-3	Problems in these dimensions do not qualify client for this LOC; must have severity in Dimensions 1-3
Opioid (Narcotic) Treatment Program	1-OTP	Physiological dependence on opioid; requires this LOC to prevent withdrawal	Can be managed with outpatient medical monitoring	None; can be managed in an outpatient structured setting	Ready to change from opioid use but not for total abstinence from illicit prescription/ non- prescription drug use	High risk of relapse without this LOC and structured therapy	Supportive environment; patient has coping skills

Ambulatory Withdrawal Management: Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	Minimal risk of severe withdrawal that is manageable at this LOC; at least mild withdrawal symptoms or withdrawal is imminent
Ambulatory Withdrawal Management: With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	Moderate risk of severe withdrawal outside the program setting; no severe physical and psychiatric complications; safely responds to several hours of monitoring, medication and treatment; signs and symptoms of withdrawal or withdrawal is imminent
Residential Withdrawal Management: Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	Not at risk of severe withdrawal; moderate withdrawal safely managed at this LOC; signs and symptoms of withdrawal or withdrawal is imminent
Inpatient Withdrawal Management: Medically Monitored	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	Severe withdrawal syndrome that is manageable at this LOC; signs and symptoms of severe withdrawal or withdrawal is imminent
Inpatient Withdrawal Management: Medically Managed & Intensive Services	4.0-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Signs and symptoms of severe withdrawal; severe withdrawal is imminent; requires primary medical and nursing care services, and 24-hour observation, monitoring and treatment

DAS 6027 SAPT Placement Referral

Type of Referral:

Riverside University HEALTH SYSTEM Behavioral Health

Referral Date:

Agency Completing Referral: **Staff completing referral:**

Client Name: (Last) **(First)** **Gender:** **Medical Record#:**
Phone Number: **Permission to leave voicemail:** **City of Residence:**

Source & History

Source of Referral:

Pregnant:

Funding Source Confirmed
Private Insurance Medi-Cal County Self-Pay
CalWorks Other :

Previous Treatment History/Support
Detox Residential Opioid Treatment Program
Intensive Outpatient Outpatient 12-Step
Other :

Referred To

Agency

Phone #:

Contact Name:

Appointment Date:

Time:

Case Manager Assignment ()

Assigned Case Manager:

Additional Referrals: ☐ Mental Health (MH) ☐ Primary Care (PH) ☐ MAT
Currently receiving MAT services: **If yes, location:**

Referral Comments:

Treatment Program Response to Placement Referral

Disposition: ☐ No show ☐ Not appropriate for level of care ☐ Request for Re - Evaluation
☐ Intake Provided ☐ Other

Comments: _____

_____

_____

_____

Intake Date: _____ **Admitting Practitioner:** _____

Pregnancy Related Services: Yes / No
Financial Eligibility at Intake: ☐ Private Insurance ☐ Medi-Cal ☐ County ☐ Self-Pay
☐ CalWORKs ☐ Other _____

Client Name: (Last) **(First)** **Gender:** **Medical Record#:**
Phone Number: **Permission to leave voicemail:** **City of Residence:**

ASAM Designation

Level of Care Indicated	Level of Care Provided
Level of Care:	**Level of Care:**
Level of Care: OTP(NTP)	**Level of Care:** OTP(NTP)

Reason for Discrepancy:

Drug(s) of Choice/Last date of use:

Medication(s) Prescribed:

Weekly Bed Availability Reporting

Provider:

1st Week of:

Location Address:	Current County Bed Occupancy	Number of Projected Beds Available					
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Residential Slots							

2nd Week of:

Location Address:	Current County Bed Occupancy	Number of Projected Beds Available					
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Residential Slots							

3rd Week of:

Location Address:	Current County Bed Occupancy	Number of Projected Beds Available					
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Residential Slots							

Intructions:

Modality Column	Occupancy Column	Daily Projected Beds Columns
Each Location or Population separates each boxed grouping. Your contracted modalities for each location are listed. Treat them separately.	1. Provider enter the number of current County consumers occupying beds and projected occupancy on the day you fill out the form. 2. Indicate the number of consumers in each of the modalities you currently have in your program.	1. Indicate how many beds you have available for every day of the entire week for every modality you are contracted for. Each day may vary depending on projected discharges. 2. Every day needs to be filled out so that the SU CARES personnel can potentially place people at some point during the week. 3. Project out potential bed days for the following two weeks so that SUCARES may plan for waitlisted individuals.

ANS: Revised 2/8/17

Scan and email to SAReferral@rcmhd.org

Riverside University HEALTH SYSTEM Behavioral Health

Medical / Psychiatric Clearance

Client Name _____ Date: _____

The client listed above has been assessed for Withdrawal Management (Detoxification) and/or Residential Treatment services.

In order to effectively and safely administer services for the patient we request they obtain a Medical and/or Psychiatric clearance.

A. Definitions and Treatment Environment

Withdrawal Management (Detoxification)
American Society of Addiction Medicine (ASAM) Level: • 3.2-WM: Clinically Managed Residential Withdrawal Management: ➢ Services are provided in a group setting ➢ Service delivery – social setting withdrawal management program ➢ Patient's withdrawal signs and symptoms at this time do not require the full resources of a medically monitored inpatient withdrawal management facility ➢ Protocols in place for transfer to higher level of care when warranted

Residential Treatment
American Society of Addiction Medicine (ASAM) Level: • 3.1 Clinically Managed Low-Intensity Residential Services • 3.3 Clinically Managed Population Specific High-Intensity Residential Services • 3.5 Clinically Managed High-Intensity Residential Services ➢ Services are provided in a group setting (living/sleeping accommodations and group therapy) ➢ Patient is ambulatory (able to self-groom, attend individual and group therapy/educational sessions, assist with daily living activites in a group setting, participate in recreational activites of their choice, etc.)

B. Type of Clearance Requested (Check only one box)

☐ Medical Clearance	☐ Psychiatric Clearance

Riverside University HEALTH SYSTEM Behavioral Health

C. This section to be completed by the Medical Health Provider or Behavioral Health Provider:

Medical Status	Psychiatric Status
☐ The severity of the patient's medical condition at this time would not prevent the patient from participating in Withdrawal Management (Detoxification) services.	☐ The severity of the patient's psychiatric condition at this time would not prevent the patient from participating in Withdrawal Management (Detoxification) services.
☐ The severity of the patient's medical condition at this time would not prevent the patient from participating in Residential Treatment Services.	☐ The severity of the patient's psychiatric condition at this time would not prevent the patient from participating in Residential Treatment Services.

Diagnosis(es)	

Current Medications:

Please assist the treatment facility in maintaining continuity of care by prescribing non-narcotic medications whenever possible. Thank you

Type	Dosage	Directions

Additional Instructions

LPHA/MD's Printed Name: _____

LPHA/MD's Signature: _____

LPHA/MD's License Number: _____

LPHA/MD Phone Number: _____ Date: _____

Riverside University HEALTH SYSTEM
Behavioral Health

TO: Contract Providers

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: **SUP07-2016** **EFFECTIVE DATE:** May 1, 2016

SUBJECT: **Medical Necessity Statement**

Effective May 1, 2016, all Contracted Drug Medi-Cal Providers are required to include a narrative description outlining criteria from the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition when establishing Medical Necessity for Substance Use Disorder Treatment.

Title 22 states:

"(v) The physician shall evaluate each beneficiary to diagnose whether the beneficiary has a substance use disorder, within thirty (30) calendar days of the beneficiary's admission to treatment date. The diagnosis shall be based on the applicable diagnostic code from the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association. The physician shall document the basis for the diagnosis in the beneficiary's individual patient record.

(vi) The physician shall determine whether substance use disorder services are medically necessary, consistent with Section 51303 within thirty (30) calendar days of each beneficiary's admission to treatment date."

County requirements:

The physician will write a narrative description of how diagnostic criteria specific to Substance Use Disorder treatment relates to the individual seeking services and document this medical necessity statement in the consumer medical record within (30) days of the admission to treatment date.

Please contact Heidi Gomez and/or Elizabeth Del Rio if you have any questions.

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

ACCESSING SERVICES

- If not currently receiving Medi-Cal benefits, contact your local Department of Social Services office to apply for coverage

- Substance Abuse services in Riverside County may be accessed by contacting a county clinic directly, or by calling the **SU CARES Line at (800) 499-3008.** This line is available 24 hours a day, 7 days a week.

- All individuals requesting services will receive a thorough screening to help with identifying the service and/or services that will best support the individual in their recovery journey

- Substance Abuse Prevention and Treatment services offered through RUHS-BH include:

  * *Substance Use Prevention and Early Intervention*
  * *Substance Abuse Outpatient Treatment*
  * *Substance Abuse Intensive Outpatient Treatment*
  * *Guidance and Connection Services*
  * *Individual and Family Counseling and Therapy*
  * *Medication Assisted Treatment*
  * *Residential (Inpatient) and Outpatient Detoxification and Withdrawal Services*
  * *Specialized services for Adolescents and Pregnant and Postpartum Consumers*

SU CARES Line: (800) 499-3008

Riverside University HEALTH SYSTEM Behavioral Health

Riverside University HEALTH SYSTEM Behavioral Health

Steve Steinberg, Director

Substance Abuse Prevention and Treatment Programs Consumer Rights and How to Access Services

CONSUMER RIGHTS

As a consumer of Riverside University Health System – Behavioral Health, you are entitled to:

- Non-discrimination - Recipients will not be denied the opportunity to participate or benefit from a program or activity based on ethnic group identification, religion, age, sex, color, or physical or mental disability
- Receive information on treatment options and alternatives, and receive services in a language you can understand
- Receive timely access to services
- Obtain a list of county and contracted providers in your service area including names, locations, telephone numbers, non-English languages spoken, and identification of those not accepting new clients
- Be treated with dignity and respect
- Participate in decisions regarding your health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation
- Request a change of provider, a second opinion, or a change in level of care
- Request and receive a copy of your medical records, and request that they be amended or corrected unless precluded by HIPAA regulations
- File a grievance, appeal, or request a State Fair Hearing without retaliation
- Consumers receiving services in a county clinic or with a provider in the community may file a grievance by phone and/or by completing the Grievance form:
  - By phone: Call **Riverside County Health Plan at (800) 660-3570**
  - By mail: Complete the Appeal & Grievance Request Form located in the program lobby and mail it in the pre-labeled envelope available with the form
- In accordance with the Alcohol and/or Other Drug Program Certification Standards, any individual also has the right to file a grievance, appeal, or inspection of an alcoholism, drug abuse recovery, or treatment center with the state. Complaints should be directed to: ***Department of Health Care Services***
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 322-2911
- Consumers not covered by Medi-Cal may file a complaint by contacting the ***Department of Health Care Services SUD Compliance Division at (877) 685-8333***

Riverside County Health Plan
(800) 660-3570

Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 322-2911

Department of Health Care Services SUD Compliance Division
(877) 685-8333

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

Jerry A. Wengerd, Director

TO: Contract Providers

FROM: Rhyan Miller, Substance Use Program Administrator

DATE: June 24, 2015

BULLETIN: **SUP02-2015** **EFFECTIVE DATE:** July 1, 2015

SUBJECT: **County Contract Exhibit A - Staffing**

Effective July 1, 2015 all county and contract providers conducting substance use services will be required to submit annually, a list of current staff and copies of appropriate and current counselor certification or registration with an approved California agency. In addition, all county and contract providers will be responsible for submitting updated information to the County within (10) days of any changes in staffing.

The County contract Exhibit A states that each provider must maintain:

"A listing of staff personnel by name, title and professional training or degrees and license or certification shall be maintained. The list shall comply with Title 9, CCR staffing requirements."

and

"Proof of current licensure, certification, or registration; social workers and psychologists must meet business and professional codes required for licensure."

This change is in addition to the existing requirement of having these items in employee files.

Submit all information to Cynthia Lopez at (951) CLBLopez@rcmhd.org

Please contact the Contract Monitors if you have any questions.

Rhyan Miller MS, CAS
Program Administrator
Riverside County Department of Mental Health
Substance Use Administration

Riverside University HEALTH SYSTEM Behavioral Health

TO: Contract Providers

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: SUP09-2016 **EFFECTIVE DATE:** May 1, 2016

SUBJECT: Substance Use Disorder (SUD) Medical Director (MD)

Effective May 1, 2016, the County will diligently reinforce the below requirements regarding Substance Use Disorder Medical Directors adherence to Title 22 responsibilities set forth in Bulletin SUP09-2016. The modifications/additions were brought to RUHS BH's attention by DHCS as items DHCS will be monitoring strictly.

County and Title 22 requirements for Substance Use Disorder Medical Director responsibilities shall include:

The SUD Medical Director is to be a physician licensed by the Medical Board of California or Osteopathic Medical Board of California. He/she shall:

- Ensure medical care provided meets standard of care
- See to it physicians do not delegate their duties
- Make sure medical personnel follow medical policies and standards
- Make certain medical decisions are not influenced by fiscal considerations
- Ensure physicians are adequately trained to perform diagnosis of SUD, and determine medical necessity
- Make sure delegated duties to physicians are properly performed
- Develop medical policies and standards
- Receive at a minimum of five hours of continuing medical education in addiction medicine annually

Title 22 states:

§ 51000.24.4 Substance Use Disorder Medical Director
"Substance Use Disorder Medical Director" means a physician who is licensed by the Medical Board of California or the Osteopathic Medical Board of California and who meets requirements set forth in Sections 51000.70 and 51341.1(b)(28)."

§ 51341.1 (b) (28) Substance Use Medical Director
""Substance Use Disorder Medical Director" has the same meaning as in Section 51000.24.4.
(A) For outpatient drug free, day care habilitative, perinatal residential and naltrexone treatment services programs the following shall apply:
(i) The substance use disorder medical director's responsibilities shall at a minimum include all of the following:

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Behavioral Health

(a) Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
(b) Ensure that physicians do not delegate their duties to nonphysician personnel.
(c) Develop and implement medical policies and standards for the provider.
(d) Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
(e) Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
(f) Ensure that provider's physicians are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries and perform other physician duties, as outlined in this section.

(ii) 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.
(iii) A substance use disorder medical director shall receive a minimum of five (5) hours of continuing medical education in addiction medicine each year.

(B) For narcotic treatment programs, a substance use disorder medical director shall meet the requirements specified in Section 10110 of Title 9, CCR."

§ 51000.70. Substance Use Disorder Medical Director Utilization
"Each substance use disorder clinic shall have a licensed physician designated as the substance use disorder medical director, who is an agent of the substance use disorder clinic. The substance use disorder medical director shall meet the following requirements:
(a) Not be excluded from participation in any State or Federal Medicare or Medicaid program; and
(b) Be enrolled in Medi-Cal as a substance use disorder medical director; and
(c) Be acting in compliance with all laws and requirements of the Medi-Cal program."

Please contact Heidi Gomez and/or Elizabeth Del Rio if you have any questions.

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

Riverside University HEALTH SYSTEM Behavioral Health

TO: Contract Providers

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: SUP11-2016 **EFFECTIVE DATE:** June 1, 2016

SUBJECT: 90 Day Residential Stay Option

Adults requiring a longer length of stay due to medical necessity criteria will now be allowed to remain in residential treatment for up to 90 days in a continuous period.

According to the Department of Health Care Services, the average residential length of stay is 30 days for adults. However, those consumers who meet medical necessity may stay in residential treatment for up to 90 days. If a 90 day stay was not approved at the start of the treatment episode by the COUNTY, the consumer must be re-assessed to request additional lengths of stay.

When the American Society of Addiction Medicine (ASAM) screening tool or a comparable pre-approved assessment is conducted and the consumer's problems are assessed as still too great for outpatient services, an extension request form can be submitted to the COUNTY for evaluation and approval prior to the consumer's discharge for continuing residential service for a period of up to 90 days.

The determination of medical necessity shall also be documented by the physician in the consumer's individual patient record and shall include documentation that all of the following have been considered:

a. The consumer's personal, medical and substance use history.
b. Documentation of the consumer's most recent physical examination.
c. The consumer's progress notes and treatment plan goals.
d. The therapist or counselor's recommendation.
e. The consumer's prognosis.

All questions about these requirements can be directed to either Elizabeth Del Rio at (951) 782-2400 or Heidi Gomez at (951) 955-7320.

Riverside University HEALTH SYSTEM Behavioral Health

TO: Contract Providers

FROM: Rhyan Miller, Substance Abuse Prevention and Treatment Program Administrator

BULLETIN: SAPT12-2017 **EFFECTIVE DATE:** February 1, 2017

SUBJECT: Residential ASAM Levels 3.1, 3.3, and 3.5

To comply with Drug Medi-Cal Guidelines, all Residential treatment providers are required to adhere to Title 22 regulations.

The following will highlight a few of the documentation requirements. For further information, please refer to Title 22.

Progress Notes:

(1) At a minimum, all notes are to be written in DAP format. The physician, LPHA, or counselor is to type or legibly print their name, and sign and date the progress note. Each note is to be recorded within (7) calendar days of the session.
   - (i) One on one services are to be documented by the attending practitioner individually.
   - (ii) At a minimum, group services are to be documented weekly by the primary counselor.

Sign-In Sheets:

(2) Establish and maintain a sign-in sheet for each group session, which includes:
   - (i) The typed or legibly printed name and signature of each participant;
   - (ii) The typed or legibly printed name of the LPHA or counselor conducting the group;
   - (iii) The date of the counseling session;
   - (iv) The topic of the counseling session; and
   - (v) The start and end time of the group.

Treatment Plans:

(3) For each consumer admitted to residential treatment, the provider shall prepare an individualized treatment plan, based upon the information obtained in the intake and assessment process. Each treatment plan shall contain:
   - (i) A statement of problems to be addressed;
   - (ii) Goals to be reached which address each problem;
   - (iii) Action steps which will be taken by the provider, and/or consumer to accomplish identified goals;

Riverside University HEALTH SYSTEM Behavioral Health

(iv) Target dates for the accomplishment of action steps and goals;
(v) A description of the services, including the type of counseling, to be provided and the frequency thereof;
(vi) The assignment of a primary LPHA or counselor.
(vii) The consumer's diagnosis; and
(viii) If a consumer has not had a physical examination within the twelve month period prior to the consumer's admission to treatment date, a goal that the consumer have a physical examination.

Please contact Heidi Gomez if you have any questions.

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

Riverside University HEALTH SYSTEM Behavioral Health

TO: Contract Providers and County Clinics

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: **SAPT16-2017** **EFFECTIVE DATE:** July 24, 2017

SUBJECT: Leave of Absence from Residential Facilities Protocol

It is sometimes necessary for a patient to leave the residential facility after they have been admitted.

At no time should the patient be given what was once considered a "week-end" pass. If the patient meets medical necessity for residential services, and unless there are exceptional circumstances, they will remain in residential treatment for the duration of the episode.

The exceptions would include criminal justice commitments or medical appointments or hospitalization. The following outlines the protocol to follow when this occurs:

Appointments during the day and returning to the residential facility in time for services the same day: Provider is to document necessity for absence in chart and bill for treatment and room and board.

All day appointments and returning to the residential facility before 12:00 a.m. but no services: Provider is to document necessity for absence in chart and bill for room and board.

Incarceration or hospitalization 1-30 days: Provider is to document absence in chart and episode may remain open for up to 30 days. Provider may not bill for treatment or room and board. You may extend the patients stay by the amount of time they were incarcerated or hospitalized.

In the event Provider does not have bed availability when the patient returns, Provider is to work with County case manager to coordinate placement in another facility for a seamless transition.

Please contact Nicole Shaverdi (951) 782-2400 if you have any questions.

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

Substance Abuse Prevention & Treatment Recovery Services Screening Tool

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

Rate the following statements on scale from 1-3 on how strong you feel your recovery skills are in the specific area. This will help you and your counselor develop a treatment plan to strengthen your relapse prevention skills for successful transition to self-directed recovery at home:

1- **Not Confident (I very nervous)**
2- **Confident (I feel ready but also feel I could use more skills)**
3- **Highly Confident (I feel I am ready to tackle this at any time and be successful)**

	Circle one
I have the ability to identify my triggers and cravings to use/drink	1 2 3
I have the ability to refocus negative thought patterns of using and drinking	1 2 3
I have an action plan to avoid the use of mind altering chemicals	1 2 3
I have an action plan for the daily maintenance of my spiritual well-being	1 2 3
I have a strong clean and sober support system in my life	1 2 3
I know what to do to maintain my sobriety in a crisis	1 2 3
I have an action plan for physical and mental health care and know where to go	1 2 3
I have an action plan to support my desires of employment and living conditions	1 2 3

Riverside University HEALTH SYSTEM Behavioral Health

Treatment Services Timeline

Level of Care	Initial ASAM	Physician Intake (NTP Only)	Dx by MD or LPHA (NTP Only)	Admission/Intake	Dx/ASAM LOC by MD or LPHA Face-to-Face	Assessment	Initial Treatment Plan	TX Plan Signatures By MD or LPHA	Continuing TX Plan	6 Month Justification for Continued Services	CalOMS Annual Update	Discharge Planning	Transition ASAM	Discharge Summary
Outpatient Level 1	Completed outside of open episode prior to admission			Complete day 1	Complete 1-7 days from Intake date	Complete 1-14 days from Intake date	Complete within 30 days from intake date	Complete within 15 days from treatment plan development	Complete (at minimum) 90 days from intial treatment plan completion	Complete between month 5-6 from intake date, and no later than day 1 of the 6th month	Complete Between month 10-12 from intake date	Complete within last 30 days from discharge date	Complete within Last 14 days of treatment	Complete within 30 days from last face-to-face appointment
Intensive Outpatient Level 2.1	Completed outside of open episode prior to admission			Complete day 1	Complete 1-7 days from Intake date	Complete 1-14 days from Intake date	Complete within 30 days from intake date	Complete within 15 days from treatment plan development	Complete (at minimum) 90 days from intial treatment plan completion	Complete between month 5-6 from intake date, and no later than day 1 of the 6th month	Complete Between month 10-12 from intake date	Complete within last 30 days from discharge date	Complete within Last 14 days of treatment	Complete within 30 days from last face-to-face appointment
Residential Level 3.1, 3.3, 3.5	To be completed by County Staff			Complete day 1	Complete 1-7 days from Intake date	Complete 2-7 days from Intake date	Complete within 2-10 days of Intake date	Complete within 15 days from treatment plan development	*Complete (at minimum) 90 days from intial treatment plan completion	Complete between month 5-6 from intake date (IF PERI ONLY)	Complete between month 10-12 from intake date	Complete within last 30 days from discharge date	Complete within Last 14 days of treatment	Complete within 30 days from last face-to-face appointment
NTP (OTP)	Completed outside of open episode prior to admission	Complete day 1				Complete within 14 days from Intake date	Complete within 28 days from Intake date	Complete within 14 days from treatment plan development	Complete (at minimum) every 3 months from Intake date	Update ASAM & 6 month Justification Complete between month 5-6 from Intake date	Annual Complete Between month 10-12 from intake date	Complete within last 30 days from discharge date	Complete within Last 14 days of treatment	Complete within 15 days from last face-to-face appointment

MN = Medical Necessity DX = Diagnosis LOC = Level of Care

Admission/Intake = Complete health questionnaire, Release of Information, Client rights, consent to treat, admission agreement, fee waiver/sliding scale, TB test (as applicable), HIPAA, Informed Consent, program application, treatment alternatives acknowledgement (NTP), CalOMS admission, and client history.

Assessment = ASI or other biopsychosocial assessment as approved by the county.

LPHA = Licensed Professional of the Healing Arts (MFT, MFTi, MSW, LCSW, etc.)

Outpatient/IOT Documentation = All progress notes are composed with-in 7 days of service rule.

Residential Treatment Documentation = Clinical services are to be documented individually by the practitioner who provided the service within 7 days of date provided. Group notes are documented weekly.

NTP Documentation = Per Title 9 Section 10345 the counselor conducting the session shall document in the patient's record within 14 calender days from the session.

*** If granted an extension by SAPT Admin**

Riverside University HEALTH SYSTEM Behavioral Health

TO: Contract Providers

FROM: Rhyan Miller, Substance Abuse Prevention and Treatment Program Administrator

BULLETIN: **SAPT13-2017** **EFFECTIVE DATE:** March 13, 2017

SUBJECT: **Individual Services**

Riverside Substance Abuse Prevention and Treatment is requiring each consumer to record their attendance at individual sessions. This can be accomplished by implementing a sign in process for individual appointments.

At a minimum, confirmation of attendance in one-on-one services will be available for review as requested by RUHS-BH, SAPT and/or QI personnel.

Please contact Heidi Gomez if you have any questions.

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

POLICY NO:	**248**
SUBJECT:	**ADVERSE INCIDENT REPORTS, REVIEWS, AND THE MORBIDITY AND MORTALITY REVIEW COMMITTEE**
REFERENCES:	S/D Medi-Cal Manual for the Rehabilitation Option (Rev. 7/1/95); RCDMH Policy 312 – Accident and Injury Reporting; Board of Supervisors Policy C-27, Workplace Violence, Threats and Security; County Safety Document 2010
FORMS:	Adverse Incident Report Form 248 (Attachment A); Riverside County SOP Form #2010-1 – Workplace Violence Reporting (Attachment B)
EFFECTIVE DATE:	May 25, 2000
REVISED DATE:	August 15, 2011, March 4, 2009 and December 26, 2001

POLICY:

It is the policy of the Riverside County Department of Mental Health (RCDMH) that all adverse incidents involving RCDMH clients are reported, reviewed, and analyzed in a systematic way to identify opportunities for improvement in client care and treatment services, as well as clinical operations of RCDMH. The policy is intended to establish a method for conducting reviews of adverse incidents to identify systems and other issues/problem areas that may be adversely affecting the outcomes of care for enrolled county mental health and substance abuse clients. Through a systematic review of adverse incidents, identifying issues of concern, and developing corrective action plans responding to issues that may need to be addressed and corrected, improvements in outcomes, quality of care and treatment services and quality of life for consumers can be achieved.

Adverse Incident review activities will include all County operated and contract providers serving Mental Health clients (both mental health and substance abuse clients). For incidents involving clients being served only through a contractor, the region/program manager or designee shall, at a minimum,

review the contractor's incident report and quality assurance review to determine what, if any, additional information is needed to complete a thorough review of the incident. For incidents involving clients who are being served through both a county operated clinic/program and a contractor, the region/program manager or designee shall review both the contractor's report and the client's care provided through the county clinic or program.

PROCEDURE:

A. Scope

All currently open/enrolled RCDMH mental health or substance abuse services clients and clients whose treatment episodes were closed within three (3) months of the date of the incident.

B. Definition

An adverse incident is any event which, in the mind of a reasonable person, jeopardizes or is considered to be seriously harmful to clients, employees, or visitors. The most likely examples of adverse incidents are listed below:

1. All client deaths for all causes

2. Incidents involving significant dangerousness to self, including serious suicide attempts or self-injury

3. Incidents involving significant dangerousness to others, including serious assaults, homicide attempts and homicides

4. Incidents involving significant injury that requires medical intervention for any client or visitor at a program site or during a treatment activity off-site

C. Privileged Communication

All documents, forms, and written communications related to the reporting, review, and follow-up actions taken are strictly confidential and must be processed in a confidential manner and in compliance with HIPAA regulations. All forms and documents must be stamped or identified as "Confidential".

D. Region/Program Reporting and Review

1. All adverse incidents shall be verbally reported by the involved staff member immediately to the clinic/program supervisor. The RCDMH Adverse Incident Report, Form 248 (Attachment A), shall

be completed and submitted by the reporting staff member to the clinic/program supervisor as soon as possible thereafter, but no later than within one (1) business day. Form 248, Section A, that is completed by the reporting staff member and submitted to the clinic/program supervisor, shall initiate the formal reporting process.

(Note: Incidents involving workplace violence as defined in Safety Office Document 2010 and involving RCDMH clients or visitors are to be reported on the "Workplace Threat Incident Report" form (Attachment B – Sample), and sent immediately to the Human Resources Office.)

2. The service provider for the clinic/program shall make a brief progress note in the client's clinical record stating factually what happened and how it affected the client, in addition to the documentation of medically necessary treatment services provided. There shall be no reference to, or copy of, the Adverse Incident Report placed into the client's clinical record. Any other clients involved in the incident shall be identified only by client's ID or by their relationship to the client (e.g., "client's roommate") in the client's clinical record (i.e., no names).

3. The clinic/program supervisor shall complete Section B of Form #248 as soon as possible and within three (3) business days. Supervisors are to note any possible professional staff or facility license violations.

4. When more than one staff member is involved or witnesses the incident, each staff member shall provide a brief written statement regarding the incident and what occurred to attach to the Adverse Incident Report Form 248.

5. The supervisor shall forward the completed Sections A & B of Form 248 to the Region/Program Manager for review.

6. Upon notification of the possible occurrence of an adverse incident and receipt of Form 248, the Regional/Program Manager shall review the information and documentation received to determine what actions will be taken at the region/program level regarding the incident.

7. The Region/Program Manager will determine whether or not immediate notification to RCDMH Administration is needed and will complete urgent notification verbally and by forwarding a copy of the adverse incident report to the RCDMH Administrative Office.

This will include notification to Risk Management as determined on a case-by-case basis.

8. The Region/Program Manager will complete the manager's portion, Section B of Form 248, sign, date, and forward copies of Form 248 to the RCDMH Medical Director upon completion.

9. The Region/Program Manager will determine which incidents will require a review by the Region/Program Adverse Incident Review Committee based upon the seriousness of the incident, liability risk for RCDMH, and other factors. The goal and intent of the review of an incident is the identification of systems issues, individual clinician issues, or policy and procedural issues that are significant and that may be important to address that result from the incident review.

10. The manager may choose to:

    a. Conduct a personal review of the incident and use Section C of Form 248 to provide an analysis of the incident with the review, summary and recommendations for the review.

    b. Assign a clinical staff member who is outside of the direct clinic/program area in which the incident occurred, to conduct an analysis of the incident and use Section C of Form 248 to provide an analysis of the incident with the review, summary and recommendations for the review.

    c. Assign a Region/Program Adverse Incident Review Committee to conduct an analysis of the incident and use Section C of Form 248 to provide an analysis of the incident with the review, summary and recommendations for the review.

    d. If the manager is unclear whether or not a report constitutes an adverse incident that must be reported, or has questions regarding the type and extent of review needed, the manager shall consult with the RCDMH Medical Director for guidance.

11. The person or committee assigned to conduct a review of an incident shall assure that the confidentiality of the client, employees, and reviewers is maintained and file all written reports of the incident separately from any client clinical records.

12. Section C of Form 248 provides the outline and structure for conducting and completing the Region Program Adverse Incident

Report, Summary and Recommendations. This form is to be utilized regardless of the method selected for the review.

13. For all incidents involving deaths, the manager will determine whether or not a copy of the Sheriff Coroner's Investigation Report and/or Autopsy Protocol needs to be requested and obtained in order to complete the review process. If these are necessary to complete an adequate quality review of the incident, the manager may decide to hold the review process to be completed until after receipt of these reports.

14. Generally, incidents involving deaths due to natural causes do not require an extensive review. The manager shall determine which, if any, natural cause death cases are reviewed beyond just providing the information in Sections A & B of the Adverse Incident Report Form 248. If the manager determines that a review is needed, the manager will select the type and method of review to be conducted as identified in #10 above. If the manager is unclear about whether or not further review is needed, the manager will consult with the RCDMH Medical Director for guidance.

15. The incident review process shall include all relevant information pertaining to the incident including the following:

    a. Sections A & B of the Adverse Incident Report Form 248.

    b. The client's clinical records for at least the six (6) month period prior to the incident.

    c. The Riverside County Sheriff Coroner's Investigation Report and Autopsy Protocol as available.

16. The person or committee assigned to conduct a review of an incident shall make written recommendations for administrative action as appropriate including but not limited to:

    a. Making mandated reports regarding clients (abuse of a child, elder, or dependent/vulnerable adult)

    b. Reporting professional staff licensing violations

    c. Reporting facility licensing violations

    d. Providing additional specific staff education or training

e. Recommending policy or procedural changes at the clinic, program or department level

f. Recommend increased supervision of staff members

g. Recommending personnel actions including corrective and/or disciplinary actions

h. Request departmental clarification of legal standards, compliance oversight and standards of care, etc.

17. If the manager determines that a Region/Program Adverse Incident Review Committee will be utilized for conducting an incident review, the manager will determine the composition of the review committee and assign staff members to the committee. The composition of the committee may vary as determined by the manager for any incident to be reviewed. A psychiatrist should be assigned to each committee when necessary to review the medical or medication related issues and relevant system issues. Any employee who was directly involved in an incident shall not be assigned to conduct the incident review.

a. The committee will be responsible to conduct a thorough review of the incident with a focus on identification of systems issues, individual clinician issues or policy and procedural issues that may be important to address that are significant and identified as a result of the incident review.

b. Using Section C of Form 248 as the report format, the committee shall document their review report, summary, and provide any specific recommendations for improvement to address the systems or other issues that are identified.

c. The chairperson for the committee shall sign and date the final Form 248.

Section C of Form 248 will be forwarded to the Region/Program Manager to complete the region/program review process.

18. Regardless of the review method selected, the manager shall receive Form 248 for managerial review. The manager shall make any comments or notations on Section C of the Form 248 or on an attachment, and forward all forms to the Medical Director for the RCDMH Morbidity and Mortality Review Committee to process.

19. The Region/Program Manager shall review the incident findings and recommendations from each incident and discuss them with the supervisor(s). The manager will assure that any necessary corrective actions are completed and all recommendations are appropriately addressed and acted upon, and clearly identify any professional staff or facility licensing issues that may still require further administrative action. The manager will establish the process, method and timelines required to complete all action items from the region/program review and record this information on Section C of Form 248 or an attachment to forward to the Medical Director for the Morbidity and Mortality Committee review.

20. The manager shall forward all completed reports and reviews to the RCDMH Medical Director for Morbidity and Mortality Review Committee to process within five (5) business days of receipt of a completed review report.

E. RCDMH Morbidity and Mortality (M&M) Review Committee

1. The Morbidity and Mortality Review Committee membership shall include at a minimum:

   a. The RCDMH Medical Director (Chairperson)

   b. The RCDMH Chief of Psychiatry

   c. At least one other RCDMH psychiatrist

   d. The RCDMH Assistant Director for Programs

   e. At least one clinician from RCDMH Quality Improvement,

   f. The Outpatient Quality Improvement Supervisor.

2. The committee will conduct confidential clinical and administrative reviews of all adverse incidents involving RCDMH clients. All proceedings, minutes, communications and documents will be held as strictly confidential, will not be subject to public disclosure and will be held in the RCDMH Director's administrative offices for three (3) years after case closure. The M&M Review Committee will perform reviews of all adverse incidents for quality improvement and system performance improvement purposes. The Chairperson of the M&M Review Committee will review adverse incident reports received and will determine which cases require review by the Regional Adverse Incident Review Committee and the M&M Committee.

3. Upon receipt of an Adverse Incident Report, the Medical Director's office will assign an M&M case number for tracking purposes. When adequate information has become available for review, the case will be assigned for review by the M&M Committee. The M&M Review Committee will meet monthly to review cases. The Committee will generally be expected to review the Adverse Incident Report, the Regional Adverse Incident Committee's Review, Summary and Recommendations, and the Sheriff's Investigation Report and/or Autopsy Protocol as determined necessary and appropriate to do so. The M&M Committee will make determinations for each case regarding:

   a. The adequacy of the information available for review and what, if any, additional information may be needed in order to complete the review.

   b. Whether or not the quality of care provided to the client is consistent with the community standards of care for such clients.

   c. Whether or not to accept the recommendations of the Regional Adverse Incident Review Committee.

   d. Any further recommendations for corrective or other actions deemed appropriate and necessary in order to improve the quality of care and/or services provided for RCDMH clients.

   e. Whether or not an incident needs to be forwarded to the County's Risk Management division regarding incidents that may involve legal exposure for the County.

   f. Whether or not any professional staff violations of clinical practice or ethical standards have occurred and should be reported to the board for the professional discipline, i.e. discipline-specific professional licensing board or certifying body.

   g. Whether or not any facility licensing violations have occurred and should be reported to California's facility licensing authority.

   h. Case Closure when all items have been completed and no further action is necessary.

F. Contractor Operated Programs

1. Contractors shall be required to provide to the contract's program monitor, or regional/program manager, all of the same information that is required of county operated programs, including:

   a. The contractor's own report of the incident, addressing the same information contained in Form 248.

   b. The client's medical records for at least the six (6) month period prior to the incident.

   c. The Riverside County Sheriff Coroner's Investigation Report and/or Autopsy Protocol as available.

   d. A quality assurance review of the incident conducted by the contractor's supervisor, program manager, or quality assurance designee addressing the areas as outlined in the county's Adverse Incident Committee Review, Summary and Recommendations, Section C of Form 248.

   e. Timely written responses to any additional inquiries or follow-up action requested by the RCDMH Region/Program Manager, or the Morbidity and Mortality Review Committee.

2. Contractors are responsible to report professional staff violations of clinical practice or ethical standards regarding licensed professional staff to the appropriate professional licensing board or certifying body, and to the National Practitioner Data Bank (NPDB) as required.

3. Contractors are responsible to report facility licensing violations have occurred and should be reported to California's facility licensing authority.

4. The RCDMH Assistant Director for Programs shall be responsible for making reports to the County's Risk Management Division regarding incidents that may involve legal exposure for the County that involve a contractor.

5. The RCDMH Assistant Director for Programs shall be responsible for making mandated reports to the California State Department of Mental Health of any facility licensing issues involving county-operated programs/facilities involving Department clients and assure that mandated reports have been completed as required for contractor-operated programs/facilities.

6. The RCDMH Assistant Director for Programs shall be responsible for making mandated reports to the appropriate California licensing or certifying board/body regarding any professional staff violations of license or certification standards of professional staff other than physicians involving Department clients in county-operated programs/facilities and assure that mandated reports have been completed as required for professional staff of contractor-operated programs/facilities.

7. The RCDMH Medical Director shall be responsible for making mandated reports to the California Medical Board any physician violations of licensing standards involving Department clients in county-operated programs/facilities and assure that mandated reports have been completed as required for contractor-operated programs/facilities.

8. The RCDMH Quality Improvement Division will assist the Medical Director and Assistant Director for Programs with monitoring and oversight of any adverse incidents.

Approved by: _____ Date: 8-15-11
Mental Health Director

Attachments
Adverse Incident Report Form 248, Attachment A
Workplace Threat Incident Report Against County or Riverside Employee (Sample), Attachment B)

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

Policy 248 - ADVERSE INCIDENT REPORT

(CONFIDENTIAL – Attorney Client Privileged Information)

SECTION A – TO BE COMPLETED BY PARTY SUBMITTING REPORT

Program/Clinic Name	RU #	Name of Reporting Staff
Client/Person (Last Name, First Name)	DOB	RCDMH Client ID

If the incident involved a person other than the client such as an employee or visitor, provide the person's name and contact #:

Last Name, First Name	Contact Phone	Involved as (e.g. staff, visitor, etc.)

Attach a copy of the client's current face sheet.

The above named client/person was involved in an act/action which meets/may meet (circle one) the requirements of the formation of the Adverse Incident Committee. The incident falls into the following reportable incident category(ies).

- ☐ All client deaths for any cause
- ☐ Incident involving significant dangerousness to self, including serious suicide attempts or self-injury
- ☐ Incident involving significant dangerousness to others, including serious assaults, homicide attempts and homicides
- ☐ Incident involving significant injury that required medical intervention for any client or visitor at a program site or during a treatment activity off-site.

Specific location where the incident occurred:	
Date of Incident	Time of Incident
Date FIRST reported to RCDMH	Time Reported to RCDMH

THE EVENTS WHICH OCCURED ARE AS FOLLOWS:

SUBMIT REPORT TO SUPERVISOR WITHIN ONE BUSINESS DAY OF INCIDENT

Reported submitted to:	
Submission completed:	Date: Time:

DO NOT FILE THIS FORM IN THE CLIENT'S CLINICAL RECORD

Riverside County Department of Mental Health
Policy 248 - ADVERSE INCIDENT REPORT
(CONFIDENTIAL – Attorney Client Privileged Information)

SECTION B – TO BE COMPLETED BY PROGRAM SUPERVISOR

Client/Person's (Last Name, First Name) _____ RCDMH Client ID _____

Diagnosis: Circle Primary [P] or Secondary [S] when applicable

AXIS I	P / S	1.
	P / S	2.
		3.
AXIS II	P / S	
AXIS III		

Medications: ☐ On medication(s) (list below) ☐ No Medication(s) ☐ Unknown

	Medication	Dose	Indication		Medication	Dose	Indication
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Suspected or Known Substance Use Disorder(s): ☐Yes ☐No If yes, describe:

Treating Psychiatrist: ☐Program MD ☐Pvt MD

Family/Legal Guardian - Aware of Incident: ☐Yes ☐No

Family Attitude/Response:

Client Comments:

DO NOT FILE THIS FORM IN THE CLIENT'S CLINICAL RECORD

Riverside County Department of Mental Health
Policy 248 - ADVERSE INCIDENT REPORT
(CONFIDENTIAL – Attorney Client Privileged Information)

SECTION B (CON'T) – TO BE COMPLETED BY PROGRAM SUPERVISOR

Witness Reports

1. _____ _____
Last Name, First Name (Area Code) Phone

Account of Incident: _____

2. _____ _____
Last Name, First Name (Area Code) Phone

Account of Incident: _____

3. _____ _____
Last Name, First Name (Area Code) Phone

Account of Incident: _____

Supervisor's Comments/Concerns/Issues Identified:

Supervisor's action (s) taken:

☐ Workplace Violence, Threats and Security Document # 2010 applies and report submitted as required by Safety Office Policy.
☐ Urgent RCDMH Administration notification recommended. *Refer to Policy 248.* If yes, requires IMMEDIATE filing of report to Regional Manager/Administrator.

Regional Manager/Administrator Must Be Notified ASAP or within three (3) business days.

_____ _____
Original Written Report Submitted to Date/Time Notified

DO NOT FILE THIS FORM IN THE CLIENT'S CLINICAL RECORD

Riverside County Department of Mental Health
Policy 248 - ADVERSE INCIDENT REPORT
(CONFIDENTIAL – Attorney Client Privileged Information)

REGION/PROGRAM ADVERSE INCIDENT COMMITTEE REVIEW, SUMMARY, AND RECOMMENDATIONS SECTION C

Client/Person's (Last Name, First Name)	RCDMH Client ID

Date of Incident	Time of Incident

Sheriff/Coroner Investigation Report Needed? ☐Y ☐N		If Yes, Date Requested:	
Name of Person who requested report:			
Sheriff/Coroner Autopsy Report Needed? ☐Y ☐N		If Yes, Date Requested:	
Name of Person who requested report:			

Incident Reviewed By (Name and Job Classification)			
1.		3.	
2.		4.	
Date of Review:		Period of Treatment Reviewed:	

Brief Description of Incident:

Additional Treatment Information
Diagnosis(es) if different than reported by program:
Medications if different than reported by program:
Relevant Laboratory or Other Diagnostic Information:
Describe/resolve reason for conflicting information:
Significant Medical/Surgical Conditions/Tx:
Recent Changes in Behavioral/Physical Health:

DO NOT FILE THIS FORM IN THE CLIENT'S CLINICAL RECORD

Riverside County Department of Mental Health
Policy 248 - ADVERSE INCIDENT REPORT
(CONFIDENTIAL – Attorney Client Privileged Information)

REGION/PROGRAM ADVERSE INCIDENT COMMITTEE REVIEW, SUMMARY, AND RECOMMENDATIONS SECTION C (CON'T)

Review Summary/Findings

Policy, Procedure, Program Issues Identified

☐ Coordination of Care with PCP	☐ Coordination of Care with another service or provider
☐ Identification of a Substance Use Disorder	☐ Referral to Substance Use or Co-Occurring Disorder Tx
☐ Risk Assessment	☐ Follow-up after missed appointment or "No-Show"
☐ Monitoring of psychotropic medications	☐ Psychotropic Medication Poly-pharmacy
☐ Prescribing controlled substance to a known substance abuser	☐ Other medication-related issue
☐ Delay in getting appt within reasonable time	☐ Case closed without adequate efforts to contact or engage/re-engage client
☐ Client lost to follow-up/unable to locate	☐ Other Issue(s)
Brief Description of Above Issues Identified:	

Does this incident involve a possible professional staff license/certification violation? ☐ Y ☐ N

If Yes, briefly describe:

Does this incident involve a possible facility licensing violation? ☐ Y ☐ N

If Yes, briefly describe:

If Yes, has licensing agency been notified?	☐ Y ☐ N
Has copy of incident report from licensee to licensing agency been obtained?	☐ Y ☐ N If Yes, attach copy of report

Reviewer(s) concur with supervisor whether Workplace Violence Report provision applies: ☐ Y ☐ N

If No, action taken by reviewer (s):

DO NOT FILE THIS FORM IN THE CLIENT'S CLINICAL RECORD

Riverside County Department of Mental Health
Policy 248 - ADVERSE INCIDENT REPORT
(CONFIDENTIAL – Attorney Client Privileged Information)

REGION/PROGRAM ADVERSE INCIDENT COMMITTEE REVIEW, SUMMARY, AND RECOMMENDATIONS SECTION C (CON'T)	
Reviewer(s) concur with supervisor that immediate notification to RCDMH administration required (Refer to Policy 248): ☐ Y ☐ N If different and reviewer(s) initiate notification:	
Person Notified	Date/Time Notified
Review Recommendations and Corrective Action Plan(s)	
1.	
Person(s) Responsible	Proposed Completion Date
2.	
Person(s) Responsible	Proposed Completion Date
3.	
Person(s) Responsible	Proposed Completion Date
Reviewer or Committee Chairperson Signature	Date Report Completed
If this is a review committee report, the original must be sent to the Region/Program manager within three (3) business days of completion of the report.	
Region/Program Manager/Admin Review/Comments/Actions:	
Manager/Administrator Signature	Date

DO NOT FILE THIS FORM IN THE CLIENT'S CLINICAL RECORD

(SAMPLE)

WORKPLACE VIOLENCE, THREATS AND SECURITY
DOCUMENT NUMBER: 2010-1
WORKPLACE THREAT INCIDENT REPORT
AGAINST COUNTY OF RIVERSIDE EMPLOYEE

1. **Name of Individual threatening County employee:** _____

2. **Relationship to County:** _____

3. **Physical description: Hair** _____ **Eyes** _____ **Height** _____

   Weight _____ **Ethnicity** _____

   Distinguishing characteristics (Attach picture if possible) _____

   _____

4. **Circumstances of threat:** _____

   _____

5. **Location of threat:** _____

6. **Date:** _____ **Time:** _____

7. **Exact words of threat:** _____

   _____

8. **Threatened County Employee's Name:** _____

9. **Department:** _____

10. **Work address:** _____

11. **Work telephone:** _____ **Home telephone:** _____

12. **Additional Comments:** _____

    _____

13. **Supervisor:** _____ **Work Phone:** _____

I certify under penalty of perjury the above information is true and correct to the best of my knowledge.

_____ ____/____/____
Threatened County Employee Signature **Date**

_____ ____/____/____
Supervisor's Signature **Date**

A copy must be sent to the County Safety Division. SOP Form 2010-1 Revised 1/99

DO NOT FILE THIS FORM IN THE CLIENT'S CLINICAL RECORD

Riverside University HEALTH SYSTEM
Behavioral Health

TO: Contract Providers

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: **SUP08-2016** **EFFECTIVE DATE:** May 1, 2016

SUBJECT: **6 Month Justification for Continuing Services** RM

Title 22 Justification for Continuing Services guidelines changed when the Emergency regulations were distributed on June 25, 2014. The Emergency Title 22 regulations became permanent on July 14, 2015. This bulletin is to notify all Contracted Drug Medi-Cal Providers that they will be held to the following standard.

Title 22 states:

"(5) Continuing services shall be justified as shown below:

(A) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services:

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

(ii) For each beneficiary, no sooner than five (5) months and no later than six (6) months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the physician shall determine whether continued services are medically necessary, consistent with Section 51303. The determination of medical necessity shall be documented by the physician in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:

(a) The beneficiary's personal, medical and substance use history.

(b) Documentation of the beneficiary's most recent physical examination.

(c) The beneficiary's progress notes and treatment plan goals.

(d) The therapist or counselor's recommendation pursuant to Paragraph (i) above.

(e) The beneficiary's prognosis.

(iii) If the physician determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment."

Riverside University HEALTH SYSTEM
Behavioral Health

In summary, the counselor or therapist is now responsible for:

- Between five (5) and six (6) months from the date of admission;
    - Review the consumer's progress and eligibility to continue to receive treatment services; and
    - Make a written recommendation as to whether or not services should be continued.

The physician is then responsible to:

- Complete Continuing Services Justification unless continuing treatment services are determined no longer medically necessary
    - Between five (5) and six (6) months from the date of admission
    - Document determination of medical necessity
        - Shall include documentation that all of the following have been considered:
            - Consumer's personal, medical, and substance use history;
            - Consumer's most recent physical exam;
            - Consumer's progress notes and treatment plan goals;
            - Therapist or counselor's recommendation; and
            - Consumer's prognosis.
- If the physician determines that continuing services are not medically necessary; then the provider shall discharge the consumer from treatment and connect to the next indicated ASAM level of care.

Please contact Heidi Gomez and/or Elizabeth Del Rio if you have any questions.

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

Riverside University HEALTH SYSTEM Behavioral Health

TO: Substance Use Medi-Cal Contract Providers

FROM: Rhyan Miller, Substance Use Program Administrator

DATE: May 12, 2016

Bulletin: SUP 10-2016

Subject: **Addition of Youth Treatment Services Codes and Change to Youth Treatment Rates**

On May 1, 2016, California Senate Bill 4 went into effect, giving undocumented children under the age of 19 eligibility for Medi-Cal coverage. As such, beginning with Fiscal Year 2016/2017 contracts, the rate for youth treatment services will be reimbursed at Medi-Cal rates and settled based on Medi-Cal guidelines. It is anticipated that the number of non-Medi-Cal eligible youth will drop significantly since the majority of those currently seen are undocumented. Due to these changes, it is important that Medi-Cal eligibility is determined.

The Medi-Cal rates for youth treatment services will be reimbursed at the following rates:

Service Code(s)	FY 16/17 Rate
SA421YT SA442YT SA443YT SA444YT SA445YT SA450YT	$66.93
SA440 YT	$27.14

All outpatient contracted providers will be receiving these YT codes starting July 1st 2016 for use in the ODF Modality.

- Adolescent programs (12-17yo) will only use YT codes listed above for all services and will no longer use the mirror adult codes (SA421, SA442, etc).
- Adult programs (18+) will also receive these YT codes but will only be authorized for use for the 18-21 yo population and these adult programs will not receive the SA440YT code.
- These codes will be used, documented, and billed by the provider for services conducted with consumers between the ages of 12 and 21 only. It will be the provider's responsibility to ensure that the service codes are used appropriately.

Riverside University HEALTH SYSTEM Behavioral Health

TO: Contract Providers

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: **SAPT14-2017** **EFFECTIVE DATE:** May 3, 2017

SUBJECT: Corrective Action Plan (CAP) Certification

Effective May 3, 2017, the County will require all Contract Providers to adhere to the protocol set forth in Bulletin SUP14-2017.

The County of Riverside is required to review all Corrective Action Plans (CAP) prior to the submission to DHCS.

1. Within (15) days of receipt of the Final Report from the Department of Health Care Services (DHCS), all Contract Providers are required to submit a copy of the CAP via email to Heidi Gomez, Supervising Behavioral Health Specialist at Quality Improvement. Final Reports may be a result of reviews conducted by various units within DHCS, including but not limited to, DMC Postservice Postpayment (PSPP), DMC Monitoring (DMCM), and County Monitoring Unit (CMU).

2. Upon receipt of the CAP from the Contract Provider, the County has (10) days to review and respond.
    a. If CAP is not approved, Contractor is to adjust and resubmit for approval until Contractor and County agree on content of the CAP.
    b. When CAP is approved, Contract Provider may submit to DHCS.

The County of Riverside is required to ensure provider CAP has been implemented.

1. A representative(s) from RUHS-BH will conduct a site visit to follow up on implementation of corrective action.
    a. If corrective actions have not been implemented according to CAP, then the County representative will:
        i. Work with DHCS to communicate areas of deficiency, and
        ii. Work with the Contractor to assist with compliance.
    b. If corrective actions have been implemented according to plan, then the County will communicate this to DHCS.

Please contact Heidi Gomez at (951) 955-7320 if you have any questions.

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

Riverside University HEALTH SYSTEM
Behavioral Health

TO: Contract Providers and County Clinics

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: **SAPT15-2017** **EFFECTIVE DATE:** May 12, 2017

SUBJECT: Pregnant Outpatient Guideline for Youth Ages 12 – 17

Historically, per Title 22 51341.1 (b)(11), a beneficiary 17 years or younger shall not participate in group counseling with any participant who is 18 years of age or older unless the counseling was provided at a certified school site.

Pursuant to us asking permission, effective May 12, 2017, DHCS will allow a pregnant 12 - 17 year old female into a Perinatal Outpatient program, regardless of her age, as long as this is clinically appropriate. Clinical documentation shall define the circumstances and substantiate the need for placement of a 12 - 17 year old into a group with adult participants. Services are to be in alignment with Title 22, Perinatal, and Youth Treatment Guidelines.

Please contact Heidi Gomez at (951) 955-7320 if you have any questions.

Rhyan Miller

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

Riverside University HEALTH SYSTEM Behavioral Health

TO: Contract Providers

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: **SAPT17-2017** **EFFECTIVE DATE:** September 18, 2017

SUBJECT: ASAM Level of Care Data Collection

To ensure beneficiaries have access to the full continuum of care for substance use disorder (SUD) treatment, the array of benefits offered through the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver are modeled after the American Society of Addiction Medicine (ASAM) Criteria. DHCS and UCLA have mandated the tracking and data collection of all Waivered Counties to make specific ASAM data available to them on a monthly basis. DMC-ODS Waiver counties are required to submit their ASAM LOC data for all DMC beneficiaries to through DHCS' Information Technology Web Services (ITWS), which is the same system counties already use to submit data to the California Outcomes Measurement System (CalOMS). Although ASAM LOC and CalOMS data must be submitted in separate files, submission rules will be similar. ASAM LOC data submission will be cumulative and must be submitted at least once monthly, no later than 45 days after the month of service. However, counties are not limited to once per month reporting and can choose to submit ASAM LOC data more often as needed.

To ensure adherence to this mandate and minimize the amount of work needed for contractors/providers RUHS BH will collect and send the data as required. RUHS BH SAPT has modeled a short ASAM Data form that the contractor must fill out for every ASAM completed, this includes initial, update, and transitional ASAM's. This mandate takes effect on Monday September 18th 2017 and will fulfill the contractor/provider obligation out lines in MHSUDS INFORMATION NOTICE NO.: 17-035.

Please contact Substance Abuse Administration at (951) 782-2400 if you have any questions.

Rhyan Miller, MS
Program Administrator
Riverside University Health System - Behavioral Health
Substance Use Administration

Riverside University HEALTH SYSTEM Behavioral Health

TO: SAPT Contract Providers and County Clinics

FROM: Rhyan Miller, Substance Use Program Administrator

BULLETIN: **SAPT 18-2017** **EFFECTIVE DATE:** September 14, 2017

SUBJECT: Waiver Intake and Assessments

Contractual Biopsychosocial Intake Reminder:
The ASI is no longer a contractual requirement for RUHS-BH Substance Abuse Prevention and Treatment County Clinics or Contracted Providers. Treatment providers may use the ASI structured assessment if desired, but it is not mandated. The ASI focuses on seven life domains which is incongruent with the six dimensions of ASAM. In the continually transforming Waiver system-of-care, the desire of and mandate from DHCS is that ASAM criteria drive all aspects of treatment, continuum of care, and consumer treatment goals. *If a provider chooses not to complete the ASI and the provider's Intakes and Assessments do not cover the minimum DHCS requirements listed below, entire episodes could be disallowed in a DHCS monitoring review.*

DHCS Waiver Intake Requirements:
As a reminder and to ensure treatment providers understand the intake requirements, included below are the DHCS mandated and minimum requirements of data collection for a complete intake assessment. In recent monitoring visits, many programs were missing the data in red:

- Drug/Alcohol History, Medical History, Family History, Psychiatric/Psychological History;
- Social/recreational History, Financial Status/History, Educational History, Employment History;
- Criminal History, Legal Status, Previous SUD Treatment History;
- American Society of Addiction Medicine (ASAM) Criteria.

Medical Necessity and Diagnosis:
The Medical Director or LPHA must evaluate the consumer's assessment and intake information if they completed it. If the beneficiary's assessment and intake information is completed by a counselor, the Medical Director or LPHA shall document and meet with the consumer or counselor through a face-to-face or telehealth review to establish that the beneficiary meets medical necessity criteria. The narrative note must also identify a Substance Use Disorder Diagnosis, symptoms, and criteria based on the DSM 5 along with an identified ASAM level of care.

Suggested Treatment Plan Adaptation:
RUHS-BH SAPT is strongly suggesting, and may mandate at a later date, that treatment providers modify treatment plans to use the six dimensions of ASAM instead of the current process of building treatment plans with the seven life domains. Some providers have already switched to this and the consumer and program goals appear more congruent with the ASAM criteria, charting requirements, and consumer treatment flow.

Please contact Heidi Gomez at (951) 955-7248 if you have any questions.

RIVERSIDE UNIVERSITY HEALTH SYSTEM –

BEHAVIORAL HEALTH

POLICY NO:	**239**
SUBJECT:	**CONFIDENTIALITY/PRIVACY DISCLOSURE OF PERSONAL INFORMATION (PI), PERSONALLY IDENTIFIABLE INFORMATION (PII) OR PROTECTED HEALTH INFORMATION (PHI)**
REFERENCES:	HIPAA Privacy Rule 45 CFR Sections 164.502, 164.504, 164.508, 164.510, 164.522, & 164.524; CA Civil Code Sections 56.10 & 56.11; 42 CFR Part 2; Welfare & Institutions Code Sections 5328 & 5330; Policy #229 "Public Records Act"; Policy #288 "PHI – Minimum Necessary for Use & Disclosure" Policy #299 "Authorization to Use/Disclose Individually Identifiable Health Information
FORMS:	Oath of Confidentiality; Consent to Treatment
EFFECTIVE DATE:	April 14, 2003
REVISED DATE:	June 7, 2017

POLICY:

Riverside University Health System – Behavioral Health (RUHS – BH) is committed to protecting the personal and health information of all consumers. It is the policy of RUHS – BH to keep all Protected Health Information (PHI), Personal Information (PI), and Personally Identifiable Information (PII) private. PHI is considered to be any information that reasonably identifies an individual and their past, present, or future physical or mental health or condition. This includes the fact that an individual is a client of RUHS – BH, and would include any combination of the person's first and last name, address, SSN, or date of birth, and any medical record information. Personal Information (PI) is information that can be used to identify an individual, including but not limited to first and last name, social security number, physical description, home address, home telephone number, education, financial matters and medical or employment history as well as statements made by or attributed to the individual. Personally identifiable information (PII) is any information that can be used to identify, contact, or locate an individual, either alone or combined with other easily accessible sources.

PROCEDURE:

A. Oath of Confidentiality

All employees, volunteers and guests are required to sign an Oath of Confidentiality (Attachment A) to certify that they agree not to divulge, to any unauthorized person, any client/patient data information considered to be PI, PII or PHI obtained by RUHS – BH. Employees and volunteers are to renew this Oath annually, and it will be retained in the supervisory file for six (6) years. PHI will be only be used and/or disclosed with a valid authorization in accordance with DMH Policy #299, "Authorization to Use/Disclose Individually Identifiable Health Information." This policy also outlines instances where disclosure of PHI is required by law. When ready for discard, any document containing PHI is to be shredded.

B. Exchanging PHI

Exchanging PHI with another provider for treatment purposes is permitted by the client signing the 'Consent to Treat' form (Attachment B) Exchanging PHI for payment and healthcare operations is also permitted by having the client sign the 'Consent to Treat' form. Exchanging PHI with a vendor who provides a service to the County other than treatment, payment and healthcare operations will require a Business Associate Agreement (BAA). A Business Associate Agreement allows the exchange of PHI for other healthcare operations purposes, such as data aggregation services or a Consultant providing Quality Assurance. The Business Associate Agreement must be in place before exchanging consumer PHI. If an employee is unsure about exchanging PHI with someone who may or may not be a Business Associate, he/she should contact the Compliance Officer.

C. Appropriate and Minimum Use

Access to PI, PII and PHI is limited to the minimum amount necessary for an employee to perform their job duties. No employee or volunteer of RUHS – BH shall knowingly disclose confidential client PHI except as authorized or required by law. RUHS – BH staff and volunteers are specifically prohibited from viewing their own medical records and PHI, as well as the medical records and PHI of their family members, friends, acquaintances, colleagues, or any other individual, unless it is required to perform their job duties.

In accordance with Policy ##288 "PHI – Minimum Necessary for Use & Disclosure", RUHS – BH will take reasonable steps to limit the use of, disclosures, and requests for PI, PII, and/or PHI to the minimum necessary

information to accomplish the intended purpose. This applies to verbal, written, and electronic PHI for all clients served at any County facility or contracted provider site governed by RUHS – BH.

It is unacceptable to use PI, PII and/or PHI for purposes other than as necessary to perform assigned job duties. Staff will take steps to protect and secure client information at all times.

D. Communications

Verbal communications discussing PHI will only be done in private, where a third party cannot overhear the conversation. Public communications of consumer PHI will not be tolerated. If a consumer engages in conversation discussing PHI in a public place, it is in the best interest of the consumer to move the conversation into a private place, where the conversation cannot be overheard by a third party.

RUHS – BH may exercise professional judgment, which would be in the consumer's best interest to limit disclosure to persons assisting in the care of the consumer. RUHS – BH may also exercise professional judgment that is consistent with any known preferences of the consumer and in the consumer's best interest, not disclose direct information to the consumer.

Consumers are permitted to request confidential communications of their own PHI. This applies to communications RUHS – BH may make to the consumer, and communications RUHS – BH may make to another party for treatment, payment or healthcare operations.

The consumer must make the confidential communications request in writing. The request must include enough information to accommodate confidential communication; such as consumer's name and alternative address to send confidential communication. RUHS – BH must accommodate all reasonable requests. The reasonableness of any request is made by RUHS – BH, solely on the basis of the administrative difficulty of complying with the request and as provided by state law and HIPAA regulations. RUHS – BH cannot require the consumer to provide a reason for the request as a condition of accommodating the request. RUHS – BH may refuse to accommodate a request if the consumer has not specified an alternative address or method of contact.

E. Enforcement

This policy applies to all employees, per-diem, temporary personnel, and/or service providers of the RUHS – BH, including affiliated students, interns,

contractors, volunteer workers, and employees from other agencies who have access to PI, PII and/or PHI.

This policy does not impact the mandated reporting requirements placed on licensed staff. Mandated reporting as required by law is not to be considered unauthorized release of confidential information.

Unauthorized release of confidential consumer health information is subject to employment, professional, and legal sanctions.

Approved by: _____ Date: 06.07.17
Director

Attachments:
Oath of Confidentiality, Attachment A
Consent to Treatment, Attachment B

Riverside University HEALTH SYSTEM Behavioral Health

CONFIDENTIALITY STATEMENT

The Riverside University Health System – Behavioral Health (RUHS – BH) is committed to protecting the personal and health information of all consumers. I have read Policy #239 "Confidentiality/Privacy Disclosure of Individually Identifiable Health Information" and understand that I am obligated to comply with the standards outlined. It is the policy of RUHS – BH to keep all Protected Health Information (PHI), Personal Information (PI), and Personally Identifiable Information (PII) private. PHI is considered to be any information that reasonably identifies an individual and their past, present, or future physical or mental health or condition. This includes the fact that an individual is a client of RUHS – BH, and would include any combination of the person's first and last name, address, SSN, or date of birth, and any medical record information. PI and PII can be used to identify an individual. RUHS – BH will take reasonable steps to limit the use of, disclosures and requests for PHI, PI and/or PII to the minimum necessary information to accomplish the intended purpose. When ready for discard, any document containing PHI, PI or PII is to be shredded.

This facility is run by RUHS – BH, and contains confidential client information. As an employee or guest of RUHS – BH, you are required to sign the following "Oath of Confidentiality" as a condition of admittance to or performing duties in a confidential setting.

OATH OF CONFIDENTIALITY

As a condition of admittance to a confidential setting or performing my duties as an officer, employee or guest of RUHS – BH, I agree to the minimum necessary standards, and I agree not to divulge, to any unauthorized person, any client/patient data information obtained by RUHS – BH, from any individual or facility. I recognize that the unauthorized release of confidential information may subject me to civil actions, under the provisions of the Welfare and Institution Code. In addition, I understand that if I knowingly and willfully violate state or federal law for improper use or disclosure of an individual's Protected Health Information (PHI), Personal Information (PI), and Personally Identifiable Information (PII), I am subject to criminal investigation and prosecution and/or civil monetary penalties, in accordance with the final HIPAA Privacy and Security Rules.

_____	_____
Print Name	Employer Name
_____	
Position/Title	
_____	_____
Signature	Date

Riverside University HEALTH SYSTEM Behavioral Health

CHILD/ADULT CONSENT TO TREAT

Attachment B

Consumer: _____ **Date of Consent:** _____

I, _____, consent and agree voluntarily to receive psychological services from Riverside University Health System – Behavioral Health. These services may include, but are not limited to, diagnostic assessments, psychological testing, crisis intervention, individual, group, and/or family therapy, consultations, and referrals to other professionals.

I understand by consenting to treatment, personal health information may be exchanged in a limited way for treatment, payment, and other health operations purposes only. This may include the exchange of information with Riverside County Substance Abuse Prevention and Treatment.

I understand that I have the right to terminate services at any time. I also understand that I have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I understand that I am expected to benefit from treatment, but there is no implied or expressed guarantee that I will.

INFORMED CONSENT GUIDELINES

ISSUES AND LIMITATIONS OF CONSUMER – THERAPIST CONFIDENTIALITY

All Behavioral Health Staff are mandated reporters of suspected child abuse and will report such suspicions to the appropriate authorities in accordance with applicable laws. Your records will be held in strict confidence except where disclosure is required by law and/or as noted in this section.

You may give your written permission to release all or part of your confidential file to a specific agency or person(s) at any time and at your discretion. Examples where confidentiality and the consumer/therapist privilege is waived include but are not limited to:

- Consumer has treated the information as if it were not confidential. Examples: a consumer verbally disclosed the information to a third party outside the therapy setting; Consumer has signed a written release covering specific disclosures such as to a doctor, school staff, associated therapist, or other agency.
- Court or Legally Mandated Disclosure: Reporting child, dependent adult, or elder abuse; and duty to protect about serious threat or bodily harm to a reasonably identifiable other.
- Consumer is dangerous to him/herself or others due to a mental disorder and the therapist has reasonable cause to believe this is the case.
- Where the consumer is under 16 and has been a victim of a crime specified in Penal Code section 111.60 (i.e., injuries by deadly weapon, assault, or abusive conduct).
- Where the consumer has waived or tendered his/her emotional condition pursuant to any legal proceeding. A legal proceeding to establish consumer's mental competence.
- Where the services of the therapist are sought or obtained to enable or aid anyone to commit or plan to commit a crime or tort.

Riverside University HEALTH SYSTEM Behavioral Health

CHILD/ADULT CONSENT TO TREAT

APPOINTMENTS

Consumers/Parents/Guardians are responsible for attending all scheduled appointments. If an appointment cannot be kept, you must contact the clinic to cancel at least 24 hours in advance. Appointments not kept or previously cancelled will be viewed as a "No-Show" and **two "No-Shows" or repeated absences *may* jeopardize continued treatment at the clinic**. Punctual attendance to all scheduled appointments is necessary. If you are more than 15 minutes late to an appointment, your appointment will be rescheduled and no services will be rendered that day. Repeated tardiness will jeopardize continued treatment at the clinic.

PSYCHIATRIC APPOINTMENTS

The above appointment punctuality and attendance guidelines also apply to appointments with the clinic psychiatrists. If you miss an appointment and need refills, you may be required to wait on a "first come first served" basis when the doctor is next in the office. Telephone requests for refills are generally not accepted.

TRANSPORTATION SERVICES

Clinic transportation services may be available to consumers in limited situations. It is the responsibility of the recipients of transportation services to notify the clinic of any changes (i.e., cancellations, rescheduling) in the agreed upon arrangements for transportation services. ***Use of transportation services may be suspended or terminated if there are two failures to change arrangements and the consumer was not available for pick-up upon the van's arrival to transport.***

CONSUMER'S GUIDE TO MENTAL HEALTH SERVICES/PROVIDER LISTING

I have been provided with a written copy of the Consumer's Guide to Mental Health Services and the Provider Listing. I have also been made aware that there is an audiotape version available.

My signature below indicates that the above clinic policies and information were reviewed with me and I understand them. I understand a copy of this form will be given to me.

_____ _____

Consumer Signature Date

_____ _____

Parent/Guardian Signature Date

RIVERSIDE UNIVERSITY HEALTH SYSTEM –

BEHAVIORAL HEALTH

POLICY NO:	**298**
SUBJECT:	**PROTECTED HEALTH INFORMATION – MINIMUM NECESSARY FOR USE AND DISCLOSURE**
REFERENCES:	HIPAA Privacy Rule 45 CFR Sections 164.502, 164.504, 164.508, 164.510, 164.514 & 164.522; CA Civil Code Sections 56.10 & 56.11; 42 CFR Part 2; Policy #239 "Confidentiality/Privacy Disclosure of PI, PII or PHI; Policy #241 "Release of Client Records and Subpoenas"; Policy #299 "Authorization to Use/Disclose PI, PII or PHI"
EFFECTIVE DATE:	April 14, 2003
REVISED DATE:	June 7, 2017

POLICY

It is the policy of the Riverside University Health System – Behavioral Health (RUHS – BH) to take reasonable steps to limit the use of, disclosures, and requests for Protected Health Information (PHI), Personal Information (PI), and Personally Identifiable Information (PII) to the minimum necessary information to accomplish the intended purpose. This applies to verbal, written, and electronic PHI, PI and PII for each and every client treated at any County facility or contracted provider site governed by RUHS – BH.

PHI is considered to be any information that reasonably identifies an individual and their past, present, or future physical or mental health or condition. This includes the fact that an individual is a client of RUHS – BH, and would include any combination of the person's first and last name, address, SSN, or date of birth, and any medical record information. Personal Information (PI) is information that can be used to identify an individual, including but not limited to first and last name, social security number, physical description, home address, home telephone number, education, financial matters and medical or employment history as well as statements made by or attributed to the individual. Personally identifiable information (PII) is any information that can be used to identify, contact, or locate an individual, either alone or combined with other easily accessible sources.

RIVERSIDE UNIVERSITY HEALTH SYSTEM –

BEHAVIORAL HEALTH

POLICY NO:	**299**
SUBJECT:	**AUTHORIZATION TO USE/DISCLOSE PERSONAL INFORMATION (PI), PERSONALLY IDENTIFIABLE INFORMATION (PII) OR PROTECTED HEALTH INFORMATION (PHI)**
REFERENCES:	HIPAA Privacy Rule 45 CFR Sections 164.502, 164.504, 164.508, 164.510, & 164.522; CA Civil Code Sections 56.10 & 56.11; 42 CFR, Part 2; Welfare & Institutions Code Sections 5328 & 5330; DMH Policy #101 "Compliance Plan"; Policy #202 "Tarasoff-Duty To Protect; Policy #222 "Accounting of Disclosures of PHI"; Policy #239 "Confidentiality/Privacy Disclosure of PI, PII & PHI; Policy #241 "Release of Client Records and Subpoenas"; Policy #288 "PHI – Minimum Necessary for Use & Disclosure"; Policy #294 "Caregivers Authorization to Consent for a Minors Medical Care"
FORMS:	Authorization Requesting Release/Receipt of Information and/or Records
EFFECTIVE DATE:	May 30, 2003
REVISED DATE:	June 21, 2017

POLICY:

Riverside University Health System – Behavioral Health (RUHS – BH) is committed to keeping all Protected Health Information (PHI), Personal Information (PI), and Personally Identifiable Information (PII) private. RUHS – BH will obtain an individual's voluntary and informed authorization before using or disclosing protected health information for any purpose not otherwise permitted or required under the HIPAA Privacy Rule and/or California Law.

An authorization is used when the consumer authorizes the release of medical information. The Authorization is written with a specific purpose and allows specific use/disclosure.

PROCEDURE:

RUHS – BH staff will always obtain a valid authorization from the consumer or their legal representative before disclosing/using any protected health information not otherwise covered/permitted by the consent regulation and/or exceptions as outlined under HIPAA regulation and/or California Law, whichever law is more strict (Attachment A). Authorizations received from outside RUHS – BH will be confirmed to be valid before the disclosure of any health information.

A. Authorization to Release Information

1. The authorization form must contain each of the following required elements:

    a. Specific description of information to be used or disclosed

    b. Identification of persons authorized by consumer to disclose/use and receive information

    c. Expiration date of authorization

    d. Right to revoke the authorization

    e. Statement that the information disclosed may be subject to re-disclosure and no longer protected

    f. Signature of the individual and date

    g. If a personal representative is involved, the authority of the representative will be described.

2. An authorization is not valid if it is expired, not filled out completely, lacks a required element or contains information known by RUHS – BH to be false.

3. When a consumer wishes to authorize a disclosure, it shall be stated on the authorization, "at the request of the individual", under purpose. The consumer may also describe the purpose, which shall also be documented.

4. Each individual authorization and the health information released shall be documented in the progress note(s). A copy of the

Authorization Form will be given to the consumer, and the original will be retained in the consumer's medical record.

5. Disclosures of Protected Health Information with a valid Authorization to Release Medical Information do not need to be accounted for on the Accounting of Disclosures log.

B. Unauthorized Release of PHI

1. Any unauthorized release of Protected Health Information (PHI) that is not permitted under HIPAA will be reported to the supervisor. The supervisor will then contact the Compliance Officer to provide details of the breach.

2. The Compliance Officer will perform an investigation in accordance with Policy #101 "Compliance Plan" and report the breach as necessary.

3. The program will document the breach in the client's chart in accordance with Policy #222 "Accounting of Disclosures of PHI".

Approved by: _____ Date: 06.21.17

Director of Behavioral Health

Attachment:
Authorization to Release Information, Attachment A

RIVERSIDE UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH Attachment A

AUTHORIZATION REQUESTING RELEASE/RECEIPT OF INFORMATION AND/OR RECORDS
(Confidential Patient Information – W&I Code Sec. 5328)

Consumer Name: _____ **Date of Birth:** ____/____/____/.

I, THE UNDERSIGNED, HEREBY AUTHORIZE: (Name and Address of Program with Records)

Name: Riverside University Health System – Behavioral Health **Phone No.:** (951) 358-5743

Street Address: 4095 County Circle Drive **Fax No.:** (951) 358-4721

City: Riverside **State:** CA **Zip Code:** 92503

TO RELEASE TO: (Name and address of party requesting access to records)

Organization/Name: _____ **Attn:** _____

Street Address: _____ **Phone No.:** ( )

City: _____ **State:** _____ **Zip Code:** _____

The following information discloses the fact that mental health and/or chemical dependency services have been/are being provided.

This disclosure of information is required for the following reason:

_____

And shall be limited to the following type(s) of information (**Please Print** and be specific in the type of information to be released). May include information such as: Legal Info., psychological testing, chemical dependency treatment, history, drug screens, diagnosis, discharge summary, HIV/AIDS related information, Medical, Neurological, Lab results, Medication, etc.

_____

_____

_____

Date of Requested Records: from: to:

_____

Please be advised that this authorization allows disclosure as described above and the County of Riverside cannot be held liable for how this information is used by the person/agency to whom the disclosure is made to and their safeguard practices.

This authorization becomes effective ___/___/___. This authorization may be revoked by the undersigned at any time, except to the extent that action has already been taken. If not revoked, it shall terminate one year from the date of authorization, or this date: ___/___/___.

_____ Date: ____/____/____
Signature of Consumer

_____ Date: ____/____/____
Signature of Parent, Guardian, Conservator

_____ Date: ____/____/____
Signature of Licensed Professional – when appropriate

****

Authorization Revoked: ____/____/____ _____
Signature of Consumer/Parent/Guardian/Conservator

PROCEDURE

Procedures for the release of information are separated into various categories. The minimum PHI, PI and PII necessary shall be released to accomplish the intended purpose of the use, disclosure, or request. Requests may include, but may not be limited to the following:

A. Treatment Requests/Releases

The release of information for treatment purposes is excluded from the Minimum Necessary rules. However, a covered entity may not use, disclose, or request an entire medical record, except where the entire medical record is specifically justified as the amount reasonably necessary to accomplish the purpose.

Although there is no limit to the type of information that may be released to a current Primary Care Provider, referring and consulting physicians, any provider associated with the specific episode of care for which information is requested, any provider with an authorization signed by the consumer, or any healthcare facility involved with the treatment of consumer, it is the policy of RUHS – BH to only release the minimum amount of information required to accomplish the task of treating and providing appropriate care to the client.

B. Legal Requests/Releases (other than subpoena)

Attorney requests, other than subpoenas, shall first be reviewed for appropriate authorization. Upon validation of the authorization, information will be provided to satisfy the purpose of the request. A standard abstract of documents/reports may be released to satisfy the requested purpose. An abstract consists of a face sheet, history, physical examination, discharge summary (or final progress note if no summary), consultation report, and any other information deemed appropriate to the request.

1. A request for "any and all information" will be reviewed for appropriateness, and followed up with the requesting party for specific purpose and need. RUHS – BH retains the right to limit the disclosure to what is determined to be appropriate for the request. When not honoring "any and all information" requests, the reason for limiting disclosure shall be documented.

2. Subpoena and/or court orders will be handled in accordance with current state laws, and Policy #241.

C. Insurance and Social Security Requests

1. Requests for information from third party payors to justify payment for services shall be limited to the specific dates of service and service justification

2. An abstract package of reports/information shall be provided when requests for information are received relative to life insurance. This includes information dating back five (5) years, unless otherwise specified in the request, and shall include a face sheet, history, physical examination, discharge summary (or final progress note if no summary), and any other information deemed appropriate to the request.

3. Requests for information relative to establishing disability shall be provided in accordance with the specific request. This includes information dating back five (5) years unless otherwise specified in the request, and shall include a face sheet, history and physical examination, discharge summary (or final progress note if no summary), and any other information deemed appropriate to the request.

D. Internal Requests

Internal access to consumer PHI, PI and PII shall be limited to the minimum necessary to accomplish the required task for the purposes of treatment, billing, payment, and health care operations of the facility.

RUHS - BH staff and volunteers are specifically prohibited from viewing their own medical records and PHI, as well as the medical records and PHI of their family members, friends, acquaintances, colleagues, or any other individual, unless it is required to perform their job duties.

Approved by: _____ Date: 06.07.17
Behavioral Health Director

Riverside University HEALTH SYSTEM Behavioral Health

CONFIDENTIALITY STATEMENT

The Riverside University Health System – Behavioral Health (RUHS – BH) is committed to protecting the personal and health information of all consumers. I have read Policy #239 "Confidentiality/Privacy Disclosure of Individually Identifiable Health Information" and understand that I am obligated to comply with the standards outlined. It is the policy of RUHS – BH to keep all Protected Health Information (PHI), Personal Information (PI), and Personally Identifiable Information (PII) private. PHI is considered to be any information that reasonably identifies an individual and their past, present, or future physical or mental health or condition. This includes the fact that an individual is a client of RUHS – BH, and would include any combination of the person's first and last name, address, SSN, or date of birth, and any medical record information. PI and PII can be used to identify an individual. RUHS – BH will take reasonable steps to limit the use of, disclosures and requests for PHI, PI and/or PII to the minimum necessary information to accomplish the intended purpose. When ready for discard, any document containing PHI, PI or PII is to be shredded.

This facility is run by RUHS – BH, and contains confidential client information. As an employee or guest of RUHS – BH, you are required to sign the following "Oath of Confidentiality" as a condition of admittance to or performing duties in a confidential setting.

OATH OF CONFIDENTIALITY

As a condition of admittance to a confidential setting or performing my duties as an officer, employee or guest of RUHS – BH, I agree to the minimum necessary standards, and I agree not to divulge, to any unauthorized person, any client/patient data information obtained by RUHS – BH, from any individual or facility. I recognize that the unauthorized release of confidential information may subject me to civil actions, under the provisions of the Welfare and Institution Code. In addition, I understand that if I knowingly and willfully violate state or federal law for improper use or disclosure of an individual's Protected Health Information (PHI), Personal Information (PI), and Personally Identifiable Information (PII), I am subject to criminal investigation and prosecution and/or civil monetary penalties, in accordance with the final HIPAA Privacy and Security Rules.

_____ _____

Print Name Employer Name

_____

Position/Title

_____ _____

Signature Date

RIVERSIDE COUNTY
DEPARTMENT OF MENTAL HEALTH

POLICY:	**295**
SUBJECT:	**BENEFICIARY/CONSUMER PROBLEM RESOLUTION PROCESS**
REFERENCE:	CCR, Title 9, Chapter 11, Sub-Chapter 5, Section 1850.205; 1850.210; 1850.215
FORMS:	None
EFFECTIVE DATE:	October 10, 2001
REVISED DATE:	March 2, 2005

POLICY:

All consumers of mental health services within the Riverside County Department of Mental Health shall have the right to file a grievance or make a complaint and to have follow-up to resolve the concern. A beneficiary/consumer grievance and beneficiary appeal process provides mental health beneficiaries or their representatives and other consumers of mental health services, with a method for resolving their concerns. Beneficiaries and/or their representatives and other consumers will be informed of their rights, at the time of initial assessment, annually thereafter, and as requested.

A. Definitions

1. Beneficiary- any person eligible under the Medi-Cal Program

2. Beneficiary/Consumer Problem Resolution Process – includes a grievance process; an appeal process, an expedited appeal process, and a State Fair Hearing are available to Medi-Cal beneficiaries

3. Consumer - any person who utilizes the Mental Health System but who does not have Medi-Cal (consumers are not eligible to file an Appeal or file a State Fair Hearing)

4. Grievance – an expression of dissatisfaction about any matter other than a matter covered by an Appeal as defined below

5. Appeal – A request for a review of an **action** or review of a provider's determination to deny, in whole or part, a beneficiary's request for a covered specialty mental health service or for a review of a determination that medical necessity criteria have not been met.

6. Action –
   a. denies or modified payment authorization of a requested service, including the type of service;
   b. reduce, suspend, or terminate a previously authorized service; denies, in whole or in part, payment for a service prior to the delivery of the service or;
   c. denies; in whole or in part, payment for a service; fails to provide service in a timely manner, as determined;
   d. fails to act in the timeframe for disposition of standard grievances, the resolution of a standard appeal, or the resolution of an expedited appeal

7. Expedited Appeal – oral or written request by the beneficiary to review an action as defined when use of the standard resolution process could jeopardize the beneficiary's life health or ability to attain, maintain, or regain maximum function

8. Notice of Action (NOA) written notice to the beneficiary when Specialty Mental Health Services are denied, reduced, modified or terminated by the Mental Health Plan or the MHP fails to act in the time frame for disposition of a standard grievance

9. State Fair Hearing – an independent review conducted by the State Department of Social Services as the final arbiter for appeals on action taken by the Mental Health Plan when services have been denied, terminated, suspended, or reduced

10. Aid Paid Pending – allows the beneficiary to continue obtaining Specialty Mental Health Services while pursuing an appeal or a State Fair Hearing

11. Beneficiary/Consumer Authorized Representative –An authorized representative is a person who is acting on the beneficiary's behalf and in the beneficiary/consumer's best interests, and who does not have a conflict of interest. Court representatives such as social workers or probation officers may act on behalf of minors under court jurisdiction. Parents, caregiver will automatically act as a representative for a minor and have the same rights as the child themselves.

PROCEDURES:

A. The Grievance Process

The majority of concerns can be resolved in the grievance process, which was designed to encourage identifying quick resolutions to beneficiary/consumer concerns.

The California Code of Regulations, Title 9, Chapter 11, and Section 1850.205 requires that each Medi-Cal beneficiary has adequate information about the grievance and appeal process. Information describing the grievance and the appeal process shall be in the beneficiary brochures.

1. Posters explaining the process are to be posted at all sites owned or operated by this Department and at all contracting provider sites where beneficiaries receive mental health services. Grievance/Appeal brochures, forms and self-addressed envelopes must be available to the beneficiary/consumer without having to make a verbal or written request to anyone. A beneficiary/ consumer may make a grievance orally or use the forms provided. A beneficiary may make an appeal orally or use the forms provided. A grievance will be logged when the beneficiary states they want to file a grievance.

2. Interpreter services and toll-free numbers along with TDD/TDY service are available to beneficiaries/consumers during normal business hours.

3. A beneficiary may authorize another person to act on his or her behalf and may select a provider (in writing) as his or her representative in the grievance or **appeal process.**

4. A beneficiary or consumer may have a legal representative to use the **grievance process.** A beneficiary may have a legal representative to use the **appeal** process.

5. Any clinical staff person in the Quality Improvement Program will assist a beneficiary/consumer with the beneficiary problem resolution process at the beneficiary/consumer's request.

6. Beneficiaries/consumers shall be informed that he/she will not be subject to any discrimination, penalty, sanction or restriction for filing a grievance. Beneficiaries shall be informed that he/she will not be subject to any discrimination, penalty, sanction or restriction for filing an appeal or Medi-Cal State Fair Hearing. The

grievance/appeal procedures shall insure the confidentiality of records. Informed consent shall be obtained from beneficiaries/consumers when any information or records are released to anyone (including the provider) not specifically authorized by law to have access.

B. General (Applied to both County and Contracted Service Providers)

DMH clinics and contract providers will provide beneficiaries/consumers with a copy of the Beneficiary's Guide to Mental Health Services when the beneficiary/consumer initially accesses service, and annually thereafter as long as the beneficiary/consumer remains in treatment, or at any other time it is requested. The Beneficiary's Guide contains a description of services available, the process for obtaining the services, and a description of the Beneficiary's Problem Resolution process. The information provided includes both the grievance and appeal resolution process, and states that Medi-Cal beneficiaries may instead file a State Fair Hearing whether or not the beneficiary uses the county's problem resolution process and whether or not the beneficiary has received a Notice of Action.

1. Copies of the Beneficiary Problem Resolution pamphlet and the grievance and appeal forms shall be readily accessible and visibly posted in prominent locations in beneficiary and staff areas, including beneficiary-waiting areas. Each clinic will designate someone to check once a day that these forms are available. The beneficiary or consumer access to the forms should not require either a verbal or a written request. Self-addressed envelopes for mailing grievances or appeals to the Quality Improvement Program shall be provided next to the pamphlets.

2. A notice shall be conspicuously displayed in all mental health facilities advising beneficiaries/consumers to contact the Program Manager, Patients' Rights Advocate, or Quality Improvement Program staff on how to register a grievance, or an appeal. Grievance and appeal information will also be available through the Central Access Team 24-hour statewide toll free number, (800) 706-7500 as well as through the Quality Improvement Unit (800) 660-3570.

3. Beneficiaries who need assistance in filing a grievance, appeal or a Medi-Cal State Fair Hearing may be assisted by their service provider, Patients' Rights staff or Quality Improvement staff. Consumers may also get help in filing a grievance. To obtain information on the status of a pending grievance, appeal, or Medi-

Cal State Fair Hearing, the beneficiary/consumer may contact the Quality Improvement Department staff.

4. The beneficiary/consumer may authorize another person to act on his/her behalf. for example, the beneficiary/consumer may ask the service provider, a friend, a family member, legal representative or Patients' Rights staff. At the beneficiary or if applicable, the consumer's request, that person may act on the beneficiary/consumer behalf in the grievance/appeal process.

5. Every program and/or clinic will maintain a grievance log. The grievance log will indicate (at a minimum):
   a. the name of the beneficiary/consumer
   b. the date of the receipt of the grievance
   c. the nature of the problem, and
   d. the final disposition of the grievance, including the date the decision is sent to the beneficiary/consumer, or documentation of the reason(s) that there has not been final disposition of the grievance

6. When a beneficiary wishes to have clinical records review with/without a representative, the Quality Improvement Program will have at least two Quality Improvement Program staff attend the review of the Grievance and or Appeal.

C. Grievance Resolution - Contract Providers

A beneficiary, beneficiary's representative or consumer may file a grievance, orally or in writing with his/her provider, the Central Access Team, or the Quality Improvement Program.

1. When a beneficiary/consumer submits a grievance to a contract provider, the contract provider will register the receipt of the grievance in their grievance log within one (1) working day and immediately fax a copy of the grievance to the Quality Improvement Program. A beneficiary/consumer is not required to complete a grievance form. If the grievance is oral from then the provider should write pertinent information on a grievance form, sign it and fax to the Quality Improvement Program. The Quality Improvement Program will also register the grievance in their grievance log with in one (1) working day.

2. When the beneficiary/consumer mails a grievance form directly to the Quality Improvement program, the program will register the receipt of the grievance in the Grievance Log within one (1) working day.

3. A beneficiary/consumer may authorize another person to represent him/her on their behalf when using the grievance process. The grievance process also allows beneficiaries/consumers to have legal representation to act on their behalf.

4. A letter acknowledging the receipt of the grievance will be sent by the Quality Improvement Program to the beneficiary/consumer within ten (10) working days. Beneficiaries/beneficiary representatives or consumers can request assistance with the grievance process, or obtain information on the status of a pending grievance by calling the Quality Improvement Program at the statewide toll-free number (800) 660-3570.

5. Every effort to provide for resolution of the beneficiary/consumer's grievance as quickly and simply as possible will be made by the recipient of the grievance. Resolution may be reached through discussions between the beneficiary, or the beneficiary/consumer's representative and the service provider, program supervisor, or other persons involved. If the contract provider reaches resolution of the beneficiary/consumer's grievance, the contract provider will notify the Quality Improvement Program of the resolution. The Quality Improvement program will review and approve the resolution. The person reviewing the grievance will not have been involved in any previous level of review or decision-making regarding the grievance.

6. The beneficiary and/or the beneficiary's representative or consumer will be sent a written decision on the grievance within sixty (60) calendar days of receipt of the grievance by the Quality Improvement Program. The Quality Improvement Program will also send a written notification to those contract providers cited by the beneficiary or otherwise involved in the grievance regarding the final disposition of the beneficiary/consumers' grievance.

7. The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary and/or the beneficiary's representative requests an extension, or if the Quality Improvement Program on behalf of the Mental Health Plan determines that there is a need for additional information and that the delay is in the beneficiary's interest. The Quality Improvement Program will send a written notification to the beneficiary and/or beneficiary's representative and the contract provider when an extension has occurred. The written notification will explain the reason for the extension.

8. A Notice of Action letter will be sent to the beneficiary and/or the beneficiary's representative advising then of their right to request a State Fair Hearing if they are not notified of the grievance decision within (60) calendar days.

9. The Quality Improvement Program and the contract provider will record the final disposition of the grievance in their respective grievance log. The record will include the date the decision was sent to the beneficiary or document the reason(s) that there has not been a final disposition of the grievance.

D. Grievance Resolution – RCDMH Program Provider

A grievance can be oral or in writing with the service provider, the RCDMH clinic supervisor, RCDMH program manager, Central Access Team, or to the Quality Improvement Program. The timeline requirement will begin at the time the oral grievance is received. It must be logged within (1) working day in the electronic Grievance Log. Grievance forms will be available at all county-operated or contracted mental health facilities. The beneficiary consumer or their representative can request assistance with the grievance process, or obtain information on the status of a pending grievance by calling the Quality Improvement Coordinator at the statewide toll-free number (800) 660-3570.

The electronic Grievance log will be available in all facilities and programs and will be used for all grievances or any complaints. The Grievance log will indicate: (a) The name of the beneficiary, (b) the date of the receipt of the grievance, nature of the problem, and (d) final disposition of the grievance, including the date the decision is sent to the beneficiary, or documentation of the reason(s) that there has not been final disposition of the grievance. If the beneficiary/consumer expresses a concern to the staff/provider the staff/provider is to **ask the beneficiary/ consumer if they want to file a grievance.**

1. If the response is "Yes" the grievance should be logged in the Grievance Log and the grievance form and/or email should be sent to QI for follow-up.

    a. A letter acknowledging the receipt of the grievance must be sent by QI to the beneficiary within ten (10) working days. Beneficiaries/ beneficiary's representative or consumer can request assistance with the grievance process, or obtain information on the status of a pending grievance, by calling the Quality Improvement Program at the statewide toll-free number, (800) 660-3570.

b. The beneficiary/beneficiary representative must be sent a written decision on the Grievance within sixty (60) calendar days of receipt of the grievance by the Quality Improvement Program. A copy will also be sent to the program about which there is a complaint.

c. The timeframe may be extended up to fourteen (14) calendar days if the beneficiary/beneficiary's representative request an extension, or if the Quality Improvement on behalf of the Mental Health Plan determines that there is a need for additional information and that the delay is in the beneficiary's interest. The Quality Improvement Program will send a written notice to the beneficiary/beneficiary's representative and the RCDMH Program when an extension has occurred. The written notification will explain the reason for the extension.

d. A Notice of Action (NOA) letter will be sent to the beneficiary/beneficiary's representative by the Quality Improvement Department if a decision on the grievance is not sent to the beneficiary/beneficiary representative within the timelines of sixty (60) days.

e. If the beneficiary/consumer wishes at any time to withdraw a Grievance, note the withdrawal in the Grievance Log and follow-up with a letter to confirm the withdrawal.

f. If a beneficiary or beneficiary representative or consumer is dissatisfied with the grievance decision the beneficiary, beneficiary's representative or consumer may request a further review by a committee established by the QI supervisor.

2. If the beneficiary/consumer has a grievance and requests follow-up but does **not** want to "file" a grievance then the grievance must still be logged and the "complaint only" box checked.

a. The provider does follow-up to resolve the complaint and dates and documents resolution in the log.

b. If the beneficiary/consumer or representative is not satisfied they may then "file" a grievance with the Quality Improvement Program.

E. Appeals Procedure for Medi-Cal beneficiaries General Information – Non-expedited Appeals (See "definitions")

An appeal may be filed, orally or in writing, with the contract provider, contract management, RCDMH clinician, RCDMH program supervisor or the RCDMH program manager, the Central Access Team, or to the Quality Improvement Program. An oral appeal must be followed up with a written appeal signed by the appellant. Medi Cal beneficiaries may file a State Fair Hearing without first going through the appeal processes. Forms and self-addressed envelopes will be available at all county-operated or contracted mental health facilities. Beneficiaries/beneficiary representatives can request assistance with the appeal process or obtain information on the status of a pending appeal by calling the Quality Improvement Program at the statewide toll-free number (800) 660-3570

1. The beneficiary/beneficiary's representative may begin the appeal process, orally or by completing an appeal request form and a release of information form, when applicable. Oral appeals must be followed up with written, signed appeals and a release of information form, when applicable. Self-addressed envelopes addressed to the Quality Improvement Program will be available for beneficiary/beneficiary's representative to use to submit their appeal request.

2. The appeal form should indicate if the beneficiary is in any Medi-Cal funded residential treatment program. The Expedited Appeals block should be checked on the appeal form when taking the time for a "standard" appeal decision could jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function. If the Expedited Appeals block is checked on the appeal form, the appeal will be processed within the Expedited Appeal guidelines (see below).

3. The beneficiary/beneficiary's representative will be given a reasonable opportunity to present evidence and allegations of fact or law in regard to the appeal requested in person or in writing to the Quality Improvement Program.

4. The beneficiary/beneficiary's representative will also be given a reasonable opportunity, when requested, to examine the beneficiary's case file, including medical records and any other documents or records considered applicable to the appeal before and during the appeal process.

5. The Quality Improvement Program will receive and process all appeal requests within the timelines

6. RDCMH programs and/or contract providers will fax the appeal to the Quality Improvement Program upon receipt of the appeal. The appeal will be processed as follows:

7. The Quality Improvement Program will enter the appeal into the Appeal Log within (1) working day of receipt. The Appeal Log will indicate: (a) the name of the beneficiary, (b) the date of the receipt of the appeal, (c) the nature of the problem, and (d) final disposition of the appeal, including the date the written decision is sent to the beneficiary, or documentation of the reason(s) that there has not been final disposition of the grievance.

8. A letter acknowledging the receipt of the appeal will be sent to the beneficiary with ten (10) working days. The letter will also inform the beneficiary of his/her right to request a State fair hearing at any time before, during, or after the appeal process has begun. The Quality Improvement Program will be responsible for monitoring the appeal process to ensure that resolution of the appeal is within the appropriate timelines.

9. The Quality Improvement Program will notify the involved inpatient facility, clinic, or contracted provider of the pending appeal. A decision about the appeal may be reached through discussions between the beneficiary, or the beneficiary's representative and the RCDMH program, contract providers, or other persons involved in the matter at hand.

10. The Quality Improvement Program will be responsible for notifying the beneficiary/beneficiary's representative of the decision in writing within forty-five (45) calendar days of the receipt of the appeal. The notice will contain the following:

    a. The results of the appeal resolution process
    b. The date that the appeal decision was made
    c. If the appeal is not resolved wholly in favor of the beneficiary, the notice will contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing for a State Fair hearing
    d. The notice will also inform the beneficiary of their right to request and receive benefits while the hearing is pending and the procedure for making the request.

11. The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary requests an extension or the Quality Improvement Program determines that there is a need for additional information and that the delay is in the beneficiary's interest. The Quality Improvement Program will send a written notification to the beneficiary and/or the beneficiary's representative and all other affected parties when an extension has occurred. The written notification will explain the reason for the extension.

12. If the beneficiary and/or provider are not notified of the decision of the appeal within the forty-five (45) calendar days of receipt of the appeal or have not requested an extension from the beneficiary, a Notice of Action form will be sent to the beneficiary advising the beneficiary of the right to request a State Fair Hearing. The Notice of Action letter will be sent on the date that the 45th calendar day period expires. (This is an additional NOA provided by the Quality Improvement Program.)

13. The Quality Improvement Program will record the final disposition of the appeal, including the date the decision was sent to the beneficiary, or document the reason(s) that there has not been a final disposition of the appeal in the Appeal Log. Notification efforts will be documented in the log if the beneficiary cannot be contacted orally or in writing.

14. The Quality Improvement Program will notify those providers cited by the beneficiary or otherwise involved in the appeal of the final disposition of the beneficiary's appeal.

15. The Quality Improvement Program will insure that the person reviewing the grievance will not have been involved in any previous level of review or decision making with the grievance.

F. Expedited Appeal Process for Medi-Cal Beneficiaries

An appeal will be handled in an expedited manner when the Quality Improvement Program determines, or the beneficiary or the provider request that taking the time for a standard resolution of an appeal could seriously jeopardize the beneficiary's life, health, or ability to attain, maintains, or regains maximum function.

1. The beneficiary's mental health specialty services will continue until there is a response to the expedited appeal from the Quality Improvement Program, unless the beneficiary poses a threat to the safety of other beneficiaries receiving services in a residential or

outpatient facility. Expedited appeals received by RCDMH programs or contract providers will be faxed to the Quality Improvement Program.

2. A beneficiary and/or beneficiary's representative will be allowed to file the request for an expedited appeal orally without a written follow-up or by using the Appeal form and checking the "expedited appeal" box for the form.

3. The Quality Improvement Program will register the receipt of the expedited appeal in the Appeal Log within one (1) working day of receipt and indicated that the appeal is an expedited appeal request.

4. When the Quality Improvement Program receives the expedited appeal from the beneficiary/beneficiary's representative, the program will have three (3) working days from receipt to review the expedited appeal and to seek resolution with the beneficiary/beneficiary's representative either in person or by telephone.

5. By the end of the third (3) working day, a written notification summarizing the discussion and the proposal of the expedited appeal shall be given to the beneficiary/beneficiary's representative. The letter will contain the following:

   a. The results of the expedited appeal resolution process

   b. The date that the expedited appeal decision was made.

6. If the expedited appeal is not resolved wholly in favor of the beneficiary, the notice will contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

7. The availability of assistance to complete the form for a State Fair Hearing will be given to any beneficiary or beneficiary's representative who wishes to appeal the expedited appeal decision.

8. Timeframes may be extended up to fourteen (14) calendar days if the beneficiary requests an extension or the Quality Improvement Program determines that there is a need for additional information and that the delay is in the beneficiary's interest. The Quality Improvement Program will send written notification to the beneficiary and/or beneficiary's representative and all other

affected parties when either party has requested an extension. The written notification will explain the reason for the extension.

9. If the Quality Improvement Program denies a request for an expedited resolution on an appeal, the Quality Improvement Program will: (a) transfer the appeal to the timeframe for a standard appeal resolution and (b) make a reasonable effort to give the beneficiary and his/her representative prompt oral notice of the denial of the expedited appeal process and follow up within two (2) calendar days with a written notice.

G. Grievances Regarding CAT or ACT

1. When a complaint is received from the Department of Social Services (DPSS) against a contract provider of the Mental Health Plan and/or an employee of the Department of Mental Health, the complaint will be logged by the recipient of the complaint and an email sent to the QI supervisor who will process it in accordance with the grievance procedure.

2. When a complaint is received from a beneficiary/beneficiary's representative or consumer about an employee of CAT and/or ACT the beneficiary/beneficiary's representative or consumer will be encouraged to call the supervisor of that employee. The beneficiary/beneficiary's representative will be asked if they would like to file a grievance. All complaints/grievances will be processed in accordance with the grievance procedure.

3. If a beneficiary/beneficiary's representative or consumer is dissatisfied with the grievance decision the beneficiary/ beneficiary's representative or consumer may be referred to the Quality Improvement Department for further review. When a beneficiary wishes to have clinical records review with/without a representative, the Quality Improvement Program will have at least two Quality Improvement Program staff attend the review of the Grievance and or Appeal.

H. Quality Improvement Program – Grievance Process and Appeals Process Monitoring

1. Monitoring Compliance

The Quality Improvement Program shall monitor compliance by reviewing the Grievance and Appeals Log weekly. The review will cover the following:

b. Logging receipt of Grievances and appeals within one working day;
c. Acknowledgement letter has been sent to beneficiary or representative within ten (10) calendar days;
d. Disposition letter has been sent within 60 days for Grievances and 45 days for Appeals;
e. Expedited appeals are processed within the three (3) working days, that the oral notification is made within two (2) days after the decision is made followed by a written letter and that documentation notes the attempted contact if unable to contact beneficiary either orally or in writing

2. Monitoring clinics and contracted facilities

a. The Quality Improvement Program will monitor the contracted facilities for compliance through personal contact by a Quality Improvement Program staff.

b. Clinics will be monitored on site using the criteria a-d above.

c. Other Quality Improvement Program activities may occur as needed.

Approved by: _____ Date: 3-2-05
Director of Mental Health

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

Beneficiary Protection

Riverside University Health System-Behavioral Health (RUHS-BH) ensures the rights of beneficiaries are protected through Departmental Policy 295 which includes the following:

A. Informing Materials

Beneficiaries are informed of their rights through:

1. Posting of their rights in both English and Spanish in the program lobby
2. Important Information About Your Rights as a Consumer poster
3. The RUHS- Substance Abuse Prevention and Treatment Programs Consumer Rights and How to Access Services Brochure
4. The RUHS Drug Medi-Cal (DMC) and Other Drug Services (ODS) Member Guide to Services Handbook
    i. The handbook is available in the counties two threshold languages (English and Spanish) via the county website
    ii. The handbook is also available in alternative formats (large print, video, and ASL) also posted on the county website
    iii. The handbook include the Provider Directory with the names, locations, telephone numbers of, and non-English language spoken by current contracted providers, including identification of providers that are not accepting new clients
5. The above is consistent with RUHS-BH Policy 290 Mental Health Consumer Brochures and Posters

B. Translation Services

Beneficiaries may receive oral interpretation and sign language services free of charge. The ability to request an interpreter shall be posted in a prominent location in each program (Interpretation Services Poster)

C. Change of Provider

Beneficiaries may request a change of provider by:

1. Making a request directly to their provider
2. Completing the Change of Provider form located in the program lobby and submitting to the office staff within the program (who will ensure the program supervisor receives it and contacts the client to discuss the request and determination)
3. Contacting their SU Care Coordinator
4. Requests for changing providers will be recorded on the Change of Provider form in ELMR by the BHSS of the program or their designee

D. <u>Problem Resolution Process</u>

6. County Policy 295- Beneficiary Consumer Problem Resolution Process outlines the department's requirements for Grievances, Appeal, and State Fair Hearings. Information on the process is located in the Guide to Services Handbook, The RUHS- Substance Abuse Prevention and Treatment Programs Consumer Rights and How to Access Services Brochure, on the Consumer Grievance/Appeal/State Fair Hearing Information poster posted in each program lobby, and in the Appeal & Grievance Procedure Request Form.

A beneficiary or their authorized representative may file a Grievance, Appeal, and State Fair Hearing through the following processes:

1. File a Grievance or Appeal using the Appeal & Grievance Procedure/Request Form located in the lobby of each program. Self-Addressed envelopes are also available
2. Call (800) 660-3570 and file an Appeal or Grievance orally (appeals must then also be sent in writing)
3. Following the resolution of an Appeal, beneficiaries may then request a State Fair Hearing if they are dissatisfied with the results of their Appeal. State Fair Hearings may be requested by calling the State Department of Social Services at (800) 952-5253.
4. All Outpatient program Grievances and Appeals are the responsibility of RUHS-BH Quality Improvement program.

E. <u>Notice of Adverse Benefit Determination</u>

Drug Medi-Cal beneficiaries will receive written notice if any of the following situations occur:

1. The beneficiary is denied for services because they don't meet medical necessity
2. Services requested are being denied, modified, or deferred beyond timeframe(s)
3. RUHS-BH denies payment for services that have already been provided
4. RUHS-BH fails to act within the timeframes for disposition of standard Grievances, Appeals, or the resolution of expedited appeals.
5. There is a significant delay in the county's ability to provide a service in a timely manner.

The NOABD forms are available in ELMR. Each should be printed out along with the attached PDF's located on each form, and mailed or handed to the beneficiary.

Riverside University HEALTH SYSTEM Behavioral Health

Reply To: Behavioral Health Administration
Quality Improvement
P.O. Box 7549
Riverside, CA 92513-7549

September 1, 2017

Provider ID: 195

Billing Month: July - August

Provider Program Name: Vista Knoll Specialized Care (33F401)
Agency Name: VISTA KNOLL
Address: 2000 Westwood Road, Vista, CA, 92083

To Whom it May Concern

This Document serves as written notification that the attached services have been denied by the Invoice Processing Unit (IPU) for reason(s) listed on the Provider Denied Service Form. Depending on the reason code, your Agency may have the option to re-bill the service during next month's billing. If it cannot be re-billed, you have the right to appeal this decision through Quality Improvement (QI).

Appeals to QI must be submitted in writing within fourteen (14) calendar days of the postmark of this letter and must include the following in order to be processed along with original written signatures on all documents:

- An Appeal Letter signed by the Provider's Authorized Personnel.
- A Provider Appeal Form signed by the Provider.
- Copy of the "Provider Denied Service Form"
- A Copy of the Authorization.
- Copies of any Supporting Documents

QI will notify you in writing of their decision within thirty (30) calendar days from its receipt of a complete Appeal packet.

If you are unsure as to whether a service can be re-billed, please contact the Invoice Processing Unit (IPU) at ELMR_PIF@rcmhd.org.

Denied services not appealed within the listed time period will remain denied due to lack of correspondence and will therefore not be included during final Cost Report settlement.

Sincerely,

Riverside University Health System – Behavioral Health
Substance Abuse Prevention and Treatment Program
Invoice Processing Unit

Riverside University HEALTH SYSTEM Behavioral Health

IPU Provider Denied Service Report

PROVID: XXX

prov_pgm_name: PROVIDER NAME (33XXXX)

claim_status_value:	BATCHID:	authorization_number:	date_of_service:	PATID	procedure_code_code	duration:	service_units:	approved_units:	expected_disburse:	claim_status_reason_c	claim_status_reason_value:
Denied	13431	337224	7/1/2017	198XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337220	7/1/2017	255XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337218	7/1/2017	5101XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337231	7/1/2017	5852XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337222	7/1/2017	95071XXXX	245NB	1	1	1	$119.00	70	DUPLICATE CLAIM
Denied	13431	337232	7/1/2017	95082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337216	7/1/2017	96082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337216	7/1/2017	96082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337214	7/1/2017	96084XXXX	245NB	1	1	1	$119.00	70	DUPLICATE CLAIM
Denied	13431	337234	7/1/2017	96089XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337229	7/1/2017	96089XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337224	7/2/2017	198XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337220	7/2/2017	255XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337218	7/2/2017	5101XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337231	7/2/2017	5852XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337222	7/2/2017	95071XXXX	245NB	1	1	1	$119.00	70	DUPLICATE CLAIM
Denied	13431	337232	7/2/2017	95082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337216	7/2/2017	96082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337216	7/2/2017	96082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337214	7/2/2017	96084XXXX	245NB	1	1	1	$119.00	70	DUPLICATE CLAIM
Denied	13431	337234	7/2/2017	96089XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337229	7/2/2017	96089XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM

Riverside University HEALTH SYSTEM Behavioral Health

IPU Provider Denied Service Report

PROVID: XXX

prov_pgm_name: PROVIDER NAME (33XXXX)

claim_status_value:	BATCHID:	authorization_number:	date_of_service:	PATID	procedure_code_code	duration:	service_units:	approved_units:	expected_disburse:	claim_status_reason_c	claim_status_reason_value:
Denied	13431	337224	7/31/2017	198XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337220	7/31/2017	255XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337218	7/31/2017	5101XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337231	7/31/2017	5852XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337232	7/31/2017	95082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337216	7/31/2017	96082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337216	7/31/2017	96082XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337234	7/31/2017	96089XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
Denied	13431	337229	7/31/2017	96089XXXX	245NB	1	1	0	$0.00	70	DUPLICATE CLAIM
						339	*339*	*60*	*$7,140.00*		

Riverside University Health System Behavioral Health

PROVIDER APPEAL FORM

Program Name: _____ Location: _____

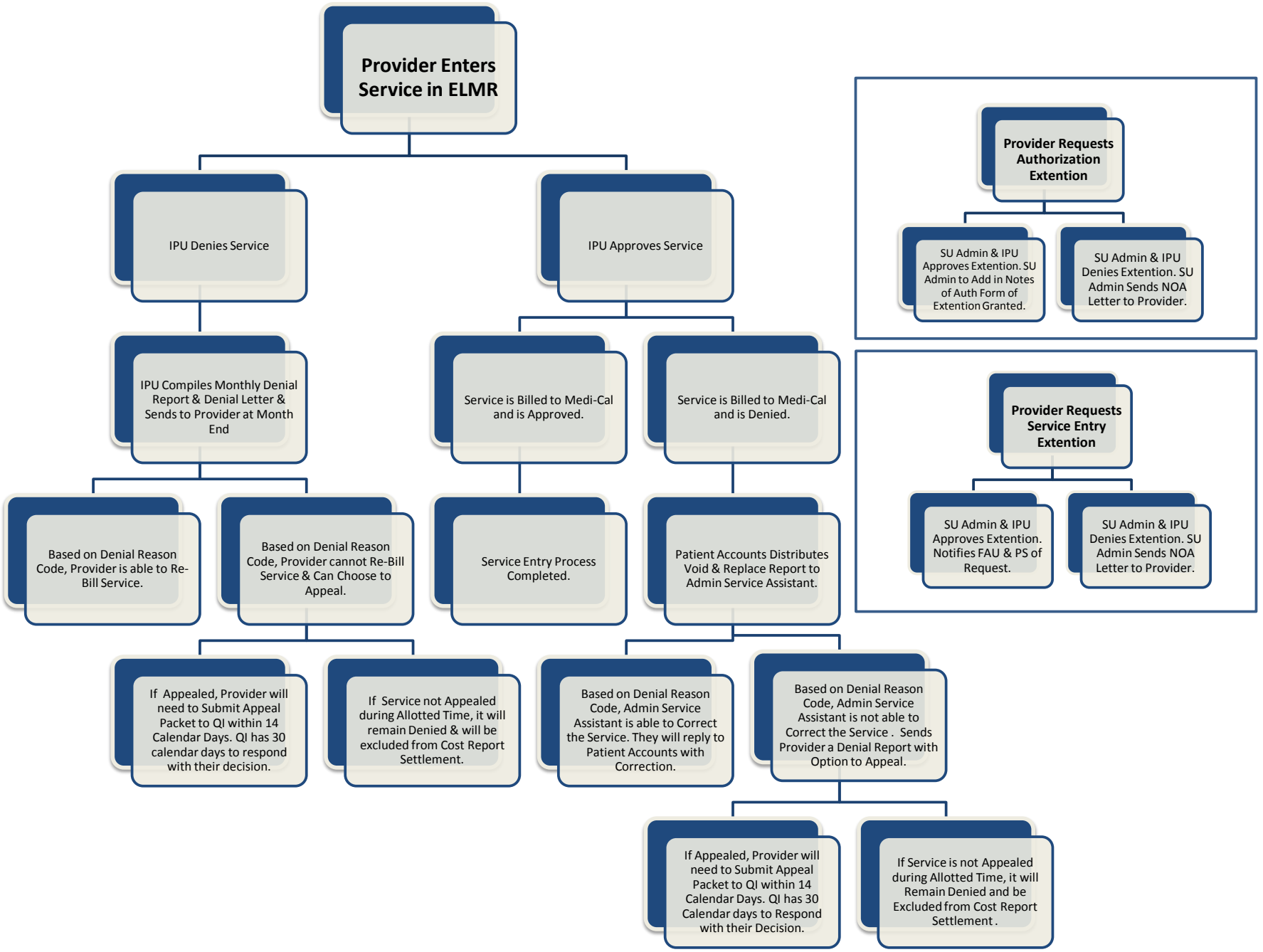
Today's Date: _____ Page: _____ of _____

Denied / Disallowed Services Being Appealed

Client #	DOS	Service Code	Duration	Denial Reason Code	Disallowance Reason (from IPU Denial or QI Report)	Date of Denial/ Disallowance	Comments

Provider Signature: _____ Print Name/Title: _____

SUBSTANCE ABUSE & PREVENTION TREATMENT
SERVICE DENIAL & APPEAL PROCESS



Quality Improvement Work Plan

2016 - 2017

Riverside University HEALTH SYSTEM Behavioral Health

Riverside University Health System – Behavioral Health
2085 Rustin Avenue, Suite 2002, Riverside, CA 92507

QUALITY IMPROVEMENT WORK PLAN
(2016-2017)

About Riverside County

Riverside County is one of 58 counties in the state of California, the fourth most populous county in the state. The United States Census reported the 2015 population to be estimated at 2,189,641.

Covering more than 7,200 square miles, the county has 28 cities, large areas of unincorporated land, and several Native American tribal entities. It is bordered on the west by Orange County; the east by La Paz County, Arizona; the southwest by San Diego County; the southeast by Imperial County; and on the north by San Bernardino County.
Hispanic/Latino make up the largest race/ethnic group serviced for both mental health and substance abuse consumers. The second largest group served is Caucasian.

Riverside University Health System- Behavioral Health

In December 2015 both the RUHS-BH Department Director and Medical Director retired. These retirements, along with organizational restructuring resulted in significant changes throughout the entire departmental management structure. Specific changes include:

Executive Management:

- The Assistant Director of Programs was promoted to Department Director
- The Medical Director position was filled through a promotion of an Associate Medical Director
- The Central Children's Administrator was promoted to the Assistant Director of Programs
- The Deputy Director of Fiscal was promoted to Assistant Director of Finance in preparation for a (pending) retirement within that current position later this year
- Three Deputy Director positions were added resulting in a new layer of management and re-organization of reporting responsibilities

Management/Administration:

- Promotions of managers/administrators into the 3 Deputy Director positions resulted in promotions of additional managers/administrators into those positions, and promotions of current program supervisors into the now vacated manager/administrator positions
- New management positions were added in the mid-county and desert regions

- Individuals entirely new to RUHS-BH were hired into the Detention, Cultural Competency, and Transitional Age Youth Manager positions
- Additional Associate Medical (AM) positions were added to make a total of 9 AM positions (department psychiatrists in AM positions allocate .25 of their time to the administrative duties required in assisting the Medical Director)

These major changes within the leadership of the department, together with changes occurring due to county restructuring of the Behavioral Health Department under the county hospital, changes at the state and federal level, and the continuing integration of health care, have and are resulting in a new climate directed toward behavioral healthcare. Innovative new ideas and approaches are in process for improving the services provided throughout Riverside County.

During Fiscal year 2015-2016 Riverside County Department of Behavioral Health served 54,368 consumers through mental health and substance abuse services. In mental health a total of 46,933 consumers were served through outpatient mental health, detention services, and inpatient psychiatric services. In substance abuse a total of 7,435 consumers were served through detoxification, residential services, outpatient substance abuse treatment services, and intensive half day treatment programs (e.g. Drug Court, MOMs).

Quality Improvement Work Plan

Counties are expected to utilize any information that identifies strengths, challenges, and overall need(s) to develop goals, monitor performance, and implement strategies to improve quality and performance.

The purpose of the QI Work Plan is to report on this information. Performance Improvement Projects designed to improve outcomes within the overall system, feedback provided from the External Quality Improvement Organization (EQRO), and areas identified in need of improvement as a result of the state's tri-annual systems review are all considered in developing the Work Plan.

Quality Management

The purpose of a Quality Management program is to assist with the department's mission by monitoring the overall performance of the system through the collection, reporting, and analysis of data; developing goals and standards; and providing information to improve processes and overall efficiency/effectiveness of service delivery.

Quality Management in Riverside County is a compilation of several specific programs: Research & Technology, Outpatient Quality Improvement, and Inpatient Quality Improvement. Collectively, these programs provide information and evaluation of current processes, identify areas for improvement, and ensure that the department complies with state and federal mandates related to behavioral health services.

The Research and Technology department is divided into three areas of responsibility:
Research: The Research Program is responsible for Quality Improvement types of reporting. Examples of reports include state-mandated reports, client satisfaction reports (including the bi-annual administration of the State required Performance Outcome Quality Improvement surveys), Change of Provider Reports, Medication Monitoring, Problem Resolution, and Chart Reviews among others. This includes designing methods to collect data on these topics and generating reports to communicate results of these efforts. Reports generated by this unit provide opportunities to analyze the quality of services being provided.

Evaluation: The Evaluation Program is responsible for the collection and analysis of outcome data. Working closely with the full range of the Department's Evidence Based Practices (EBP) to ensure fidelity to the EBP models and collect clinical outcomes resulting from these programs. This unit is also responsible for the administration and reporting of outcomes relating to MHSA funded programs including Full-service Partnership programs, Prevention and Early Intervention programs, and Innovation programs.

ELMR: The ELMR unit is responsible for working to maintain and improve the Department's Electronic Health Record (EHR) called ELMR (Electronic Management of Records). This includes developing forms, and creating reports for users to call on an as-needed basis. This unit also works to create additional functionality in the system to auto-populate various fields to reduce redundancy, embed error checking routines, and promote interoperability with EHRs from other partner agencies. Other responsibilities include supporting contract providers in working with the Department to register their clients into ELMR.

Outpatient Quality Improvement: This program is responsible for the resolution and monitoring of beneficiary complaints, appeals, and grievances; provider complaints and appeals; state fair hearings; extensive clinical/medical records review for all the county and contracted Substance Abuse and Mental Health programs- including detention facilities and Cal Works; trainings on documentation and the department's electronic health record; processing Medication Declarations on dependent minors; and coordinating state/federal audits. This program works as the liaison with the information generated by Research & Evaluation, state and federal regulations, and staff working in the department.

Inpatient Quality Improvement: This program is responsible for 5150 designations, County and Fee-For-Service Hospitals, and the approval/denial of Acute and Administrative Bed Days related to mental health hospitalizations. This program works to improve on the quality of documentation related to inpatient services to facilitate improved client care.
Overseeing the activities of the Quality Management activities is the Quality Improvement Committee (QIC). The QIC reviews these activities through the department's multiple reports, identifies opportunities for improvement, develops and recommends interventions to improve performance, and monitors/evaluates the effectiveness of the interventions. The QIC is chaired by the Assistant Director of Programs, includes a multi-disciplinary group of county employees from various regions/programs throughout the county, a current consumer of services, a representative from a contracted agency, and at least one member of the Mental Health Board.

Outcome of 2015-16 Quality Improvement Work Plan Goals

The work occurring within the department extends beyond the specific goals included in the QI Work Plan. During the past fiscal year, Riverside County identified and implemented a number of quality improvement strategies to enhance the service delivery system including:

- Adding nursing assistants in children's programs to assist the psychiatrists. This is enabling doctor's to provide more direct care to their clients.
- Expanded capability to provide Telemedicine. This has increased capacity to serve clients residing in the more remote areas of the county.
- Increased behavioral health services provided to individuals in detention settings while also implementing a single electronic health record shared with correctional physical health.
- Established workgroup with Dept. of Social Services to improve compliance on the revised JV220 forms and improve monitoring of psychotropic medications prescribed to dependent minors
- Established a Best Practices Committee to review data related to timeliness, no show rates, and staff productivity
- Identifying the need for/hiring a Transitional Age Youth program manager to focus on developing programs specific for the TAY population

The percentage of goals included within the 2015-16 Work Plan that were met or partially met was at 78%. Two (2) goals were not measureable due to changes in processes, and one (1) goal was postponed pending completion of higher priority projects. Outcomes for specific objectives/goals are reported below:

REQUIREMENT: Monitoring/Improving the Service Capacity and Delivery of Services

Objective 1: **Goal 1**: Review current maps on the type, number, and location of services a minimum of two times annually in the QIC meetings.
Outcome: Goal partially met.
The department did create, and Administrators continue to review, maps on the distribution of Behavioral Health service locations in each region. At the same time, the QIC has been working toward more data driven recommendations which have filled the monthly agenda with other issues that have interfered with the ability of the committee to review these same maps. Reviewing service capacity via means other than maps is being utilized in the work on performance indicators. For example, the department evaluated beneficiaries currently receiving services by sorting of their home zip codes to identify where additional clinic sites may be needed to improve timeliness to service.

Objective 2: **Goal 2a**: Establish one CSU in the mid-county region by June 2016
Outcome: Goal not met.
The county has continued to identify potential sites, but has no control over the approval process of the cities within the mid-county region. Identified sites have been repeatedly denied by various cities declining the location of a mental health facility within their boundaries. A new site has again been identified, and is currently going through that city's planning commission for approval.

Objective 2, Goal 2b: Establish one new CSU in the desert region by June 2016
Outcome: Goal met.
This program was established in early 2016, and is scheduled to open in Palm Springs in October.

Objective 2, Goal 2c: Purchase a building for the Perris clinic by June 2015, with projected opening of the new clinic by December 2016
Outcome: Goal partially met.
The site has been selected, planning application submitted, environmental studies have been ordered, loan approval is in process, the public hearing is anticipated to be scheduled in early 2017. The facility will house the Perris Family Room, Substance Use Services, Older Adults, the Regional Multidimensional Family Therapy (MDFT) team, the HHOPE housing program, and the Regional Vocational Services. It will also be outfitted with exam rooms, for the potential of

"integrated care" occurring there. Evidence-based WRAP groups and Recovery Management groups will occur on a regular basis.

REQUIREMENT: Monitor Timeliness to Services

Objective 3: **Goal 3a**: Obtain appointment for routine request for mental health services within the county standards in 75% of requests for all regions of the county by 2016, 85% by 2017, and 95% by 2018.
Outcome: Goal met
The county standards have been replaced with the timeliness standards identified by the Department of Health Care Services. The most recent report for routine requests (8/16) indicated that over 80% of all offered appointments fell within 10 business days from the initial request. The goal as defined will continue on the 2017 and 2018 Work Plans.

Objective 3, Goal 3b: Obtain appointment for routine request for psychiatric services within the county standards in 65% of requests for all regions of the county
Outcome: Unable to measure
The previous method of measuring timeliness to the first psychiatric appointment did not factor in missed appointments, cancellations, and/or appointments offered but not accepted by the consumer. A new methodology is being designed that will more accurately reflect timeliness to service.

Objective 4: Goal 4: Obtain "urgent" appointment within the county standards in Managed Care and County Clinic systems in 90% of requests.
Outcome: Unable to measure
As indicated in Objective 3, the methodology of measuring timeliness to service is being redesigned. Data is not yet available for urgent appointments using the new methodology.

Objective 5: **Goal 5**: Review monthly call logs for compliance with Title IX standards from afterhours contractor each month
Outcome: Goal not met
The call logs were not being submitted regularly by the contractor, and did not consistently reflect the required elements according to CCR, title 9 standards. Goals for the after-hours line will be included in Objective 4 in the 2016-17 Work Plan.

Objective 6: **Goal 6a**: Increase test calls to the access line to a minimum of 10 calls quarterly
Outcome: Goal met.
The department conducted an average of 13 calls per quarter.

Objective 6, Goal 6b: Call response time on 800# to be an average of 3-5 minutes/call
Outcome: Goal met
Reports generated on the access line for the last two quarters indicate all calls are being responded to in an average of 4:07 minutes.

REQUIREMENT: Maintain/Improve Beneficiary Satisfaction

Objective 7: **Goal 7a**: Complete a direct interview with a minimum of 400 beneficiaries contacted to complete a beneficiary satisfaction survey
Outcome: Goal met.
The Managed Care, County Providers & Other Contracted Providers Client Satisfaction Phone Survey Results Report for FY 2015-16 indicated 3,373 calls were attempted, 484 beneficiaries completed the survey. These surveys are providing consumers with an opportunity to provide more personalized feedback on their experience with this county's behavioral health service programs.

Objective 7: Goal 7b: Satisfaction with Access to services will reach an average of 90% on Consumer Perception Surveys
Outcome: Goal met
The Managed Care, County Providers & Other Contracted Providers Client Satisfaction Phone Survey Results Report for FY 2015-16 indicated that 92.2% of adult consumers, and 97.7% of parents/legal guardians were satisfied with access.

Objective 8: **Goal 8**: Beneficiary grievances and fair hearings related to Quality of Service: Interaction/Conduct of Staff to be utilized as a category for a complaint in less than 30% of grievances filed.
Outcome: Goal not met.
The Problem Resolution Report (dated July 2016) indicated this category to be at 100% of grievances filed for the first half of the fiscal year, and 51.6% for the second half (an average of 75.8%. This goal will be further analyzed to ensure the categories are recorded with internal consistency, and will be carried over to the 2016-17 QI Work Plan.

Objective 9: **Goal 9a**: Change of provider requests due to Dissatisfaction, without details of why the consumer was dissatisfied with the provider and/or service, to be less than 30% for both individual and organizational providers
Outcome: Goal not met
The Change of Provider Report (dated 6/1/16) indicated dissatisfaction without detail was an average of 88.0%. This goal will be carried over to the 2017 Work Plan.

Objective 9, Goal 9b: Change of provider requests due to Individual Providers not responding to the consumer to be less than 20%
Outcome: Goal not met
The Change of Provider Report (dated 6/1/16) indicated Individual Providers not responding to the consumer was 37.7%. This goal will be carried over to the 2017 Work Plan.

Objective 10: **Goal 10**: Receive a minimum of 50% response to provider surveys
Outcome: Goal met
The Provider Satisfaction survey report for 2015-16 indicated a 59.8% response rate.
Up from 42% in 2014-15, this increase in responses indicates a positive trend in providers input into the county's operations.

REQUIREMENT: Maintain/Improve Service Delivery System

Objective 11: **Goal 11a**: Develop orientation training for all new managed Care providers by January 2016
Outcome: Goal met.
The department began providing orientation trainings in September 2015 and continues to provide trainings on a quarterly basis. In addition to these formal trainings, additional trainings are being provided as needed. These trainings are reducing errors in provider's documentation and other areas of submissions to the county.

Objective 11: **Goal 11b**: Establish a minimum of one performance outcome based upon the initial assessment
Outcome: Goal met.
The CANS and ANSA have been added to the revised assessment forms. These new forms are in the process of being beta tested prior to rolling out to all programs.

Objective 12: **Goal 12**: Develop a process to identify completing/updating AIMS scores.
Outcome: Goal met.
Completion of the Abnormal Involuntary Movement Scale (AIMS) on consumers prescribed psychotropic medications is now included on the 'Hot Sheet' when the consumers file is accessed in the county's electronic health record (ELMR). The Hot Sheet is a listing of all the required forms for the consumer, when they've been completed, and when next due.

Objective 13: **Goal 13a**: Program staff to complete Substance Abuse history in 95% of assessments completed
Outcome: Goal partially met
The previous baseline from the 2015-16 QI Work Plan indicated Substance Abuse history was incomplete in an average of 9% of Children's Assessments (91% complete) and 14% of Adult Assessments (86% complete). The July 2015-December 2015 Clinical Documentation Reviews Report indicated some improvement. In Children's the average incomplete was 7.5% (92.5% complete) and the Adult average was 11.3% incomplete (88.7% complete).

Objective 13: **Goal 13b**: Develop new training materials for assessments/care plans based on results of Cultural Competency pilot study conducted in Banning Clinic
Outcome: Goal postponed
The individual responsible for leading this study has been focusing exclusively on the work in constructing a new Crisis Stabilization Unit. Due to the high need, the CSU has taken priority over this specific goal. At the same time, the department has hired a new Cultural Competency Manager who is initiating other activities to improve the focus on culture within county programs.

Objective 14: **Goal 14a**: Provide training to all department staff on correctly completing information in the MH contact logs by June 2016
Outcome: Goal met
The department provided information in March 2016 and has continued to send out repeated information on the correct usage of the contact log.

Objective 14, Goal 14b: Provide training to all department staff on issuing the Notice of Action (NOA), when applicable, by June 2016
Outcome: Goal met
The department provided information to all department staff in March 2016, and will be re-training staff on this and other forms in late 2016/early 2017.

Objective 15: **Goal 15**: Develop dashboard reports/systems to provide programs with regular feedback on completion of documentation in a timely fashion
Outcome: Goal partially met
The dashboard report is partially complete, resources and other priorities have delayed its full implementation.

Objective 16: **Goal 16**: Add one provider and one family member to the Quality Improvement Committee
Outcome: Goal met
A contracted provider that represents both Substance Abuse and Mental Health services has been added to the committee. The Family Advocate manager is representing the family perspective in the QIC meetings.

Objective 17: **Goal 17**: Provider appeals due to provider error to be under 15%
Outcome: Goal not met
Data from the Provider Appeals Report (July 15-June 16) indicated Provider error in 21.1% of approved appeals, and 33.8% of denied appeals. This goal will be suspended in place of implementing a quarterly provider meeting in the 2017 Work Plan to assist providers in increasing awareness of issues related to submitting claims.

REQUIREMENT: Maintain/Improve Continuity and Coordination

Objective 18: **Goal 18**: Begin provision of Integrated Health Services in the Riverside Family Wellness Center by June 30, 2016
Outcome: Goal partially met
The program is physically prepared to provide services, and Behavioral Health staff have been hired. Public Health is responsible for providing a Nurse Practitioner or Physician Assistant. This hiring has been delayed while approval for a Board Certified Pediatrician (rather than an NP or PA) is being sought.

Objective 19: **Goal 19**: Develop ability to access information from Telecare CSU programs within 24 hours of client admission into the CSU
Outcome: Goal met
Information is available in the Report Distribution Center (RDS).

Objective 20: **Goal 20a**: Continue with Memorandum of Understanding (MOU) with Riverside County Health Plans (IEHP, Molina)
Outcome: Goal met
Both MOU's continue.

Objective 20: Goal 20b: Continue with monthly or bi-monthly meetings with each health plan to identify and discuss individual clients who may be transitioned from RCDMH clinic services and providers to services and providers of the health plans who have mildly to moderately severe mental health conditions
Outcome: Goal met
Meetings are scheduled quarterly.

2016-17 Quality Improvement Work Plan Goals

The RUHS-Behavioral Health Quality Improvement Work Plan for this fiscal year has been reformatted to better organize and represent the extensive range of activities the department is engaging in to improve service delivery and positive performance outcomes.

Section 1: Performance Improvement Projects

Objective 1.1 *Clinical Mental Health PIP*
Goal: Consumers who have a Psychiatric Hospitalization should receive an Outpatient service within 7 days
Objective 1.2 *Clinical Mental Health PIP*
Goal: Decrease psychotropic medication dosages beyond state recommended guidelines for foster youth
Objective 1.3 *Non-Clinical Mental Health PIP*
Goal: Time from first contact to first offered appointment should be within 2 weeks.
Objective 2.1 *Clinical Substance Abuse PIP*
Goal: Increase continuity of care for adults in substance abuse treatment
Objective 2.2 *Non-Clinical Substance Abuse PIP*
Goal: Increase the penetration rate for adolescents served in substance abuse programs

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Section 2: Service Capacity and Delivery of Services

Objective 2.1: *Review the current type, number, and geographic distribution of Mental Health Services within the Delivery System.*

Goal 2.1a: Continue review of current maps on the type, number, and location of all Behavioral Health services

Goal 2.1b: Continue review of service data by:

a. Region/gender/race/ethnicity/diagnosis
b. Program/service type

Responsibility: Research, Managers/Administrators

Evaluation Tool(s): Maps, Who We Serve Report, Fiscal service detail reports

Plan: Review in QIC, Managers, and Directors meetings

Baseline: Who We Serve Report reviewed annually, Maps developed/reviewed annually and upon request for additional data.

Objective 2.2: *Establish goals for the number, types, and geographic distribution of Mental Health Services in the Delivery System.*

Goal 2.2a: Establish one CSU in the mid-county region by June 2018

Responsibility: Management, Facilities Management

Evaluation Tool(s): Opening of the CSU

Plan: Communicate need with County Board of Supervisors, contract with external organization

Baseline: There is currently no CSU available in the mid-county region

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Objective 2.2: *Establish goals for the number, types, and geographic distribution of Mental Health Services in the Delivery System.*

Goal 2.2b: Opening of a new clinic in Perris by December 2018

Responsibility: Adult Programs Deputy Director, Mid County Adult Administrator, Management, Facilities management

Evaluation Tool(s): Opening of the site

Plan: Continue to work with city to approve construction plans

Baseline: Original projection was to open the site by June 2016, revised projection timeframe is mid-2018.

Objective 2.2: *Establish goals for the number, types, and geographic distribution of Mental Health Services in the Delivery System.*

Goal 2.2c: Add one new county operated Substance Abuse program in each region by December 2017

Responsibility: Forensics Deputy Director, Substance Abuse Administrator, Management, Facilities Management

Evaluation Tool(s): Opening of new programs
Plan: Finalize site plan(s), begin/continue with construction at the identified sites
Baseline: No current MOMs program in Temecula area, no MOMs or Teen programs currently available in Moreno Valley area, no Substance Abuse services available on the west side in the city of Riverside

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Section 3: Timeliness to Services

Objective 3.1: *Monitor time to first appointment.*
Goal 3.1a: Obtain appointment for first offered routine request for mental health services within the county standards in 85% of requests for all regions of the county by 2017, and 95% by 2018.
Responsibility: Administrators, Clinic Supervisors, QI, Research
Evaluation Tool(s): Timeliness to Services report
Plan: Administrators to review workflow in programs outside their region to develop a best practice model
Baseline: This goal was over a 3 year period. The 2016 goal of 75% was met.

Objective 3.1: *Monitor time to first appointment.*
Goal 3.1b: Completion of the First Encounter Form to track time from initial contact through time to actual first service, including no shows and cancellations to be completed on an average of 75% across all programs
Responsibility: Administrators, Clinic Supervisors, QI, Research
Evaluation Tool(s): First Encounter Form Report
Plan: Train supervisors/line staff on purpose of the form and how to complete it
Baseline: The August 2016 First Encounter Form Report indicated 49.3% of dispositions are being recorded.

Objective 3.1: *Monitor time to first appointment.*
Goal 3.1c: Develop system to measure request for psychiatric appointments
Responsibility: ELMR, Research, Associate Medical Directors, QI
Evaluation Tool(s): Measuring tool
Plan: Work with administrators and supervisors on workflow
Baseline: No current system in place to measure time from request to psychiatric appointment

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Section 4: Access to Services

Objective 4.1: *Monitor access to after-hours care*
Goal 4.1: Review monthly reports on Crisis Team contacts after hours
Responsibility: Crisis Team
Evaluation Tool(s): Monthly contact logs
Plan: Continue engagement with emergency rooms and local law enforcement to educate on availability of services offered through this team
Baseline: Crisis Team contacts during FY 15-16 indicated 1,263 contacts for REACH, and 795 for CREST during the period of December, 2014 – June, 2016.

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2a: Test call reporting on the 800# providing information about how to access specialty mental health services to be no less than 95% each quarter ***during*** business hours
Responsibility: CARES, Research
Evaluation Tool(s): Test calls report
Plan: Conduct test calls quarterly
Baseline: Quarterly data for the test calls reports (FY 15-16) on information being provided about how to access services ranged from 57% - 100% during regular business hours.

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2b: Test call reporting on the 800# providing information about how to access specialty mental health services to be no less than 80% each quarter ***after*** regular business hours
Responsibility: CARES, Research
Evaluation Tool: Test calls report
Plan: Review contract requirements with provider, conduct test calls quarterly
Baseline: Quarterly data for the test call reports (FY 15-16) on information being provided about how to access services ranged from 9% - 40% after regular business hours.

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2c: Test call reporting on the 800# contact log to include the date, the name of the beneficiary, and the disposition to be no less than then 90% each quarter for calls ***during*** regular business hours
Responsibility: CARES, Research

Evaluation Tool: Test calls report
Plan: Continue to train staff, conduct test calls quarterly
Baseline: Quarterly data for the test calls reports (FY 15-16) on the contact log having all the required elements ranged from 0% - 71% during regular business hours.

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2d: Test call reporting on the 800# contact log to include the date, the name of the beneficiary, and the disposition to be no less than then 90% each quarter for calls *after* regular business hours
Responsibility: CARES, Research
Evaluation Tool: Test calls report
Plan: Review contract requirements with provider, conduct test calls quarterly
Baseline: Quarterly data for the test calls reports (FY 15-16) on the contact log having all the required elements ranged from 0% - 80% after regular business hours.

Section 5: Beneficiary Satisfaction

Objective 5.1: *Survey beneficiary/family satisfaction*
Goal 5.1a: Complete a direct interview with an a minimum of 400 beneficiary's contacted to complete a beneficiary satisfaction survey
Responsibility: Research, Sr. Peer Support Specialist
Evaluation Tool: Consumer Satisfaction Survey
Plan: Recruit staff/volunteers to conduct phone surveys
Baseline: Phone surveys are being conducted annually

Objective 5.1*: Survey beneficiary/family satisfaction*
Goal 5.1b: Complete the POQI bi-annually in all direct service programs
Responsibility: Evaluation, Program Administrators, Program Supervisors
Evaluation Tool: POQI Survey results
Plan: Run reports of active programs and number of consumers, distribute POQI's to each program for completion
Baseline: POQI's are being completed bi-annually

Objective 5.2: *Evaluate beneficiary grievances, appeals, and fair hearings*
Goal 5.2: Beneficiary grievances and fair hearings related to Quality of Service:

Interaction/Conduct of Staff to be utilized as a category for a complaint in less than 30% of grievances filed.
Responsibility: Research, QI, Program Managers/Administrators, Program Supervisors
Evaluation Tool(s): Problem Resolution Report
Plan: Share report with managers, administrators, and program supervisors to increase awareness of complaints related to perceptions of staff behaviors.
Baseline: The Problem Resolution Report (dated July 2016) indicated this category to be at 100% of grievances filed for the first half of the fiscal year, and 51.6% for the second half (an average of 75.8%.

Objective 5.3: *Evaluate change of provider requests*
Goal 5.3a: Change of provider requests due to Dissatisfaction, without details of why the consumer was dissatisfied with the provider and/or service, to be less than 30% for both individual and organizational providers
Responsibility: Research, CARES, ACT, QI
Evaluation Tool(s): Change of Provider Request Report
Plan: Re-training, improved procedures for follow up of providers
Baseline: The Change of Provider Report (dated 6/1/16) indicated dissatisfaction without detail was an average of 88.0%.

Objective 5.3: *Evaluate change of provider requests*
Goal 5.3b: Change of provider requests due to Individual Providers not responding to the consumer to be less than 20%
Responsibility: Research, CARES, ACT, QI
Evaluation Tool(s): Change of Provider Report
Plan: Analyze data related to specific providers, follow up with providers on barriers to contacting consumers
Baseline: The Change of Provider Report (dated 6/1/16) indicated Individual Providers not responding to the consumer was 37.7%.

Section 6: Provider Appeals

Objective 6.1: *Monitor provider issues and appeals*
Goal 6.1a: Authorize TARS within 14 days
Responsibility: CARES
Evaluation Tool(s): TAR authorization tracking sheet

Plan: Develop tracking system for TARs, review monthly for compliance to avoid delays in authorizations that result in provider appeals
Baseline: The 2016 Tri-annual Systems Review found 15% of TARS were not authorized within the 14 day timeframe.

Goal 6.1b: Implement tri-annual meetings with contracted providers
Responsibility: CARES, Children's Administrator, Adult Administrator
Evaluation Tool(s): Meeting agendas
Plan: Contact providers to develop structure, schedule quarterly meetings, utilize meetings to provide information, problem solve any issues
Baseline: Provider meetings occur annually.

Section 7: Clinical Care and Beneficiary Services

Objective 7.1: *Address meaningful clinical issues that affect beneficiaries*
Goal 7.1a: Develop and implement a single assessment to be used by Psychiatrists and Clinicians
Responsibility: QI, Associate Medical Directors, ELMR analysts, ELMR Implementation team
Evaluation Tool(s): Availability of a single assessment in ELMR
Plan: Meetings with MD's and CT's to develop the tool, analyst to develop in ELMR
Baseline: Current practice is separate assessment tools based on the specific information each discipline has historically captured resulting in reduced appointment availability for both Psychiatrists and Clinicians.

Objective 7.2: *Address meaningful clinical issues that affect beneficiaries*
Goal 7.2a: Analyze staff productivity and delivery of services
Responsibility: Best Practices Committee, Managers/Administrators, Deputy Directors
Evaluation Tool(s): Productivity Reports
Plan: Review processes in individual programs to gather innovative ideas on workflow
Baseline: Data on staff productivity indicates significant client supportive services with a low percentage of mental health services

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Objective 7.3: *Review safety and effectiveness of medication practices*
Goal 7.3: Develop a new monitoring/tracking process for psychotropic medications prescribed to dependent minors
Responsibility: QI, Medical Director, Associate Medical Director

Evaluation Tool(s): Medication Declaration Report
Plan: Designate additional psychiatrist time to review of Medication Declarations, develop new forms for tracking
Baseline: New JV220 forms require additional time to review, current tracking system does not include all the information related to reviewing psychotropic medication for dependent minors in one central location.

Objective 7.4: *Quantitative measures are in place to assess performance and identify areas for improvement*
Goal 7.4a: Provide coordination of care to outpatient services following inpatient psychiatric hospitalization by implementing a Navigation Center by June 2017
Responsibility: WET, Consumer Affairs, Management
Evaluation Tool(s): Opening of the Navigation Center, QI Indicators Hospitalizations Report
Plan: Repurpose the Recovery Learning Center building/program
Baseline: Data from the QI Indicators Hospitalizations Report (5-01-16) indicates the follow up rate after discharge to be an average of 61.2%. No consistent centralization of coordination of care following hospitalization currently exists in the department.

Objective 7.4: *Quantitative measures are in place to assess performance and identify areas for improvement*
Goal 7.4b: Analyze rate of residential substance use clients receiving outpatient services following
Responsibility: SA Clinical Coordination Team
Evaluation Tool(s): Claims data
Plan: Implement case management linkage between levels of care
Baseline: No previous system to track transfer of clients between treatment modalities

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Section 8: Monitor Clinical Documentation

Objective 8.1: *Interventions are implemented to address problem areas*
Goal 8.1a: Provide mandatory training for all program supervisors on chart documentation requirements per CCR, title 9, chapter 11.
Responsibility: QI, Manager/Administrators, Supervisors
Evaluation Tool(s): Training attendance log
Plan: Obtain feedback from supervisors/management, QI to create and implement trainings
Baseline: Last supervisor training was conducted in 2015

Objective 8.1: *Interventions are implemented to address problem areas*
Goal 8.1b: Provide mandatory training for all program clinical therapists on chart documentation requirements per CCR, title 9, chapter 11.
Responsibility: QI, Manager/Administrators, Supervisors
Evaluation Tool(s): Training attendance log
Plan: Obtain feedback from supervisors/management, QI to create and implement trainings
Baseline: The Clinical Documentation Report for January 1-June 30 2016 indicated staff completing adult, child, and 0-5 assessments had an overall documentation compliance average of 40.8%.

Section 9: Cultural Competence

Objective 9.1: *Cultural Competency and Linguistic Standards*
Goal Develop service based trainings specific to Asian, Native American, African American, and Latino communities
Responsibility: Cultural Competency Manager, WET
Evaluation Tool(s): Training schedule
Plan: Consult with advisory groups, research/update training materials
Baseline: Current trainings are academic in nature and not formatted for the diverse workforce in place at RUHS-BH

Section 10: Continuity and Coordination with Physical Health Care

Objective 10.1: *Coordinate mental health services with physical health care*
Goal 10.1: Continue with integrated services through IEHP
Responsibility: IEHP, CARES manager
Evaluation Tool(s): PHQ9 and SDQ monthly reports
Plan: County to provide monthly Physical Health Questionnaire and Strengths and Difficulties Questionnaire data to IEHP monthly on consumers enrolled in the Behavioral Health Integration/Complex Care Integration (BHI/CCI) program
Baseline: MOU with IEHP for the BHI/CCI program initially implemented in 2015

Objective 10.2: *Exchange information in an effective and timely manner with other agencies*
Goal 10.2: Implement ability to receive and provide Continuity of Care document with Tech Care (EHR in the detention system)

Responsibility: Forensics Deputy Director, Forensics Program Administrator, IT, Research
Evaluation Tool(s): CCD's
Plan: Develop workflow to produce/accept CCD's between Tech Care and ELMR
Baseline: Tech Care is a new EHR, no current workflow exists

Objective 10.3: *MOU's to guide effective practices with physical health care plans/agencies*
Goal 10.3: Continue with MOU's with IEHP and Molina
Responsibility: Administration
Evaluation Tool(s): Memorandums of Understanding
Plan: Continue to meet quarterly
Baseline: Meetings occurring quarterly

Riverside University HEALTH SYSTEM Behavioral Health

Substance Abuse Prevention and Treatment Program
Contractor Extension Request

FAX Request to: SAPT Administration 951-683-4904

Treatment Program completes top portion of form. Include all consumer demographics listed.

Consumer Name: (Last)_____ **(First)**_____**Gender:**_____
(Male, Female, Other)

Medical Record#: _____

MR# will be known at time of extension request.

Date of Birth: _____/_____/_____

Social Security Number: _____-_____-_____
(Make every attempt to obtain consumer's SSN)

Episode Admission Date: _____/____/_____

Extension Request Date: _____/____/_____

Program: _____ Must include Program Name and ID (RU)
(Program Name and Program ID)

Service Authorization (End Date Extension):_____
(Number of Days or Extend to MM/DD/YYYY)

Service Authorization (Add Units to CPT Code): *(List all Service Codes and the number of additional units per code needed)*

_____

_____

Ensure this section is completed as specific as possible

Complete both the End Date and Add Units when both apply.

Current Level of Care: Level of Care must be indicated

- ☐ **0.5** Early Intervention
- ☐ **1.0** Outpatient
- ☐ **2.1** Intensive Outpatient
- ☐ **2.5** Partial Hospitalization
- ☐ **3.1** Clinically Managed Low-Intensity Residential
- ☐ **3.3** Clinically Managed Population Specific High-Intensity Residential
- ☐ **3.5** Clinically Managed High-Intensity Residential
- ☐ **3.7** Medically Monitored High-Intensity Inpatient
- ☐ **4.0** Medically Managed Intensive Inpatient
- ☐ **OTP Level 1** Opioid Treatment Program
- ☐ **1.WM** Ambulatory Withdrawal Management (W/O Extended Onsite Monitoring)
- ☐ **2.WM** Ambulatory Withdrawal Management (with Extended On-Site Monitoring)
- ☐ **3.2WM** Residential/Inpatient Withdrawal Management Monitoring
- ☐ **3.7WM** Medically Monitored Inpatient Withdrawal Management
- ☐ **4.WM** Medically Managed Intensive Inpatient Withdrawal Management

Reason for Extension: _____
(Submit supporting documentation when applicable)

Treatment Program Clinician completes 'Reason for Extension' Section

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SAPT ADMIN USE ONLY

☐ **Approved (Auth#**_____**)** ☐ **Denied** ☐ **Pending**

Reason for Denied/Pending: _____

Signature of SAPT Program Manager/Designee: _____ **Date:** _____

CONFIDENTIAL PATIENT INFORMATION

Riverside University HEALTH SYSTEM Behavioral Health

Substance Abuse Prevention and Treatment Program

Procedure Code Manual

Effective: 02/01/2017

TABLE OF CONTENTS

SECTIONS:

PRIMARY PREVENTION

(ASAM: LEVEL 0.5 Early Intervention) = PRIMARY

Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-related disorder.
Screening, Brief Intervention, and Referral to Treatment (as needed).

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
861	Education	No	Practitioner	Indirect	20/13	1/600 FNL: 1/1440

This strategy involves two-way communication. Interaction between the educator/counselor and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, critical analysis (e.g., of media messages) and systematic judgment abilities. Example of activities conducted and method used for this strategy include, but are not limited to, the following:

* Classroom and/or small group sessions (all ages).
* Parenting and family management classes.
* Peer leader helper programs.
* Education programs for youth groups.
* Children of substance abuser.
* Waiting list group.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
862	Information Dissemination	No	Practitioner	Indirect	20/12	1/600

This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. This strategy is characterized by one-way communication from the Counselor to the audience, with limited contact between the two.

Examples of activities conducted and methods used for this strategy include, but are not limited to the following:

a. Clearinghouse/information resource centers.
b. Resource directories
c. Media campaigns
d. Brochures.
e. Radio/TV public service announcements.
f. Speaking engagements.
g. Health fairs/health promotion.
h. Information lines
i. Information calls from citizens.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
863	Problem Identification and Referral	No	Practitioner	Indirect	20/15	1/600

This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include, but are not limited to the following:

a. Employee assistance programs
b. Student assistance programs

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
864	Community Based Process	No	Practitioner	Indirect	20/16	1/600

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and working. Examples of activities conducted and methods used include, but are not limited to, the following:

* Community and volunteer training, e.g., neighborhood action training, training of key people in the system, staff/official training.
* Systematic planning.
* Multi agency coordination and collaboration.
* Accessing services and funding.
* Community team building.
* Capacity building training and activities.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
865	Alternatives	No	Practitioner	Indirect	20/14	1/600

This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and would, therefore, minimize or obviate resorting to the latter. Examples of activities conducted and methods used for this strategy include (but not limited to) the following:
a. Drug Free Dances and Parties;
b. Youth/Adult Leadership activities;
c. Community Drop-In Center, and;
d. Community Service Activities

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
866	Environmental	No	Practitioner	Indirect	20/17	1/600

This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy can be divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives. Examples of activities conducted and methods used for this strategy shall include, but not be limited to, the following:

a. Promoting the establishment and review of alcohol, tobacco and drug use policies in schools;
b. Technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use;
c. Modify alcohol and tobacco advertising practices; and
d. Product pricing strategies.

SECONDARY PREVENTION

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA805	Perinatal Outreach	No	Practitioner	Indirect	90/22	5/600

Those activities involved in identifying and encouraging eligible pregnant and parenting women in need of treatment services to take advantage of these services. This activity is also a means to make members of the professional community aware of perinatal services so that they become referral sources for potential consumers.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA880	Early Intervention	No	Practitioner	Indirect	30/18	1/600

This strategy is designed to come between a substance abuser and his/her actions in order to modify behavior. It includes a wide spectrum of activities, crisis counseling of non-consumer, user education to formal intervention and referral to appropriate treatment/recovery services. This code is used by County Providers and Contract Providers.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
882	Outreach / Intervention	No	Both	Indirect	30/19	1/600

Activities for the purpose of encouraging those individuals in need of treatment to undergo such treatment.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
883	California Mentor Initiative (CMI)	No	Both	Indirect	30/24	1/600

The CMI is designed to enhance and expand mentor service programs across the state. For the purposes of CMI, mentoring is defined as a relationship over a prolonged period of time between two or more people, where older, wiser, more experienced individuals provide constant, as needed support, guidance and concrete help to younger at-risk persons as they go through life. An “at-risk” youth is an individual under 19 years of age whose environment increases his/her chance of becoming a teen parent, school dropout, gang member, or user of alcohol or drugs.

OUTPATIENT SERVICES

(ASAM: Level 1, Outpatient Services)

Less than 9 hours of service/week (adult); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA421IND	Individual Counseling ODF				40/34	
	SA421INDP	Individual Counseling ODF (PERI)				90/34	
	SA421INDY	Individual Counseling ODF (Youth)				40/34	
POST	SA421INDPY	Individual Counseling ODF (P-Yth)	Yes	Both	Direct	90/34	1/120
PRE	SA421; SA421PERI; SA421YT; SA442; SA442PERI; SA442YT; SA443; SA443PERI; SA443YT; SA444; SA444PERI; SA444YT; SA445; SA445PERI; SA445YT; SA450; SA450PERI; SA450YT						

INTAKE: The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment. (STC: : Section 131, Part " a")

TREATMENT PLAN: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan. The treatment plan shall include:

a. A statement of problems to be addressed;

b. Goals to be reached which address each problem;

c. Action steps which will be taken by the provider and/or beneficiary to accomplish identified goals;

d. Target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to the be provided and the frequency thereof;

e. Treatment plans have specific quantifiable goal/treatment objectives related the beneficiary's substance use disorder diagnosis and multidimensional assessment;

f. The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration;

g. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director or LPHA. (STC: Section 131, Part "i")

CRISIS INTERVENTION: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation. (STC: Section 131, Part "h")

INDIVIDUAL COUNSELING: Contacts between a beneficiary 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. May include the following services: :

- Patient Education
- General Individual Counseling (STC: Section 131, Sections "b", "e", and "f")

COLLATERAL: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary. (STC: Part 131, Section "g")

DISCHARGE PLANNING: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. (STC: Part 131, Section "j")

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA440GRP	Group ODF				40/33	
	SA440GRPP	Group ODF (PERI)				90/33	
	SA440GRPY	Group ODF (Youth)				40/33	
POST	SA440GRPPY	Group ODF (P-Yth)	Yes	Both	Direct	90/33	1/120
PRE	SA440; SA440PERI; SA440YT; SA446; SA446PERI; SA446YT; SA447; SA447PERI; SA447YT						

Face-to-Face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in group, focusing on the needs of the individuals served. (STC: Section 131, Part "c")

PATIENT EDUCATION - Provide research based education on addiction, treatment, recovery and associated health risks. (STC: Part 131, Section "e").

FAMILY THERAPY - The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery as well as their own recovery can be conveyed. Family members can provide social support to the patient. help motivate their loved ones to remain in treatment, and receive help and support for their own family recovery as well. (STC: Past 131, Section "d")

INTENSIVE OUTPATIENT SERVICES

(ASAM: Level 2.1, Intensive Outpatient)

9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA220GRP	Group IOT				40/30	
	SA220GRPP	Group IOT (PERI)				90/30	
	SA220GRPY	Group IOT (Youth)				40/30	1/240 (Adult)
POST	SA220GRPPY	Group IOT (P-Yth)	Yes	Both	Direct	90/30	1/180 (Adol)
PRE	SA220; SA220PERI						

Face-to-face contacts in which one or more therapists or counselors treat clients in an group setting. Structured programming services are provided to beneficiaries at a minimum of 9 hours per week for adults and 6 hours per week for adolescents, with a maximum of 19 hours per week for both populations. Services may include the following:

- Group Counseling
- Patient Education
- Family Therapy (STC, Section 132)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA221IND	Individual Counseling IOT				40/30	
	SA221INDP	Individual Counseling IOT (PERI)				90/30	
	SA221INDY	Individual Counseling IOT (Youth)				40/30	
POST	SA221INDPY	Individual Counseling IOT (P-Yth)	Yes	Both	Direct	90/30	1/120
PRE	SA221; SA221PERI						

Contacts between a beneficiary and a therapist or counselor. Services can be provided in-person, by telephone or by telehealth. Services feature a minimum of 9 hours per week for adults and 6 hours per week for adolescents, with a maximum of 19 hours per week for both populations as specified by the patient's treatment plan . This includes the following services:

* Intake
* Individual Counseling
* Patient Education
* Family Therapy
* Collateral Services
* Crisis Intervention Services
* Treatment Planning
* Discharge Services (STC: Section 132)

OPIOID TREATMENT SERVICES (NTP)

(ASAM: Level 1, Opioid Treatment Programs) = NTP

Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA440NTPW	Group NTP				50/46	
	SA440NTPP	Group NTP (PERI)				90/46	
	SA440NTPY	Group NTP (Youth)				50/46	
POST	SA440NTPPY	Group NTP (P-Yth)	Yes	Both	Direct	90/46	10/200
PRE	SA440NTP						

Face-to-Face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in group, focusing on the needs of the individuals served. Services are provided in NTP licensed facilities. A patient must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity. (STC: Section 136)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA441NTPW	Individual Counseling NTP				50/47	
	SA441NTPP	Individual Counseling NTP (PERI)				90/47	
	SA441NTPY	Individual Counseling NTP (Youth)				50/47	
POST	SA441NTPPY	Individual Counseling NTP (P-Yth)	Yes	Both	Direct	90/47	10/200
PRE	SA441NTP						

Contacts between a beneficiary and a therapist or counselor. Services may be provided in-person, by telephone or by telehealth. Services are provided in a licensed NTP facility. A patient must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity. Services may include the following:

- Intake
- General Individual Counseling
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Medical Psychopharmacology
- Discharge Services (STC: Section 136)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA521NTPW	Dosing NTP				50/40	
	SA521NTPP	Dosing NTP (PERI)				90/40	
	SA521NTPY	Dosing NTP (Youth)				50/40	1-Unit
POST	SA521NTPPY	Dosing NTP (P-Yth)	Yes	Both	Direct	90/40	(Contact)
PRE	SA521NTP						

DMC-ODS Required MAT: Client dosing with methadone in an NTP licensed facility (STC: Section 136).

MEDICATION ASSISTED TREATMENT SERVICES (MAT)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA521MAT	Medication Assist Tx Non-NTP				40/36	
	SA521MATP	Medication Assist Tx Non-NTP (PERI)				90/36	
POST	SA521MATY	Medication Assist Tx Non-NTP (Youth)				40/36	
(NEW)	SA521MATPY	Medication Assist Tx Non-NTP (P-Yth)	Yes	Both	Direct	90/36	1/240

If a beneficiary receives any DMC services in a non-NTP setting, a physician working at the program may also prescribe MAT
The components of Additional MAT Includes:
a. The ordering, prescribing, administering, and monitoring of MAT
b. The use of FDA approved medications
c. Utilization of long-acting injectable naltrexone at DMC facilities
d. County proposed interim rates for additional MAT in residential and outpatient settings

Medication Assisted Treatment (MAT) is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of substance use disorders (SUD). Research shows that a combination of MAT and behavioral therapies is a successful method to treat SUD.

WITHDRAWAL MANAGEMENT SERVICES (DETOX)

(ASAM: Level 3.2-WM, Residential / Inpatient Withdrawal Management Monitoring)

Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA110DTX	Detox Inpatient					
	SA110DTXP	Detox Inpatient (PERI)					
	SA110DTXY	Detox Inpatient (Youth)					
POST	SA110DTXPY	Detox Inpatient (P-Yth)	Yes	Both	Direct	60/50	1440
PRE	SA110						

Clinically Managed Residential Withdrawal Management (sometimes referred to as “social setting detoxification”) is an organized service that may be delivered by appropriately trained staff who provide 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. Services are provided in a free-standing or integrated, appropriately licensed residential facility. Each beneficiary will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized treatment plan prescribed by a licensed physician. The components of withdrawal management services include:

- Intake
- Observation
- Medication Services
- Discharge Services (STC: Section 135)

RESIDENTIAL SERVICES

(ASAM: Level 3.1, Clinically Managed Low-Intensity Residential)
24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.

(ASAM: Level 3.3, Clinically Managed Population Specific High-Intensity Residential)
24-hour care with trained counselors to stabilize multidimensional imminent danger.
Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment. (Note: this level is not designated for adolescents).

(ASAM: Level 3.5, Clinically Managed High-Intensity Residential)
24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA210RES	Residential				60/51	
	SA210RESP	Residential (PERI)				90/51	
	SA210RESY	Residential (Youth)				60/51	
POST	SA210RESPY	Residential (P-Yth)	Yes	Both	Direct	60/51	1440
PRE	SA210						

Level 3.1: Clinically Managed Low-Intensity Residential treatment is a non-institutional, 24-hour non-medical, short term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis. Available to perinatal, non-perinatal, and adolescent beneficiaries. Has a 24-hour structure with available trained personnel. It offers a minimum of 5 hours of clinical service per week and preparation for transition to outpatient treatment.

Level 3.3: Clinically Managed Population Specific High-Intensity Residential treatment is a non-institutional, 24-hour non-medical, short term residential program that provides high intensity clinical services to beneficiaries with a substance use disorder diagnosis who also have severe cognitive deficiencies. Offers 24-hour care with trained counselors to stabilize multidimensional imminent danger. A less intense milieu and group treatment is offered for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for transition to outpatient treatment. This level is not intended for adolescent beneficiaries. This level provides a range of cognitive, behavioral and other therapies adapted to the patient's developmental stage and level of comprehension. The level provides daily scheduled professional addiction and mental health treatment.

Level 3.5: Clinically Managed High-Intensity Residential Services are offered in a 24-hour structured living environment with high-intensity clinical services for individuals who have multiple challenges to recovery and require a safe, stable recovery environment combined with a high level of treatment services. Provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for transition to outpatient treatment. Consumers receiving this level of care are able to tolerate and use the full milieu of the therapeutic community. Patients typically have multiple challenges in addition to addiction (trauma history, criminal/legal issues, psychological problems, etc). Services are available for perinatal, non-perinatal, and adolescent beneficiaries (NOTE: for adolescents, this is considered a Medium-Intensity service). The level provides daily scheduled professional addiction and mental health treatment designed to improve the patient's ability to structure and organize tasks of daily living and recovery.

The components of Residential Treatment services include the following:

- Intake
- Individual and Group Counseling
- Patient Education
- Family Therapy
- Safeguarding Medications
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Transportation Services
- Discharge Services

ROOM AND BOARD						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA190RAB	Room and Board					
SA190RABP	Room and Board (PERI)					
SA190RABY	Room and Board (Youth)					
SA190RABPY	Room and Board (P-Yth)	No	Both	Direct	90/60	1440
This services includes the cost for providing room and board at a residential facility or in a hospital setting to beneficiaries receiving residential withdrawal management (detoxification) or residential treatment services.						

POST (NEW)

PHYSICIAN / LPHA / CLINICAL THERAPIST SERVICES

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA600MDC	Physician Consultation MD-to-MD					
	SA600MDCP	Physician Consultation MD-to-MD (PERI)					
POST	SA600MDCY	Physician Consultation MD-to-MD (Youth)					
(NEW)	SA600MDCPY	Physician Consultation MD-to-MD (P-Yth)	Yes	Both	Direct	70/61	1/60

Physician consultation services include DMC physicians' consulting with addiction medicine physicians, addictions psychiatrists or clinical pharmacists. Consultations are to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. Physician consultation services can only be billed by and reimbursed to DMC providers.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA602DX	Diagnosis Review				70/68	
	SA602DXP	Diagnosis Review (PERI)				90/68	
POST	SA602DXY	Diagnosis Review (Youth)				70/68	
(NEW)	SA602DXPY	Diagnosis Review (P-Yth)	No	Both	Direct	90/68	1/90

The review of the beneficiary diagnosis by LPHA in order to establish medical necessity of treatment This includes the review of intake report, review of diagnosis by counselor, and review of Medical Necessity note.

CASE MANAGEMENT SERVICES

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA468CM	Case Management				70/68	
	SA468CMP	Case Management (PERI)				90/68	
	SA468CMY	Case Management (Youth)				70/68	
POST	SA468CMPY	Case Management (P-Yth)	Yes	Both	Direct	90/68	1/60
	SA368RSCM	Case Management RS				70/68	
	SA368RSCMP	Case Management RS (PERI)				90/68	
POST	SA368RSCMY	Case Management RS (Youth)				70/68	
(NEW)	SA368RSCPY	Case Management RS (P-Yth)	Yes	Both	Direct	90/68	1/60
PRE	SA468; SA468PERI; SA468YT						

A service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
Case Management Services include:
* Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management services
* Transition to a higher or lower level of substance use disorder (SUD) care
* Development and periodic revision of a client plan that includes service activities
* Communication, coordination, referral, and related activities
* Monitoring service delivery to ensure beneficiary access to service and the service delivery system
* Monitoring the beneficiary's progress
* Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services
* Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California Law

NOTE: Recovery Service episodes require the use of the SA368 (Series). All other Levels of Care use SA468 (Series)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA445INB	Non-Billable Case Mngt				70/68	
	SA445INBP	Non-Billable Case Mngt (PERI)				90/68	
POST	SA445INBY	Non-Billable Case Mngt (Youth)				70/68	
(NEW)	SA445INBPY	Non-Billable Case Mngt (P-Yth)	Yes	Both	Direct	90/68	1/60

Case Management Services include:
* Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management services
* Transition to a higher or lower level of substance use disorder (SUD) care
* Development and periodic revision of a client plan that includes service activities
* Communication, coordination, referral, and related activities
* Monitoring service delivery to ensure beneficiary access to service and the service delivery system
* Monitoring the beneficiary's progress
* Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services
* Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California Law

NOTE: Any SA468 (series) or SA368 (series) must be converted to a non-billable SA445 (equivalent series) when it is after the last face-to-face session. This is reviewed and edited (if applicable) when closing a non-present consumer chart, and the discharge date needs to be backdated to the last face-to-face session.

TESTING						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA475TEST	Testing				40/34	
SA475TESTP	Testing (PERI)				90/34	
SA475TESTY	Testing (Youth)				40/34	
POST SA475TSTPY	Testing (P-Yth)	No	Both	Direct	90/34	1/15
PRE	SA473; SA473PERI; SA473YT; SA474; SA474PERI; Sa474YT; SA475; SA475PERI; SA475YT; SA476; SA476PERI; SA476YT					
Services that include the use of substance use screening testing to determine whether or not a consumer has been using substances. **NOTE:** In an ODF Level of Care only.						

NO SHOW & EXCUSED ABSENCE

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
POST	SA400NS	No Show	No	Both	Direct	40/34	0/15
PRE	SA400; SA400PERI; SA200; SA200PERI						
	Services that a consumer has been scheduled to receive but does not physically show up to receive, nor call to cancel. **NOTE:** Can be used across all Levels of Care.						

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
POST	SA401EA	Excused Absence	No	Both	Direct	40/34	0/15
PRE	SA401; SA401PERI; SA201; SA201PERI						
	Services that a consumer has been scheduled to receive but does not physically show up to receive and calls with valid excuse for cancellation. **NOTE:** Can be used across all Levels of Care.						

RECOVERY SERVICES

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA321RSIN	Individual Counseling RS				42/34	
	SA321RSINP	Individual Counseling RS (PERI)				92/34	
	SA321RSINY	Individual Counseling RS (Youth)				42/34	
POST	SA321RSIPY	Individual Counseling RS (P-Yth)	Yes	Both	Direct	92/34	1/60
PRE	SA428						
	One-on-one contacts in which a beneficiary meets with a therapist or counselor to help stabilize the beneficiary and reassess if further care is needed. (Follow Outpatient Individual Guidelines)						

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA322RSGR	Group RS				42/33	
	SA322RSGRP	Group RS (PERI)				92/33	
	SA322RSGRY	Group RS (Youth)				42/33	
POST	SA322RSGPY	Group RS (P-Yth)	Yes	Both	Direct	92/33	1/90
PRE	SA448						
	Face-to-Face contacts in which one or more therapists or counselors meet with two or more clients at the same time to assist the beneficiary and reassess if further care is needed. (Follow Outpatient Group Guidelines)						

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA323RSSP	Support Services RS				42/32	
	SA323RSSPP	Support Services RS (PERI)				92/32	
POST	SA323RSSPY	Support Services RS (Youth)				42/32	
(NEW)	SA323RSPPY	Support Services RS (P-Yth)	Yes	Both	Direct	92/32	1/120

Recovery support services are designed to emphasize the beneficiary's central role in managing their health, promote the use of effective self-management support strategies, and provide internal and community resources to support ongoing self-management. The components of recovery services include the following:

* Recovery Monitoring, including recovery coaching and monitoring via telephone/telehealth
* Substance Abuse Assistance, including peer-to-peer services and relapse prevention
* Support for Education and Job Skills, such as linkages to life skills, employment services, job training, and education services
* Family Support, such as 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, such as linkages to housing assistance, transportation, and case management

STAFF TIME (Indirect Services)

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA706	SU Documentation	No	Practitioner	Indirect	10/00	1/30

To be used for charting of consumer service, case management activity, or clinical reviews in the consumer chart that is not already part of the original service time. For example; A group service of 90 minutes and documentation time of 30 minutes for those 12 individuals that were in group.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA707	General Administration	No	Practitioner	Indirect	10/00	1/600

Staff meetings, supervisory meeting, and general supervision of staff including supervision of intern and students. Grant writing for federal funding and monthly reports. Riverside University Health System health promotion activities for County employees (blood drive, United Way). Morning and afternoon breaks (one half hour minimum per day in 15 min increments for all staff). Travel and paperwork associated with these activities.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA708	Paid and Unpaid Time Off	No	Practitioner	Indirect	10/00	1/600

All time used for all types of paid or unpaid leave, i.e., vacation, extra vacation, sick leave, comp time, jury duty, holiday leave, voting time, military leave, industrial injury, bereavement, AWOP, etc.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA709	Other Activities	No	Practitioner	Indirect	45/00	1/600

Other activities can include, but are not limited to the following:

* Information Calls (non-consumer based)
* Resource Calls (non-consumer based)
* Phone Calls for inactive/closed consumers (that does not fall under the Early Intervention criteria)
* Tracking of previously unzipped time not accounted for and where the staff is unable to verify what was rendered (plug time).
* Drive time (transportation, covering for MOMs transporting, etc.)

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA711	SU Screening	No	Practitioner	Indirect	45/00	1/60

Used to document consumer contact (in person or by phone) time spent screening and assessing ASAM level of care for potential prevention and treatment participants who do not have a current active episode in a SU Program.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA712	SU Case Management	No	Practitioner	Indirect	70/68	1/

Case management with consumer prior to entry or outside a treatment episode.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA719	AB109 Case Management	No	Practitioner	Indirect	70/88	1/

Used to document time spent in case management for AB109 participants. As well as direct services with AB109 participants who do not have a current active episode in a SU Program.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA720	AB109 Screening	No	Practitioner	Indirect	45/00	1/60

Used to document time spent in case managing duties for AB109 participants, screening and assessment. As well as direct services with AB109 participants who do not have a current active episode in a SU Program.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA760	Staff Training Received	No	Practitioner	Indirect	10/00	1/600

All training received by staff, literature reviews, etc.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA907	Clinical Supervision	No	Practitioner	Indirect		1/

Clinical supervision of unlicensed clinical therapists by licensed clinical therapists.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
NEW SAPLCHLD	Appointment Placeholder	No	Practitioner	Indirect	N/A	N/A

Service Code designated to be utilized as a placeholder in the Scheduling Calendar as an appointment slot for scheduling availability and/or appointment assignment of a non-registered consumer.

NOTE: This service code is only utilized as a placeholder and MUST be overridden and NEVER posted. If posted in error edit or delete the SAPLCHLD service code in CalPM.

DRINKING DRIVER PROGRAM (DDP)

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA438	AB762 Initial Intake Assessment		Practitioner	Indirect	80/90	60 – 90
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA454	Group Orientation/Initial Structuring Group		Practitioner	Indirect	80/90	30 – 90
Face to Face contact in which one or more counselors orient identified consumers at the same time, focusing on short term behaviors and responsibilities of the consumer in order for a successful completion of court ordered DUI requirements.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA455	Group Orientation/Initial Structuring Group		Practitioner	Indirect	80/90	90 – 240
Face to Face contact in which one or more counselors orient identified consumers at the same time, focusing on short term behaviors and responsibilities of the consumer in order for a successful completion of court ordered DUI requirements. Group Orientation is at a higher level and more in-depth process due to consumers convicted of multiple DUI.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA456	Initial Structuring Individual		Practitioner	Indirect	80/90	15 – 60
Face to Face contact between a consumer and counselor focusing on treatment needs of the individual served.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA457	Restructure		Practitioner	Indirect	80/90	15 – 60
Face to Face contact between a consumer and counselor focusing on treatment needs of the individual due to DUI program termination. This service entails more in-depth case management in order to determine whether a higher level of service may be required and or may require a return to court of jurisdiction due to improper behavior.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA458	Reinstatement		Practitioner	Indirect	80/90	15 – 60
Face to Face contact between a consumer and counselor focusing on treatment needs of the individual whom has previously been sent back to court of jurisdiction and re-referred by the courts for continuing DUI case management services.						

DRIVING UNDER the INFLUENCE (DUI) & PC1000

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA410	No Show/Absence DUI/PC1000		Practitioner	Indirect	80/90	5
A service that the consumer has been scheduled to receive but does not physically show up to receive.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA411	AB541 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA412	AB1353 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA413	SB38 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA414	AB1176 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA415	DUI Group Counseling		Practitioner	Indirect	80/90	150
Face to Face contact in which one or more counselors treat identified consumers at the same time, focusing on short term personal, family, job/school, and other problems and their relationship to DUI related behavior.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA416	DUI Educational Group Counseling		Practitioner	Indirect	80/90	150
The delivery of information on issues pertinent to DUI educational strategies in a group setting as a lecture without therapeutic interaction.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA417	SB38 DUI Phase II Educational Group Counseling		Practitioner	Indirect	80/90	90
Face to Face contact in which one or more counselors treat identified consumers at the same time, focusing on short term personal, family, job/school, and other problems and their relationship to DUI related behavior.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA418	DUI Individual Face to Face Counseling		Practitioner	Indirect	80/90	15
Face to Face contact between the consumer and counselor focusing on treatment needs of the individual served.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA419	DUI Breathalyzer/Urinalysis Test		Practitioner	Indirect	80/90	5
Services that include the use of breathalyzer or urinalysis test to determine if the consumer is under the influence of a mind-altering substance.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA430	DUI/PC1000 Transfer of Program/Provider		Practitioner	Indirect	80/90	15
The process of transferring a consumer to a different provider for continuing services or a modality change.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA431	PC1000 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the Deferred Entry of Judgment Drug Diversion program: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA432	PC 1000 Group Counseling		Practitioner	Indirect	80/90	150
Face to Face contact in which one or more counselors treat identified consumers at the same time, focusing on short term personal, family, job/school, and other problems and their relationship to DUI related behavior.						

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA433	PC 1000 Educational Group Counseling		Practitioner	Indirect	80/90	150
This group focuses on the delivery of information on issues pertinent to DUI educational strategies in a group setting as a lecture without therapeutic interaction.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA434	PC 1000 Individual Face to Face Counseling		Practitioner	Indirect	80/90	30
Face to Face contact between a consumer and counselor focusing on treatment needs of the individual served.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA435	PC 1000 Exit Interview		Practitioner	Indirect	80/90	30
Face to Face service between consumer and counselor focusing on reinforcing newly developed recovery. Skills and development of a plan to maintain those skills upon completion of Deferred Entry of Judgment program.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA437	Reinstatement of DUI/PC1000 Program Consumer		Practitioner	Indirect	80/90	5
The process of reinstating the consumer back into program services following program termination. *Consumers cannot be reinstated if out of the program for two years or more, and will be assigned new initial intake assessment.						

Riverside University HEALTH SYSTEM Behavioral Health

Substance Use Program

Contract Provider User Guide

JUNE 2016 (V.2)

Table of Contents

Section

1

Section One: Introduction

*Welcome to Riverside University Health System, Behavioral Health "ELMR" system, which stands for **El**ectronic **M**anagement of **R**ecords. Effective July 1, 2016, all Substance Use Contract Providers will be able to access the County's ELMR system after opening a Virtual Private Network (VPN). (Review **ELMR System Requirement** user guide – Section 5) Providers will be able to view service authorizations, enter consumer's diagnosis as well as all CalOMS data.*

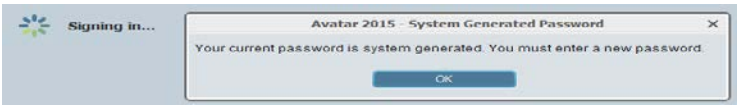
ELMR Sign-in

At the ELMR Sign-in screen, enter the Provider Authentication information:

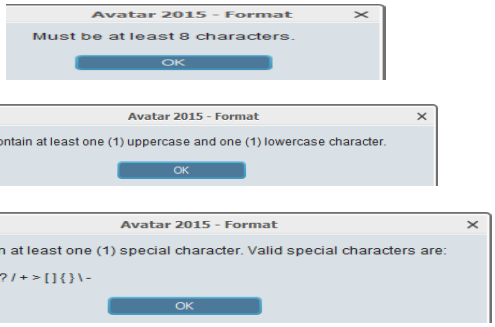
- **Server** – Default: MyAvatar Live
- **System Code** – Type in All CAPS: "**LIVE**"
- **User Name** – Type in lowercase: Personal ID assigned by County.
  - (Existing Providers: Same username used to log in to Provider Connect)
- **Password** –
  - Initial logon: Type in system generated password "123".
  - User Access: User Defined personal Password.

Select "*Sing In*" command button

System generated passwords will prompt the message below and prompt user to select "OK" to enter a new user defined personal password.



New Password Entry: Requires that the new password be no less than 8 characters, of which at least one of the characters are uppercase and one lowercase, as well as it must include one special character. Valid special characters are: % @ # $! * ? / + > [ ] { } | -



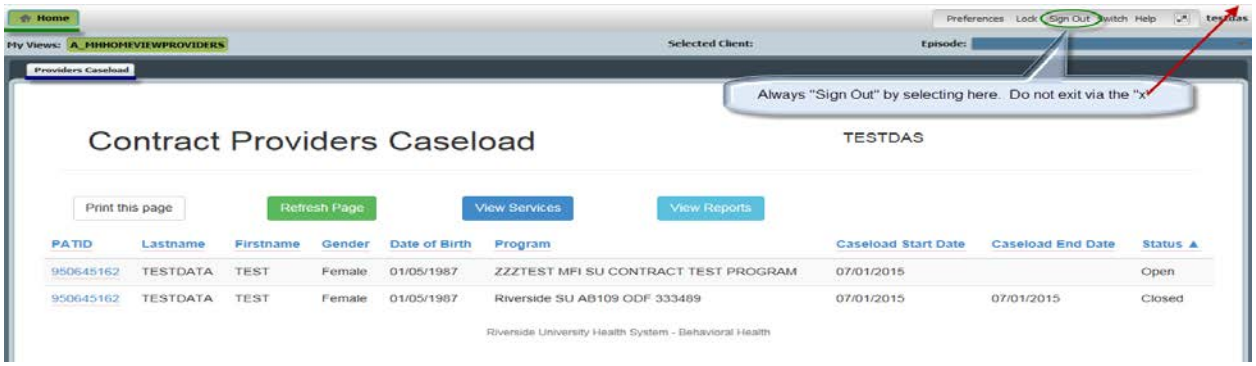
Home Page (Providers Caseload)

The Home Page or Providers Caseload page will display a list of all consumers assigned to the logged on agency. This home page will also allow navigation through command buttons to access the service entry and reports request screens. A print page and refresh command button are also available on this page.

The **PATID** (patient identification number assigned by ELMR during registration) is a hyper link to access the individual consumer's data/chart.

All **headers** on this page allow the end user to **sort** by individual column. End User can review consumers by 'Open' episode "Status" or by consumer "Lastname".

When exiting ELMR select "Sign Out" not the "X".

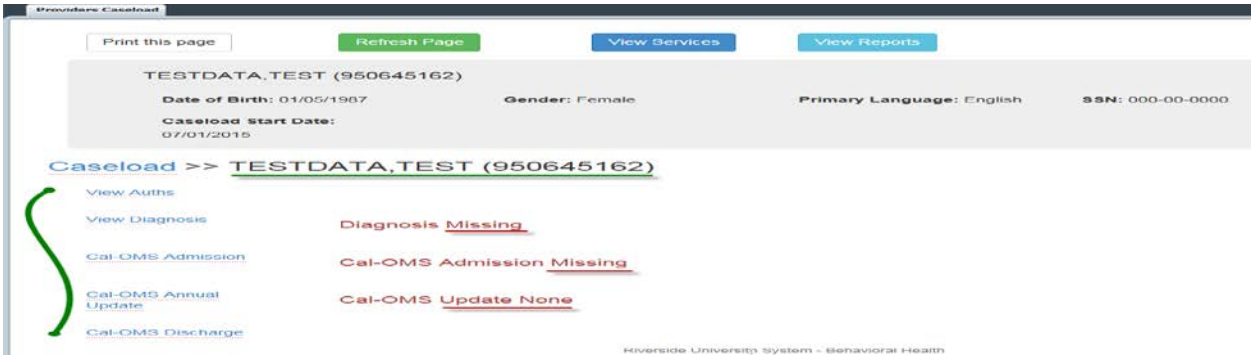


Consumer Chart View

Select the **PATID #** to open the individual consumer's data for viewing.

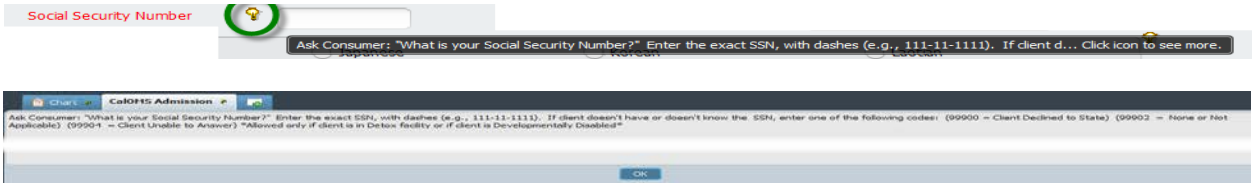
This page will display the following for the consumer:

- **Demographics Box**: *DOB, Gender, Primary Language, SSN and Caseload Start Date*
- Access to ELMR Forms (See Section 2)
    - **View Auths**: *Service Authorization*
    - **View Diagnosis**: *Diagnosis Entry*
    - **Cal-OMS Admission**
    - **Cal-OMS Annual Update**
    - **Cal-OMS Discharges**
        - *Cal-OMS Standard Discharge*
        - *Cal-OMS Youth/Detox Discharge*
        - *Cal-OMS Administrative Discharge*



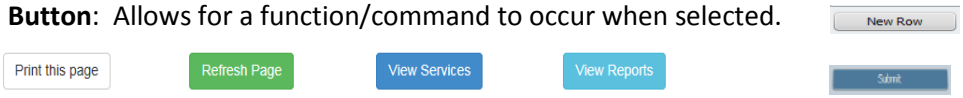
Navigation Tools

1. **Light Bulbs**: Hovering over the lightbulb will display the first row of the help message. Double-clicking the lightbulb will open a message box with the entire help message.

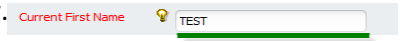


2. **Dropdown List**: Allows for a single selection. Highlight the row to select the value.

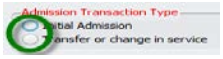
3. **Command Button**: Allows for a function/command to occur when selected.



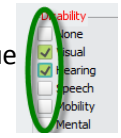
4. **Free-Text Field**: Allows for free text entry.



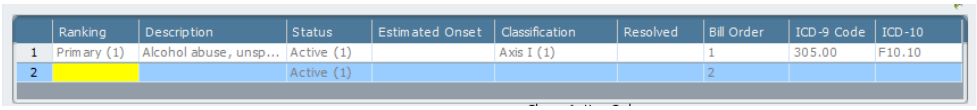
5. **Radio Button**: Allows for a single selection by selecting the circle before the value.



6. **Check-Box**: Allows for multiple selections by selecting each applicable box before the value



7. **Multiple Iteration Table**: Allows for rows to be added to display multiple entries.



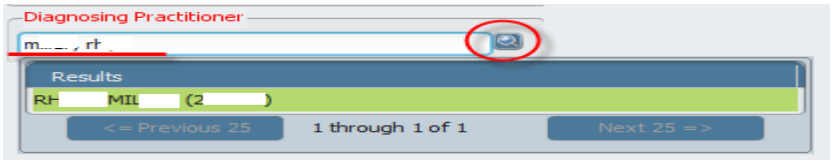
	Ranking	Description	Status	Estimated Onset	Classification	Resolved	Bill Order	ICD-9 Code	ICD-10
1	Primary (1)	Alcohol abuse, unsp...	Active (1)		Axis I (1)		1	305.00	F10.10
2			Active (1)				2		

8. **Red Required Field Name**: Field names in red font are required fields. Forms cannot be submitted or finalized without answering each required field.

9. **Hovering** over headers or displayed information can provide additional information.

10. **Dialog Box**: Error or Warning messages will pop-up/display after end user entries.

11. Process Search: Free Text field that will search system for matching data to populate in field.



CalOMS Alternative Values

The CalOMS Data Collection Guide (DCG) allows some questions to be answered with *Alternative Values*:

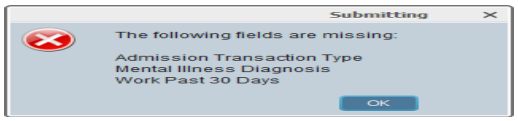
- **99900**: *Client Declined to State*
- **99901**: *Unknown or Not Sure / Don't Know*
- **99902**: *Not Applicable (None)*
- **99903**: *Other*
- **99904***: *Client Unable to Answer* (This code is only allowable if the type of service is detoxification or if the disability specified in the disability field is 'developmentally disabled')
- **00000**: *Homeless* for Zip Code Question
- **XXXXX**: *Declined to State* for Zip Code Question
- **ZZZZZ***: *Client Unable to Answer* (See comment for 99904) for Zip Code Question

CalOMS Specific Error/Warning Messages

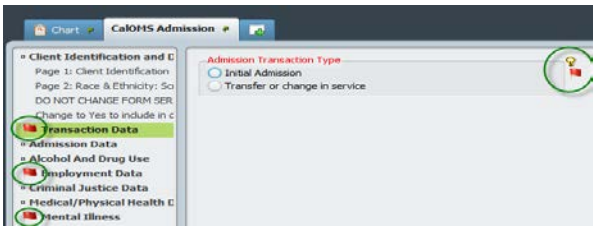
Additional samples of error/warning message dialog box pertaining to CalOMS entries.

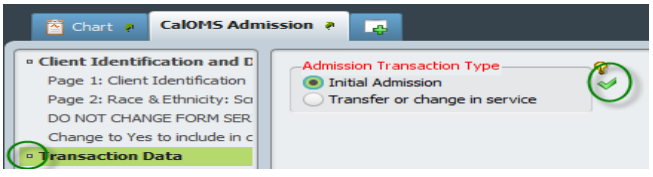
- Error Messages

- Warning Message at Submission – Missing Values

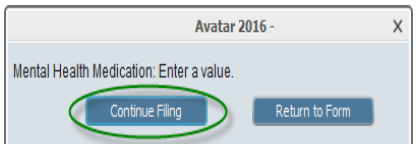


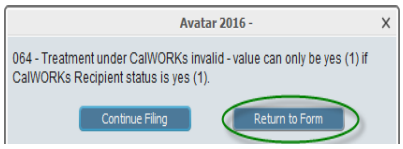
- Missing Values are Red Flagged for Correction and will clear upon entry.

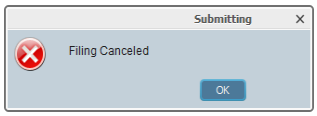




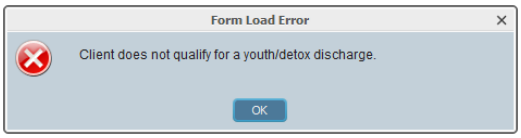
- Error Messages after submitting form – Select "*Continue Filing*" if message does not require correction. Select "*Return to Form*" if message requires a correction.







- Form loading error message



Section 2

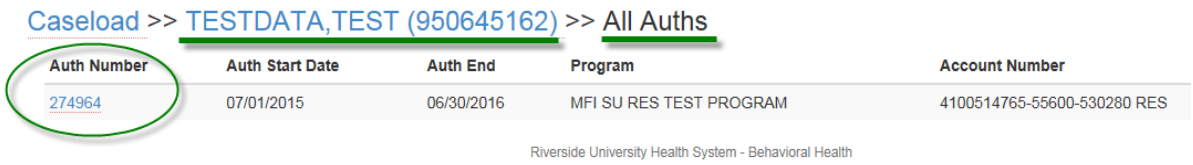
Section Two: ELMR Forms

Select the form name option to view corresponding page.

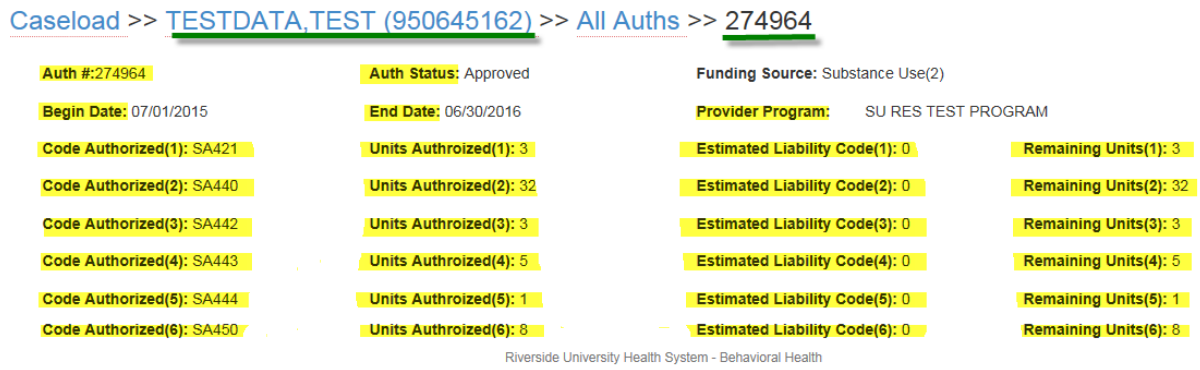
- **View Auths**: Access to view approved service authorization number, date range, program (RU) and account (dept. ID). Provider to review accuracy of service authorization prior to entering services. Any errors in displayed information MUST be reported to SU Administration for correction.
- **View Diagnosis**: '*Diagnosis Missing*' in red will display, when applicable. When a diagnosis has been entered/filed the latest submitted date will be displayed. Access to view entered diagnosis detail and ability to "Add Diagnosis".
- **Cal-OMS Admission**: '*Cal-OMS Admission Missing*' in red will display, when applicable. When the CalOMS Admission has been submitted the date of entry will display. Access to view summary of entered CalOMS admission data and ability to "Add Cal-OMS Admission".
- **Cal-OMS Annual Update**: '*Cal-OMS Update None*' in red will display, when applicable. When the CalOMS Annual Update has been submitted the date of entry will display. Access to view summary of entered CalOMS Annual Update data and ability to 'Add Cal-OMS Annual Update'
- **Cal-OMS Discharges**: Access to select one of the three available types of CalOMS Discharges, described below.
    - *Cal-OMS Standard Discharge*
    - *Cal-OMS Youth/Detox Discharge*
    - *Cal-OMS Administrative Discharge*

View Auths (Service Authorization)

All Auths for the individual consumer will be displayed in order of most current authorization. End User can access each service authorization's detailed information by selecting the blue "**Auth Number**".



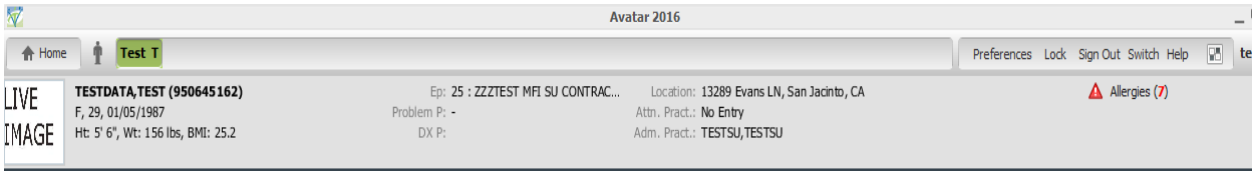
Open auth to review for appropriate date range, provider program (RU) and service code(s)/unit(s) authorized. This page will also display the remaining units per service code, based on previously entered/billed units.



View Diagnosis

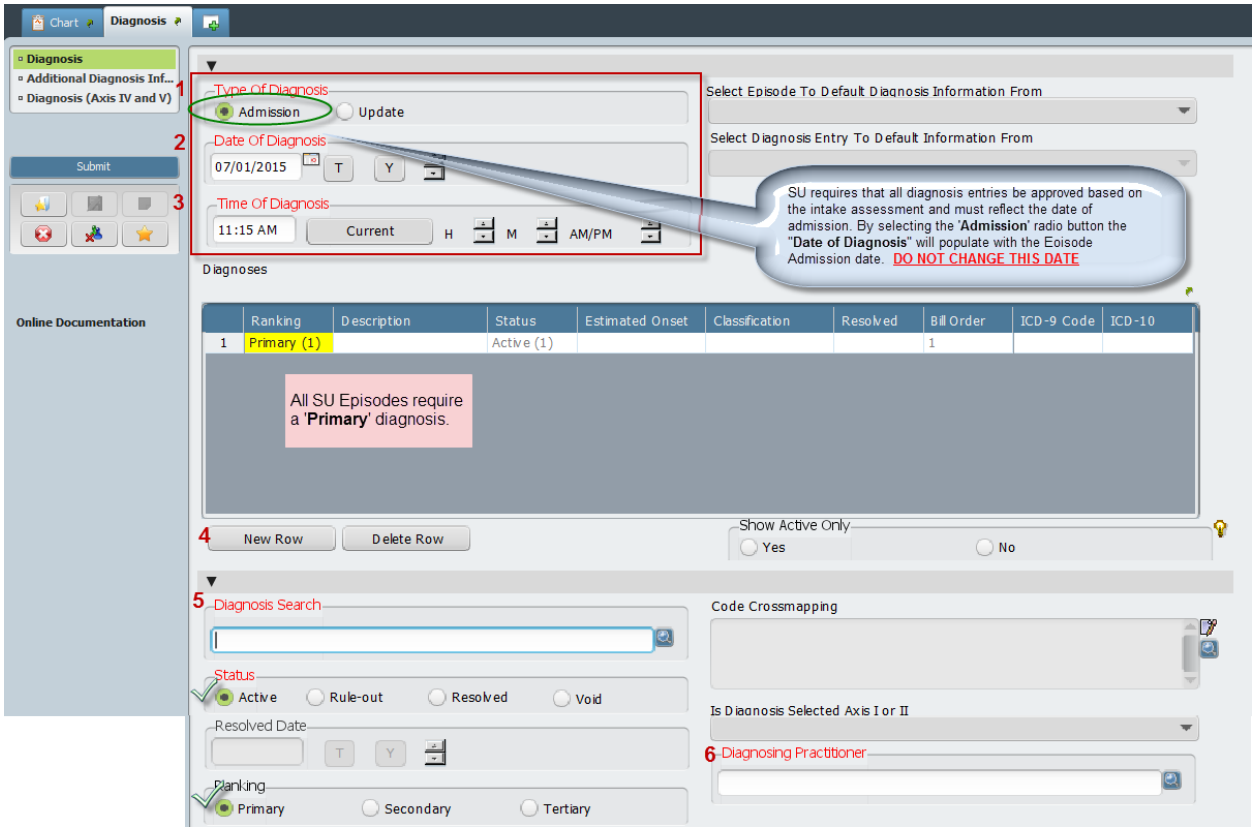
Page will display the diagnosis entered for each episode and sorted by most recent at top. End User will have access to "**Add Diagnosis**". If an error is found after the diagnosis form has been submitted, Provider is to notify SU Administration of the error so that the incorrect information can be voided. Provider will 'add' a new diagnosis to replace the incorrect/voided diagnosis. The End User is to follow the SU Diagnosis workflow and utilize the SU Diagnosis Reference Guide (see Section 5).

Once you have selected to 'add' a form entry the client toolbar will display at the top of each form page.

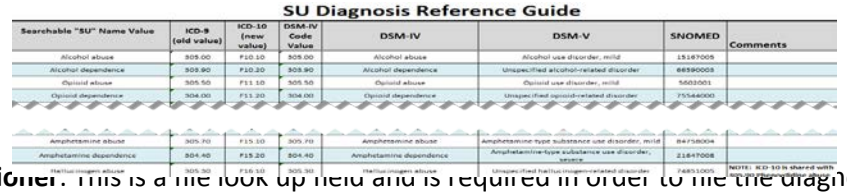


Follow the Substance Use diagnosis entry process, described below.

Diagnosis



1. **Type Of Diagnosis**: SU requires that the '***Admission***' radio button be selected in order to capture all services as of intake/admission date.
2. **Date Of Diagnosis**: Date will default the admission date of the episode when the "*Type Of Diagnosis*" is '*Admission*'. **DO NOT** change this date.
3. **Time Of Diagnosis**: Enter time as *HH:MM* space then *AM* or *PM* or end user has option to select the '*current*' command button to display current time of entry.
4. **New Row**: (Command Button) Select to add a row to the "**Diagnoses**" multiple iteration table. This step MUST be completed in order to enter/record a diagnosis for consumer.
5. **Diagnosis Search**: Utilize the ***SU Diagnosis Reference Guide*** (image shown below – see Section 5) to search for valid *SU billable diagnoses*. Example for #5: Search criteria shown below.



6. **Diagnosing Practitioner**: This is a file look up field and is required in order to file the diagnosis. Enter a diagnosis practitioner by typing last name, first name or the practitioner number assigned by the County. Highlight result and press Enter or double-click to file selection.

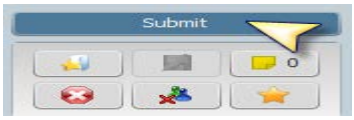
Default**: "**Status**" will default to 'Active***' **DO NOT** change

Default**: "**Ranking**" will default to 'Primary***' **DO NOT** change

Default**: "**Bill Order**" will default to '1***' **DO NOT** change

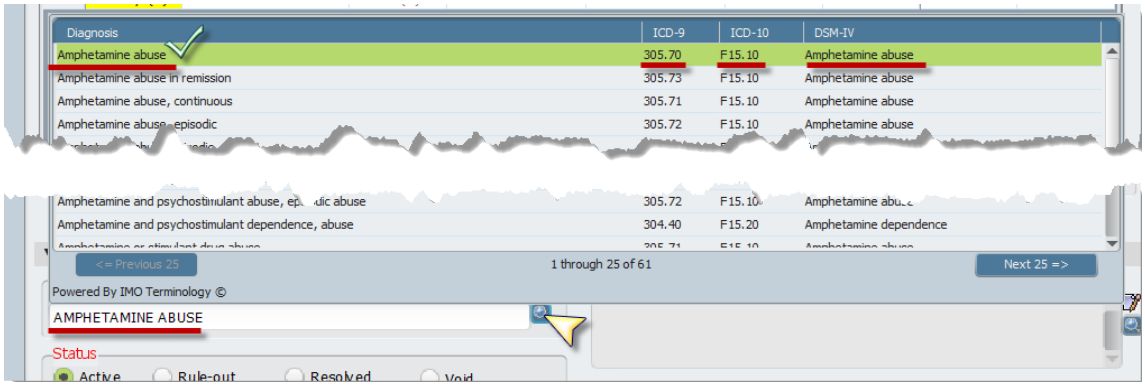
***Default**: "**Code Crossmapping**" will default with the crossmapping between ICD-9 to ICD-10 and DSM-IV to DSM-V as well as includes SNOMED code. This information MUST match the SU Diagnosis Reference Guide. If the information does not match, ensure that the "*diagnosis search*" field has the appropriate value.

When entry is complete and accurate, select the "Submit" command button.

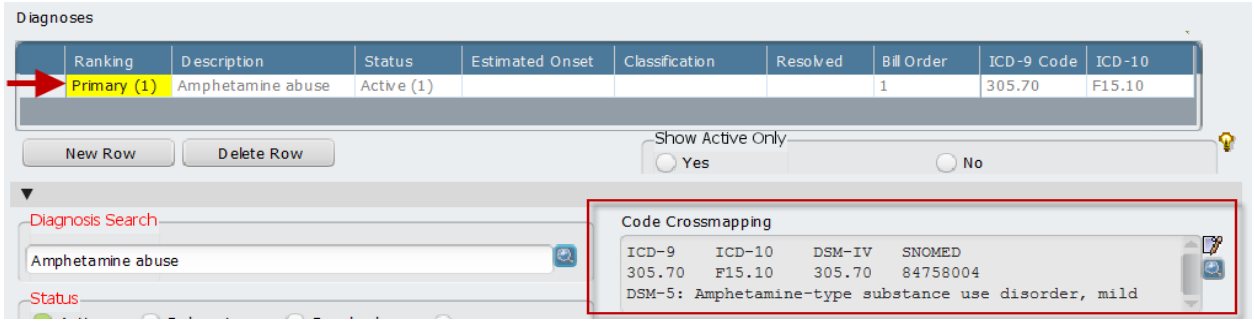


Example for #5 Above

End User has entered the name value as stated on the *SU Diagnosis Reference Guide* and selected the *process search (magnifier) command button*. System will display all associated diagnosis for that value entry. This example returned 61 options. If end user uses the full name value from the reference guide, the most appropriate value will display at the top of the list. Review the row to ensure that the diagnosis, ICD-9, ICD-10 and DSM-IV matches to the reference guide. To confirm and record entry, highlight the row press Enter or double-click. The selection will be filed in the "**Diagnoses**" multiple iteration table.



Selection filed as shown below and the "**Code Crossmapping**" data is populated.



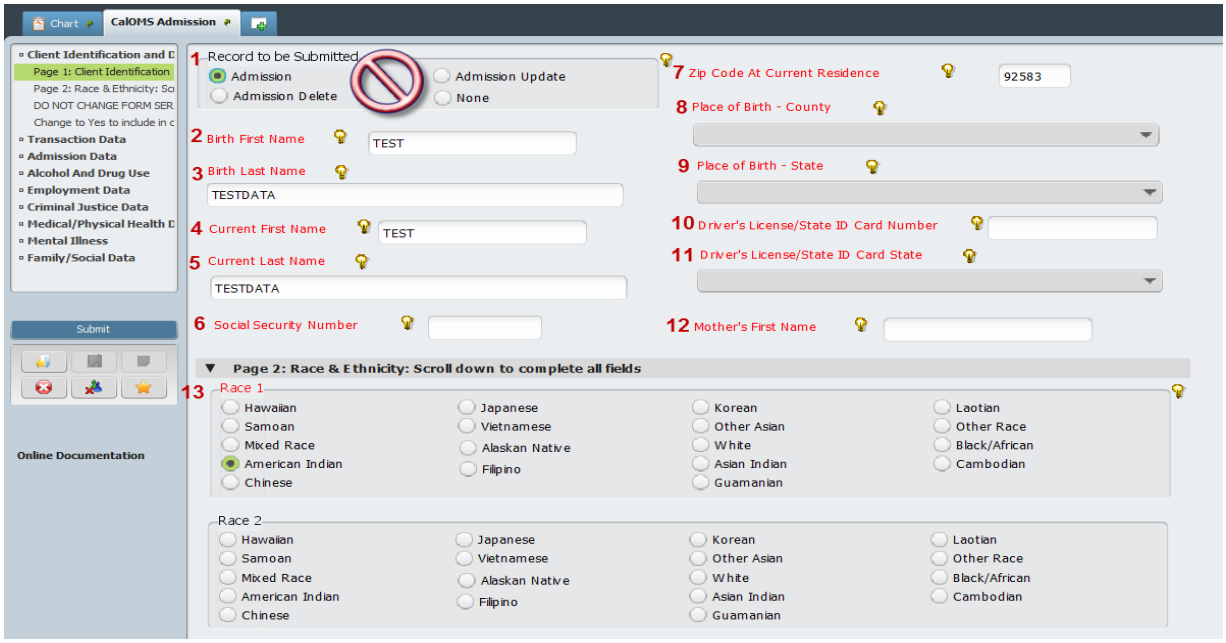
CalOMS Admission

Summary page will display the CalOMS Admission record submitted for each episode for the consumer, and sorted with the most recent at top. End User will have access to "Add Cal-OMS". Provider has access to edit CalOMS data. Provider will enter values for all required CalOMS Admission data fields.

The End User is to follow the SU CalOMS training materials and CalOMS Data Collection Guide/DCG (found in ELMR Facts page). The DCG can also be accessed from www.dhcs.ca.gov via the following link: http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

Counties are required to collect CalOMS Tx data and submit this information electronically to DHCS. Data must be collected on all service recipients, by all providers that receive funding from DHCS, regardless of the source of funds used for the service recipient. For a standard admission, all questions must be asked each participant and answered in ELMR even if the answer is '*none*'. Blank fields, incomplete entries, and invalid entries will result in rejection of the admission record.

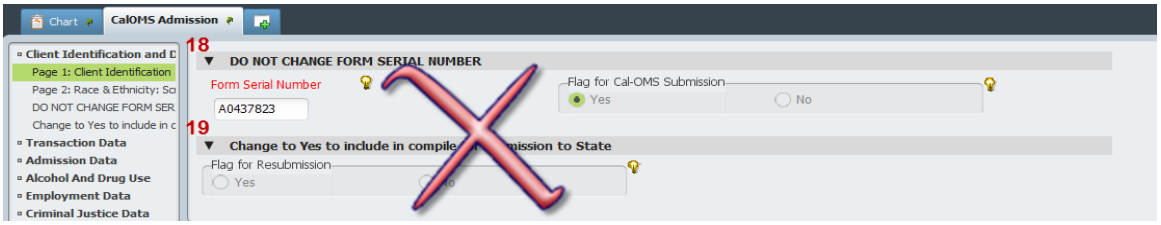
Client Identification and Demographics



1. **Record to be Submitted**: **SKIP – Do not change the prepopulated selection**.
   - **a.** *Admission* ***Default***
   - b. *Admission Update* – *Default When the admission to be edited has been submitted to the State the system will default to '*Admission Update*'.
   - c. *Admission Delete* – Contact SU Administration if you require the CalOMS Admission to be deleted.
   - d. *None* – **SKIP**

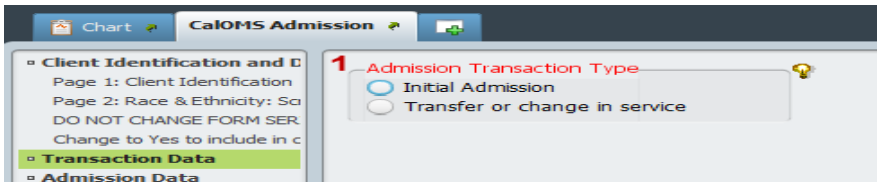
2. **Birth First Name**: (*Free Text – No Special Characters*) Defaults to current name – change if Birth Name is different.
3. **Birth Last Name**: (*Free Text – No Special Characters*) Defaults to current name – change if Birth Name is different.
4. **Current First Name**: (*Free Text – No Special Characters*) Defaults to name submitted at pre-admission form or Medi-Cal Card name.
5. **Current Last Name**: (*Free Text – No Special Characters*) Defaults to name submitted at pre-admission form or Medi-Cal Card name.
6. **Social Security Number**: (*Free Text – 9-digit number including dashes, 99900, 99902 or 99904**)
7. **Zip Code at Current Residence**: (*Free Text – 5-digit zip code, 00000, XXXXX or ZZZZZ**) This field is linked to the "*Current Living Arrangements*" question.
8. **Place of Birth – County**: (*Dropdown List – California Counties or Other (born outside of CA)*) If the consumer cannot remember or does not know, enter the county code of the county in which the individual is currently living. This field is linked to the "*Place of Birth – State*" question.
9. **Place of Birth – State**: (*Dropdown List – US States or Other (born outside of U.S.)*) If the consumer cannot remember or does not know, enter the state in which the individual is currently living. This field is linked to the "*Place of Birth – County*" question.
10. **Driver's License/State ID Card Number**: (*Free Text – alpha-numeric up to 13 characters, 99900, 99902 or 99904**) Enter numbers as displayed on card or enter '99902'. This field is linked to the "*Driver's License/State ID Card State*" question.
11. **Driver's License/State ID Card State**: (*Dropdown List – US State, Client Declined to State, None or Not Applicable, or Client Unable to Answer**) Enter State where card issued, if no card number provided select one of the alternate values. This field is linked to the "*Driver's License/State ID Card Number*" question.
12. **Mother's First Name**: (*Free Text – 20 characters*) If unknown enter '*MOTHER*'
13. **Race 1 – 5**: (*Radio Button – 18 values*) At least one race must be selected and up to 5.

14. **Ethnicity**: (*Radio Button – 5 Values*) Select One.
15. **Veteran**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) Cannot be Yes if under age 17.
16. **Consent**: (*Radio Button – Yes or No*) Since post discharge follow-up has been postponed, counties can default this field to '*no*'.
17. **Disability**: (*Multiple Selection – 7 Values, Other, Client Declined to State or Client Unable to Answer**) Select as many that apply. <u>This field is linked to allowing the use of 99904* alternate value throughout the form</u>.



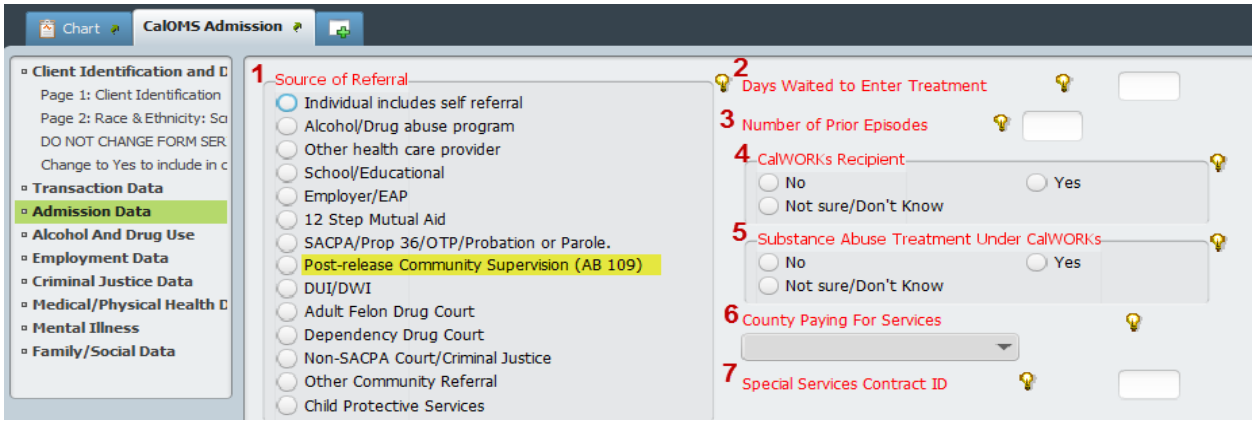
18. **<u>DO NOT CHANGE</u> FORM SERIAL NUMBER**: <u>*System generated*</u> (*Form Serial Number* and *Flag for Cal-OMS Submission)* – **SKIP**
19. **Flag for Resubmission**: <u>*System generated*</u> - **SKIP**

Transaction Data



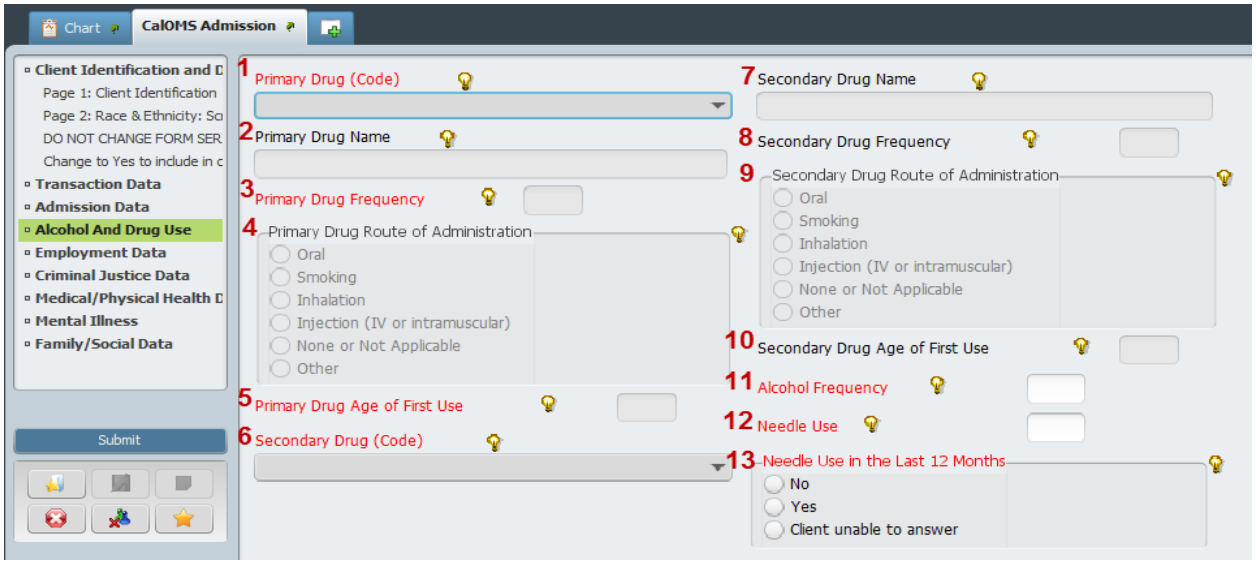
1. **Admission Transaction Type**: (*Radio Button – 2 Values*) Select One.
    a. *Initial Admission*: An initial admission is used to report the beginning of an individual's treatment episode. A treatment episode is a continuous period of planned treatment with no unplanned breaks in service exceeding 30 days.
    b. *Transfer or change in service*: This is used for reporting when an individual has already been admitted to another program or service modality and is transferring to a different program or modality (including those occurring within the same provider). Used when there has been <u>*less than 30 days*</u> since last Substance Use Treatment Episode.

Admission Data



1. **Source of Referral**: (*Radio Button – 14 values*) Select '*Post-release Community Supervision (AB109)*' for all AB109 consumers, regardless of any other source of referral. When this value is selected "***Criminal Justice Status***" will default to the appropriate AB109 status. This field is linked to the "*Criminal Justice Status*" question.
2. **Days Waited to Enter Treatment**: (*Free Text – A number from 0 to 999, 99901 or 99904**) Pertains to days waited due to unavailability of slots in a particular program or modality.
3. **Number of Prior Episodes**: (*Free Text – A number from 0 to 99, 99900, 99901 or 99904**)
4. **CalWORKs Recipient**: (*Radio Button – Yes, No or Not sure/Don't Know*) This field is linked to the "*Substance Abuse Treatment Under CalWORKs*" question.
5. **Substance Abuse Treatment Under CalWORKs**: (*Radio Button – Yes, No or Not sure/Don't Know*) If "***CalWORKs Recipient***" is '*No*', then the value here MUST be '*No*'. This field is linked to the "*CalWORKs Recipient*" question.
6. **County Paying for Services**: (*Dropdown List – CA Counties or 'None or Not Applicable'*) Agencies located outside of Riverside County select '*Riverside*' – all others select '*None or Not Applicable*'
7. **Special Services Contract ID**: (*Free Text – four-digit number or 99902*) Agencies located outside of Riverside County enter *4-digit code* (number is issued by DHCS ranging from 0000-9999) – all others enter '*99902*'

Alcohol and Drug Use



1. **Primary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) The substance that has been determined to cause the greatest dysfunction to the consumer. Cannot be None. This field is linked to #2, #3, #4 and #5 below. *Drug of choice should also correspond with diagnosis*.
2. **Primary Drug (Other)**: (*Free Text – Up to 50 Characters*) Field will open if a name is required, based on "*Primary Drug (Code)*" selected. Otherwise, skip.
3. **Primary Drug Frequency**: (*Free Text – A number 0 to 30*) Number of days used in last 30 days.
4. **Primary Drug Route of Administration**: (*Radio Button – 4 Values, 'None or Not Applicable' or Other*) Some "*Primary Drug (Code)*" selections will default the route. Answer when applicable.

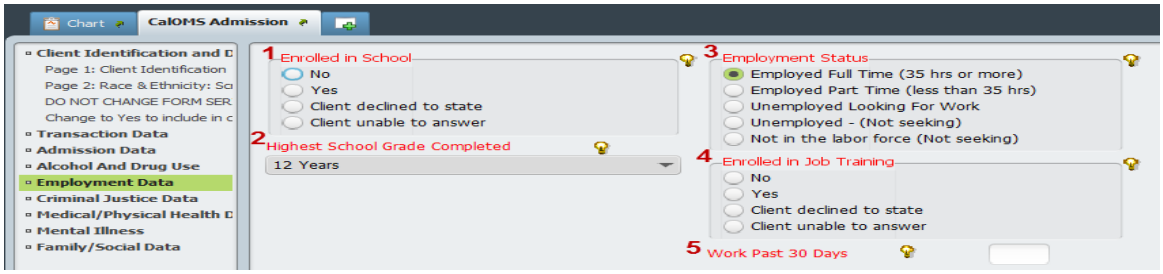
5. **Primary Drug Age of First Use**: (*Free Text – An age 5 to 105 or 99904**) Linked to DOB.
6. **Secondary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) Can be None. This field is linked to #7, #8, #9 and #10.
7. **Secondary Drug Name**: (*Free Text – Up to 50 Characters*) Field will open if a name is required, based on "*Secondary Drug (Code)*" selected. Otherwise, skip.
8. **Secondary Drug Frequency**: (*Free Text – A number 0 to 30*) Number of days used in last 30 days.
9. **Secondary Drug Route of Administration**: (*Radio Button – 4 Values, 'None or Not Applicable' or Other*) Some "*Secondary Drug (Code)*" selections will default the route. Answer when applicable.
10. **Secondary Drug Age of First Use**: (*Free Text – An age 5 to 105 or 99904**) Linked to DOB.
11. **Alcohol Frequency**: (*Free Text – A number 0 to 30 or 99902*) Defaults to '*99902*' if either "*Primary Drug (Code)*" or "*Secondary Drug (Code)*" is '*Alcohol*'. This field is linked to the "*Primary and Secondary Drug (Code)*" questions. Example shown below.
12. **Needle Use**: (*Free Text – A number 0 to 30, 99900 or 99904**) How often the consumer used needles to inject drugs in the past 30 days.
13. **Needle Use in the Last 12 Months**: (*Radio Button – Yes, No or Client Unable to Answer**) Will default to '*Yes*' if "*drug route of administration*" is '*Injection*' and "*Frequency*" is greater than '*zero*'. This field is linked to #3, #4, #8 and #9 above.

Example for #11 Above:

When Alcohol is selected as Primary or Secondary, Alcohol Frequency will default to 99902 and will not allow end user to change value.

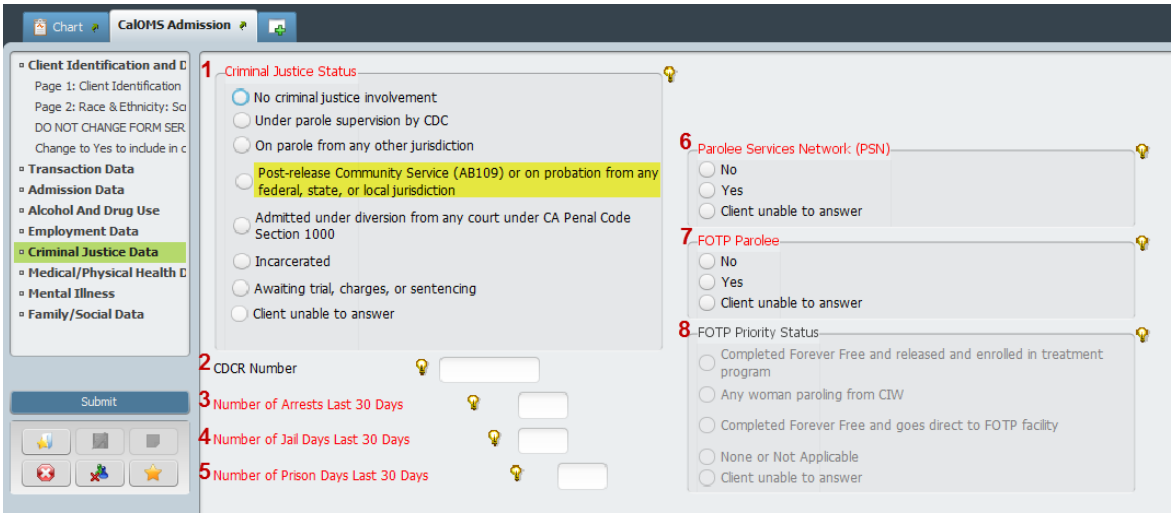
When Alcohol is not selected as Primary or Secondary, Alcohol Frequency is active for end user entry.

Employment Data



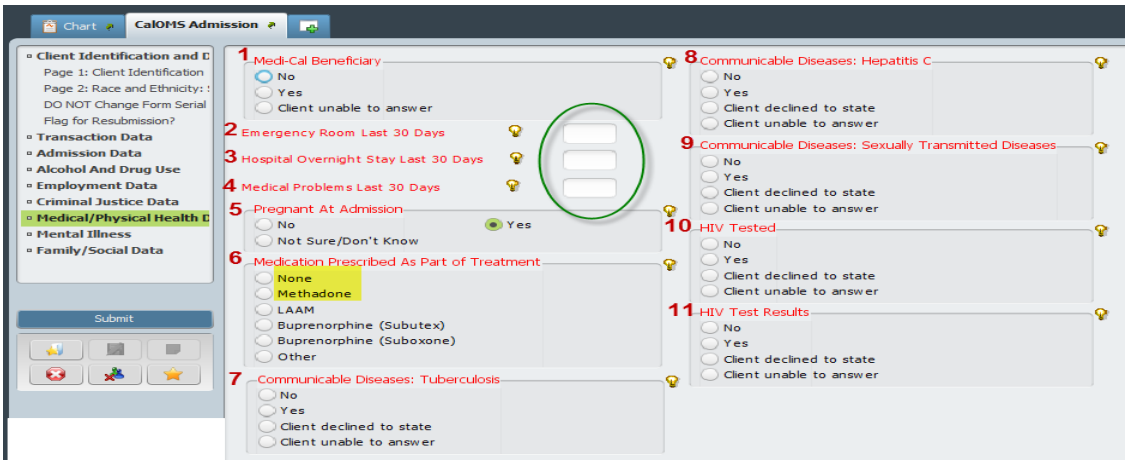
1. **Enrolled in School**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) Select One
2. **Highest School Grade Completed**: (*Dropdown List – A number from 0 to 30, Client Declined to State or Client Unable to Answer**) Values in order by first digit.
3. **Employment Status**: (*Radio Button – 5 Values*) Select One
4. **Enrolled in Job Training**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) Select One
5. **Work Past 30 Days**: (*Free Text – A number from 0 to 30, 99900 or 99904**) Paid days worked.

Criminal Justice Data



1. **Criminal Justice Status**: (*Radio Button – 7 Values or 99904**) If "*Source of Referral*" value '*Post-release Community Supervision (AB109)*' is selected, then this field will default to '*Post-release Community Service (AB109) or on probation from any federal, state, or local jurisdiction*' and will not allow end user to change value. <u>This field is linked to "*Source of Referral*" question</u>.
2. **CDCR Number**: (*Free Text – Alpha-Numeric, 99900, 99901, 99902 or 99904**) Cannot be blank if client is an adult. <u>This field is linked to the "*Criminal Justice Status*" question</u>.
3. **Number of Arrests Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)
4. **Number of Jail Days Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)
5. **Number of Prison Days Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)
6. **Parolee Services Network (PSN)**: (*Radio Button – Yes, No or Client Unable to Answer**) PSN is no longer active – Select '*No*'.
7. **FOTP Parolee**: (*Radio Button – Yes, No or Client Unable to Answer**) Must be a FOTP Program.
8. **FOTP Priority Status**: (Radio Button – 3 Values, 'None or Not Applicable' or Client Unable to Answer*) <u>This field is linked to the "FOTP Parolee" question</u>.

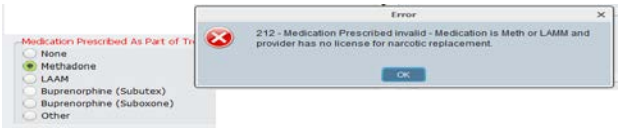
Medical / Physical Health Data



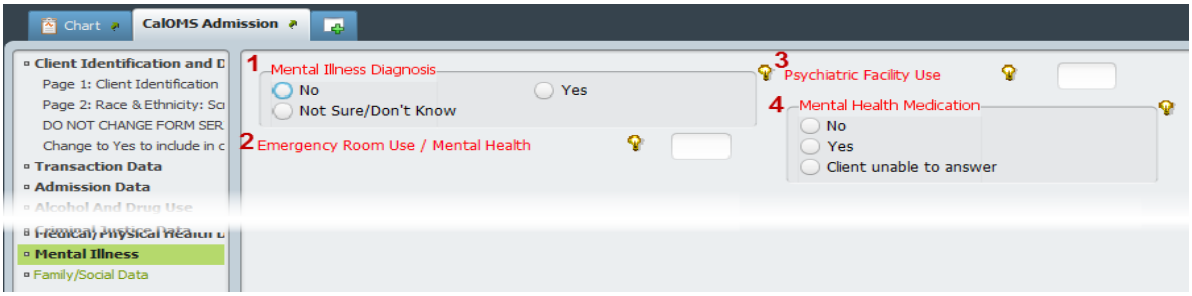
1. **Medi-Cal Beneficiary**: (*Radio Button – Yes, No or Client Unable to Answer**) Select One
2. **Emergency Room Last 30 Days**: (*Free Text – A number from 0 to 99 or 99904**) This field is linked to the "*Medical Problems Last 30 Days*" question.
3. **Hospital Overnight Stay Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**) This field is linked to the "*Medical Problems Last 30 Days*" question.
4. **Medical Problems Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**) This field is linked to the "*Emergency Room Last 30 Days*" and "*Hospital Overnight Stay Last 30 Days*" questions. Must match or exceed the previous 2 questions (#2 or #3 Above) – Example: error message shown below.
5. **Pregnant At Admission**: (*Radio Button – Yes, No or Not Sure/Don't Know*) Defaults to '*No*' for male consumers.
6. **Medication Prescribed As Part of Treatment**: (*Radio Button – 4 Values, None or Other*) NTP Providers select '*Methadone*' – all others select '*None*'. Example: error message shown below.
7. **Communicable Diseases – Tuberculosis**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) Select One
8. **Communicable Diseases – Hepatitis C**: (Radio Button – Yes, No, Client Declined to State or Client Unable to Answer*) Select One
9. **Communicable Diseases – Sexually Transmitted Diseases**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) Select One
10. **HIV Tested**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) Select One
11. **HIV Test Results**: (Radio Button – Yes, No, Client Declined to State or Client Unable to Answer*) This field is linked to "*HIV Tested*" question.

Example for #4 Above:

Example for #6 Above:

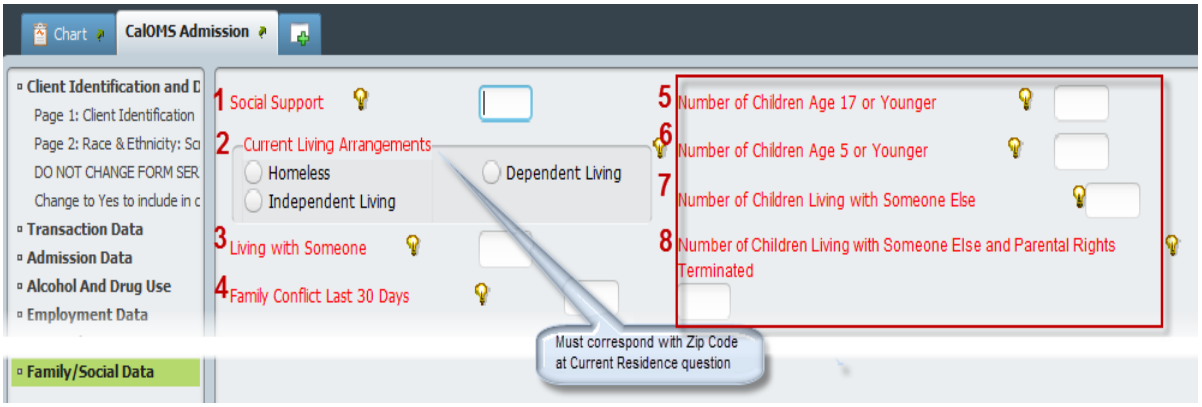


Mental Illness

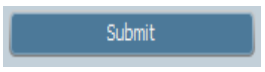


1. **Mental Illness Diagnosis**: (*Radio Button – Yes, No or Not Sure/Don't Know*) Select One
2. **Emergency Room Use / Mental Health**: (*Free Text – A number from 0 to 99 or 99904**)
3. **Psychiatric Facility Use**: (*Free Text – A number from 0 to 30 or 99904**)
4. **Mental Health Medication**: (*Radio Button – Yes, No or Client Unable to Answer**) Prescribed Medication

Family / Social Data



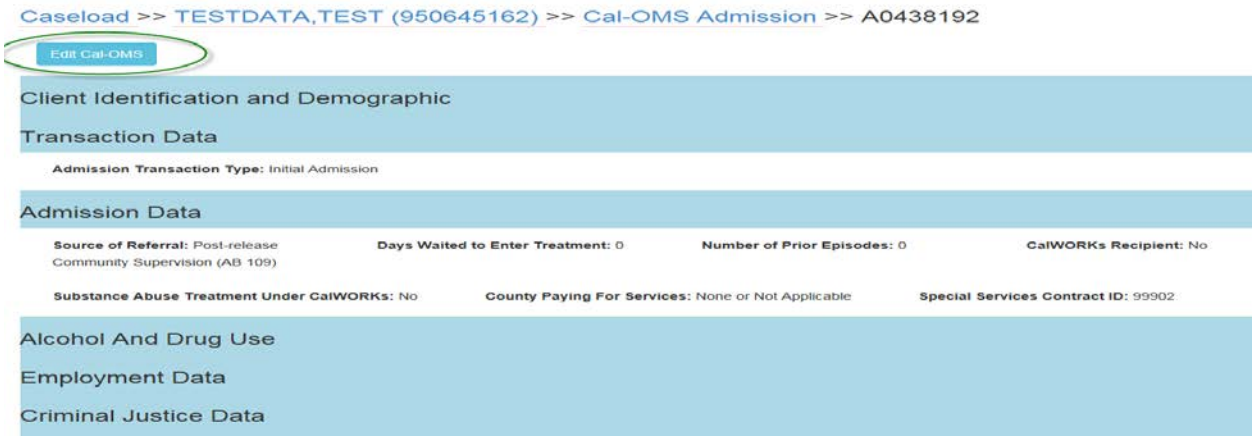
1. **Social Support**: (*Free Text – A number from 0 to 30*) Ex: 12-step meetings; Other self help meetings; Religious/Faith recovery or self-help meetings; Meetings of organizations other then those listed above; Interactions with family members and/or friend support of recovery.
2. **Current Living Arrangements**: (*Radio Button – 3 Values*) *Homeless* – consumers with no permanent residence. *Dependent Living* – Consumers living in a supervised setting or children (under age 18) living parent/family member/guardian. *Independent Living* – Individuals who contribute to their living arrangements. This field is linked to "*Zip Code at Current Residence*" question.
3. **Living with Someone**: (*Free Text – A number from 0 to 30, 99900 or 99904**) Someone who uses alcohol or other drugs.
4. **Family Conflict Last 30 Days**: (*Free Text – A number from 0 to 30, 99900 or 99904**)
5. **Number of Children Age 17 or Younger**: (*Free Text – A number from 0 to 30 or 99904**) Whether they live with the consumer or not. This field is linked to #6, #7 and #8 below and will default them to '*zero*' if this field has a value of '*0*'.
6. **Number of Children Age 5 or Younger**: (*Free Text – A number from 0 to 30 or 99904**) Of those 17 or younger, how many are 5 or younger. This field is linked to "*Number of Children Age 17 or Younger*" question.
7. **Number of Children Living with Someone Else**: (*Free Text – A number from 0 to 30 or 99904**) Due to a child protection court order. This field is linked to "*Number of Children Age 17 or Younger*" question.
8. **Number of Children Living with Someone Else and Parental Rights Terminated**: (*Free Text – A number from 0 to 30 or 99904**) Of those living with someone else, how many have the parental rights been terminated. This field is linked to "*Number of Children Age 17 or Younger*" and "*Number of Children Living with Someone Else*" question.

Submit CalOMS Admission when all fields have been completed. 

Once the CalOMS Admission form has been successfully submitted the consumer chart view home page will display the recorded CalOMS Admission date of submission.

TheCalOMS Admission page will display the recorded information as shown in the example below.

Selecting the blue "**Serial Number**" will display the detailed data for that CalOMS Admission. Select each section header to display the recorded data. End user also has option to edit data for resubmission.



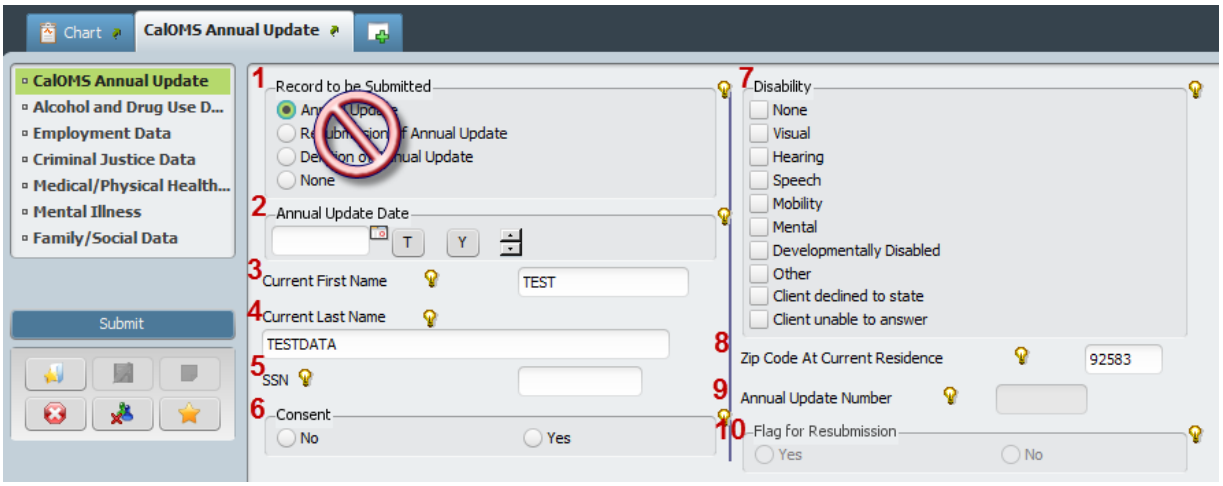
CalOMS Annual Update

When a consumer has reached their 10th month of treatment and is expected to remain in treatment for 12 months or more, a CalOMS Annual Update is required for each year the consumer remains in treatment. Annual Update can be created up to 60 days prior to the admission anniversary date.

If the consumer's episode has not yet had the Cal-OMS Admission filed or is not yet due for an annual update the end user will receive a 'Form Load Error' message.

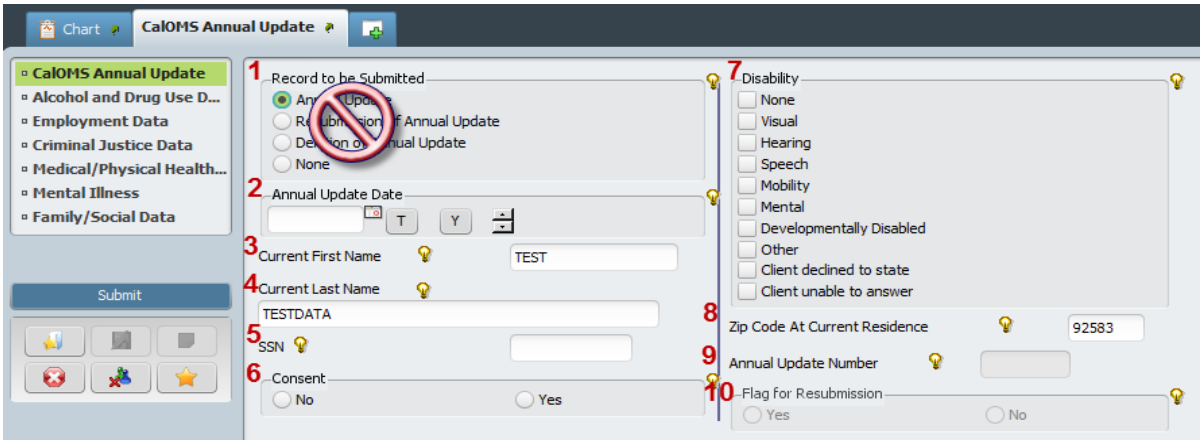
Annual update date is the date on which the consumer was interviewed to collect the annual update data.

CalOMS Annual Update



1. **Record to be Submitted**: **SKIP – Do not change the prepopulated selection**.
    a. *Annual Update* **Default*
    b. *Resubmission of Annual Update* – *Default When the annual update to be edited has been submitted to the State the system will default to '*Resubmission of Annual Update*'.
    c. *Deletion of Annual Update* – Contact SU Admission if you require the CalOMS Annual Update to be deleted.
    d. *None* - **SKIP**
2. **Annual Update Date**: (*Free Text – Date format MM/DD/YYYY*)
3. **Current First Name**: (*Free Text – No Special Characters*) Pulls from admission.
4. **Current Last Name**: (*Free Text – No Special Characters*) Pulls from admission.
5. **SSN**: (*Free Text – 9-digit number including dashes, 99900, 99902 or 99904**) Pulls from admission.
6. **Consent**: (*Radio Button – Yes or No*) Since post discharge follow-up has been postponed, counties can default this field to 'no'.
7. **Disability**: (*Multiple Selection – 7 Values, Other, Client Declined to State or Client Unable to Answer**) Select as many that apply. <u>This field is linked to allowing the use of 99904* alternate value throughout the form</u>.
8. **Zip Code at Current Residence**: (*Free Text – 5-digit zip code, 00000, XXXXX or ZZZZZ**) Pulls from admission. Change if needed. <u>This field is linked to the "*Current Living Arrangements*" question</u>.
9. **Annual Update Number**: <u>*System generated*</u> based on "*Record to be Submitted*". - **SKIP**
10. **Flag for Resubmission**: <u>*System generated*</u> - **SKIP**

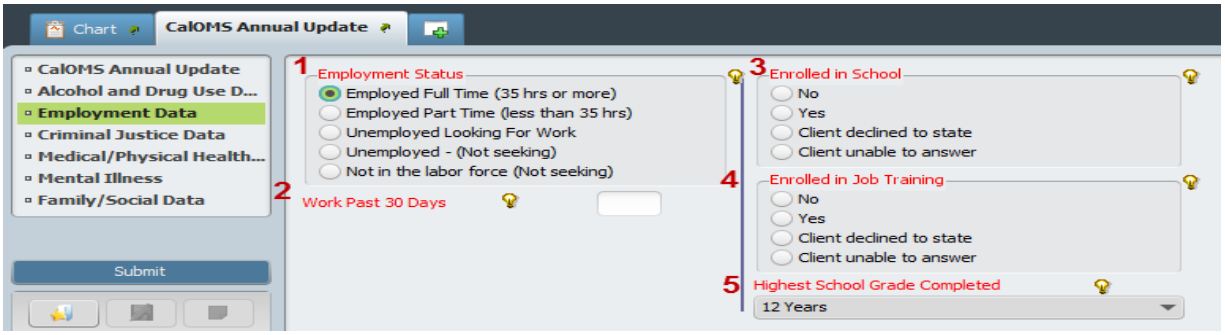
Alcohol and Drug Use Data



1. **Primary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) <u>MUST</u> match the "Primary Drug (Code)" reported at admission. <u>This field is linked to #2, #3 and #4 below</u>.
2. **Primary Drug (Other)**: (*Free Text – Up to 50 Characters)* Field will open if a name is required, based on "Primary Drug (Code)" selected. Otherwise, skip.
3. **Primary Drug Frequency**: (*Free Text – A number 0 to 30*) Number of days used in last 30 days.
4. **Primary Drug Route of Administration**: (*Radio Button – 4 Values, 'None or Not Applicable' or Other*) Some "*Primary Drug (Code)*" selections will default the route. Answer when applicable.

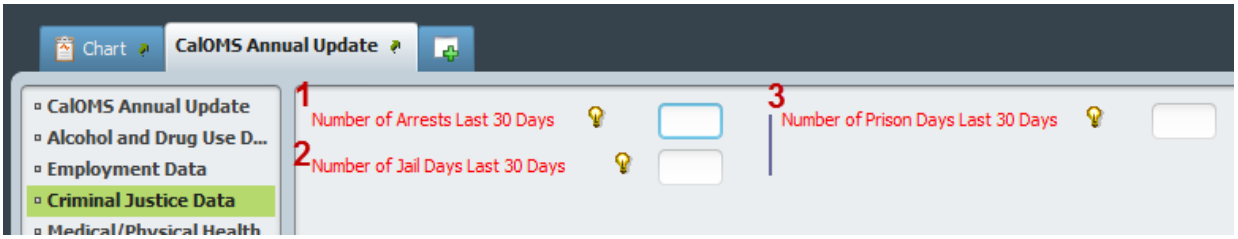
5. **Secondary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) MUST match the "*Secondary Drug (Code)*" reported at admission. This field is linked to #6, #7 and #8.
6. **Secondary Drug Name**: (*Free Text – Up to 50 Characters*) Field will open if a name is required, based on "*Secondary Drug (Code)*" selected. Otherwise, skip.
7. **Secondary Drug Frequency**: (*Free Text – A Number 0 to 30*) Number of days used in last 30 days.
8. **Secondary Drug Route of Administration**: (*Radio Button – 4 Values, 'None or Not Applicable' or Other*) Some "*Secondary Drug (Code)*" selections will default the route. Answer when applicable.
9. **Alcohol Frequency**: (*Free Text – A number 0 to 30, or 99902*) Defaults to '99902' if either "*Primary Drug (Code)*" or "*Secondary Drug (Code)*" is 'Alcohol'. This field is linked to the "*Primary and Secondary Drug (Code)*" questions.
10. **Needle Use**: (*Free Text – A number 0 to 30, 99900 or 99904**) How often the consumer used needles to inject drugs in past 30 days.

Employment Data



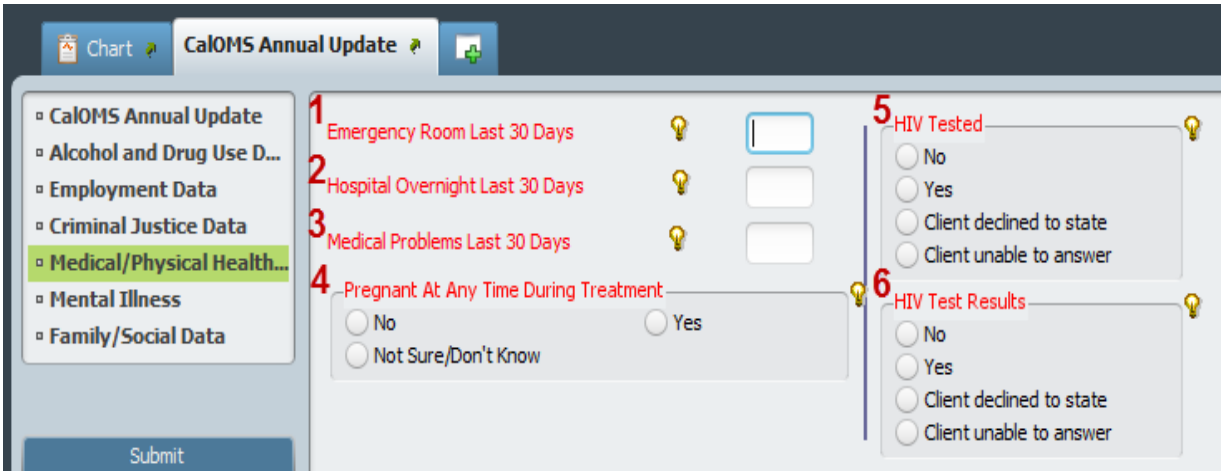
1. **Employment Status**: (*Radio Button – 5 Values*) Select One
2. **Work Past 30 Days**: (*Free Text – A number from 0 to 30, 99900 or 99904**) Paid days worked.
3. **Enrolled in School**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**)
4. **Enrolled in Job Training**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) Select One.
5. **Highest School Grade Completed**: (*Dropdown List – A number from 0 to 30, Client Declined to State or Client Unable to Answer**) Values pulls over from admission – review and change if consumer gives a different answer.

Criminal Justice Data



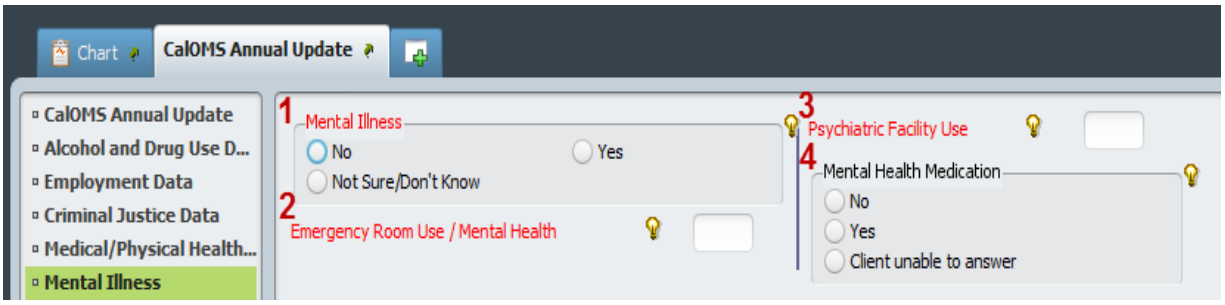
1. **Number of Arrests Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)
2. **Number of Jail Days Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)
3. **Number of Prison Days Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)

Medical /Physical Health Data



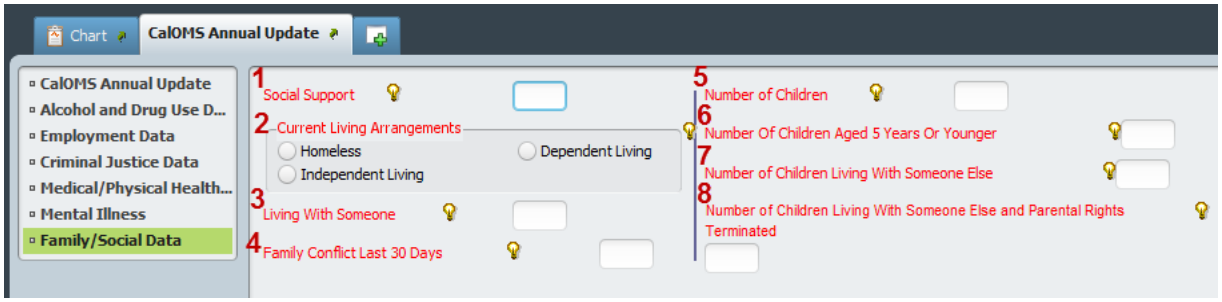
1. **Emergency Room Last 30 Days**: (*Free Text – A number from 0 to 99 or 99904**) This field is linked to the "*Medical Problems Last 30 Days*" question.
2. **Hospital Overnight Stay Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**) This field is linked to the "*Medical Problems Last 30 Days*" question.
3. **Medical Problems Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**) This field is linked to the "*Emergency Room Last 30 Days*" and "*Hospital Overnight Stay Last 30 Days*" questions. Must match or exceed the previous 2 questions (#1 or #2 Above) – (*See page 18 'Example for #4 Above'*).
4. **Pregnant At Any Time During Treatment**: (*Radio Button – Yes, No or Not Sure/Don't Know*) Defaults to '*No*' for male consumers.
5. **HIV Tested**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**)
6. **HIV Test Results**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) This field is linked to the "*HIV Tested*" question.

Mental Illness

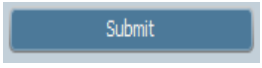


1. **Mental Illness Diagnosis**: (*Radio Button – Yes, No or Not Sure/Don't Know*)
2. **Emergency Room Use / Mental Health**: (*Free Text – A number from 0 to 99 or 99904**)
3. **Psychiatric Facility Use**: (*Free Text – A number from 0 to 30 or 99904**)
4. **Mental Health Medication**: (*Radio Button – Yes, No or Client Unable to Answer**) Prescribed Medication

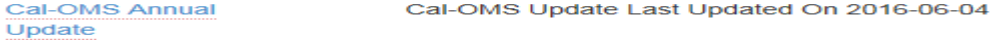
Family / Social Data



1. **Social Support**: (*Free Text – A number from 0 to 30*) Ex: 12-step meetings; Other self help meetings; Religious/Faith recovery or self-help meetings; Meetings of organizations other then those listed above; Interactions with family members and/or friend support of recovery.
2. **Current Living Arrangements**: (*Radio Button – 3 Values*) *Homeless* – consumers with no permanent residence. *Dependent Living* – Consumers living in a supervised setting or children (under age 18) living parent/family member/guardian. *Independent Living* – Individuals who contribute to their living arrangements. This field is linked to "*Zip Code at Current Residence*" question.
3. **Living with Someone**: (*Free Text – A number from 0 to 30, 99900 or 99904**) Someone who uses alcohol or other drugs.
4. **Family Conflict Last 30 Days**: (*Free Text – A number from 0 to 30, 99900 or 99904**)
5. **Number of Children Age 17 or Younger**: (*Free Text – A number from 0 to 30 or 99904**) Whether they live with the consumer or not. This field is linked to #6, #7 and #8 below and will default them to '*zero*' if this field has a value of '*0*'.
6. **Number of Children Age 5 or Younger**: (*Free Text – A number from 0 to 30 or 99904**) Of those 17 or younger, how many are 5 or younger. This field is linked to "*Number of Children Age 17 or Younger*" question.
7. **Number of Children Living with Someone Else**: (*Free Text – A number from 0 to 30 or 99904**) Due to a child protection court order. This field is linked to "*Number of Children Age 17 or Younger*" question.
8. **Number of Children Living with Someone Else and Parental Rights Terminated**: (*Free Text – A number from 0 to 30 or 99904**) Of those living with someone else, how many have the parental rights been terminated. This field is linked to "*Number of Children Age 17 or Younger*" and "*Number of Children Living with Someone Else*" question.

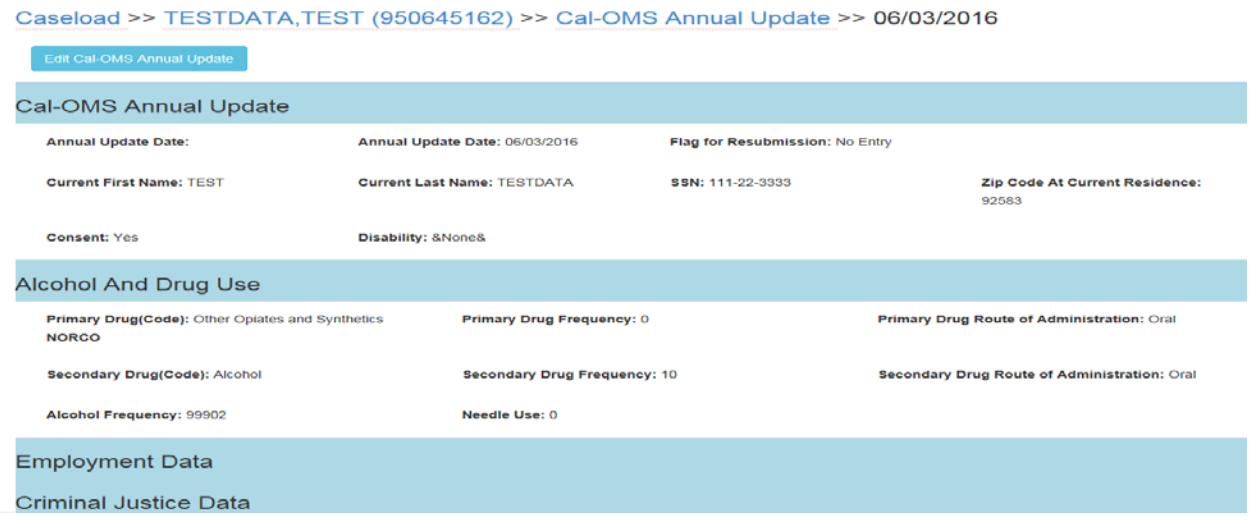
Submit CalOMS Annual Update when all fields have been completed. 

Once the CalOMS Annual Update has been successfully submitted the consumer chart view home page will display the recorded CalOMS Annual Update date of submission.



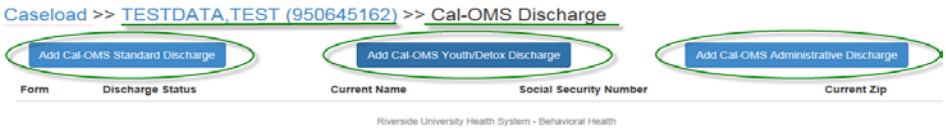
The CalOMS Annual Update page will display the recorded information as shown in the example below.

Selecting the blue "**Annual Update Date**" will display the detailed data for that CalOMS Annual Update. Select each section header to display the recorded data. End user also has access to edit data for resubmission.



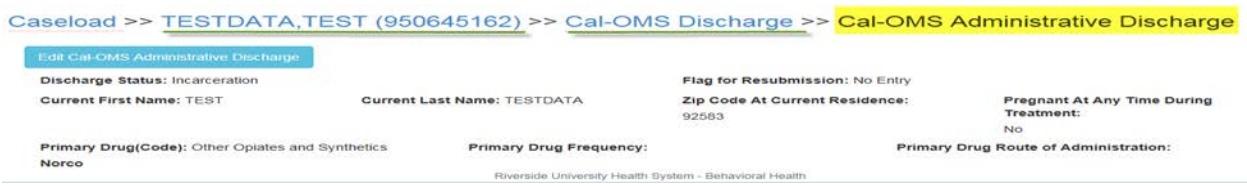
CalOMS Discharge

Date of discharge is the **date of the last face-to-face** contact the provider had with the consumer. (ADP Bulletin 11-10 Issued 08-16-11 (see Section 5) are procedures for collection of discharge data. Bulletin provides protocols for reporting standard and administrative discharges.) (ADP Bulletin 10-08 Issued 06-29-10 (see Section 5) provides criteria for using CalOMS Tx completion discharge statuses.) Review the two charts in Section 5 (Determining CalOMS Discharge Codes. Non-Detox Programs & Determining CalOMS Discharge Codes. Detox Program) to determine the correct discharge status and type.



The CalOMS Discharge page will display the recorded information as shown in the example below.

Selecting the blue "Form" name will display the detailed data for the type of discharge form submitted. Select each section header to display the recorded data.



Discharge information must be collected for all service recipients regardless of the discharge status. There are several types of discharges to report in CalOMS Tx.

The following protocols clarify business rules for discharging clients from treatment in CalOMS Tx (DCG):

1. A CalOMS Tx discharge record must be submitted for every client for whom a CalOMS Tx admission record has been submitted.

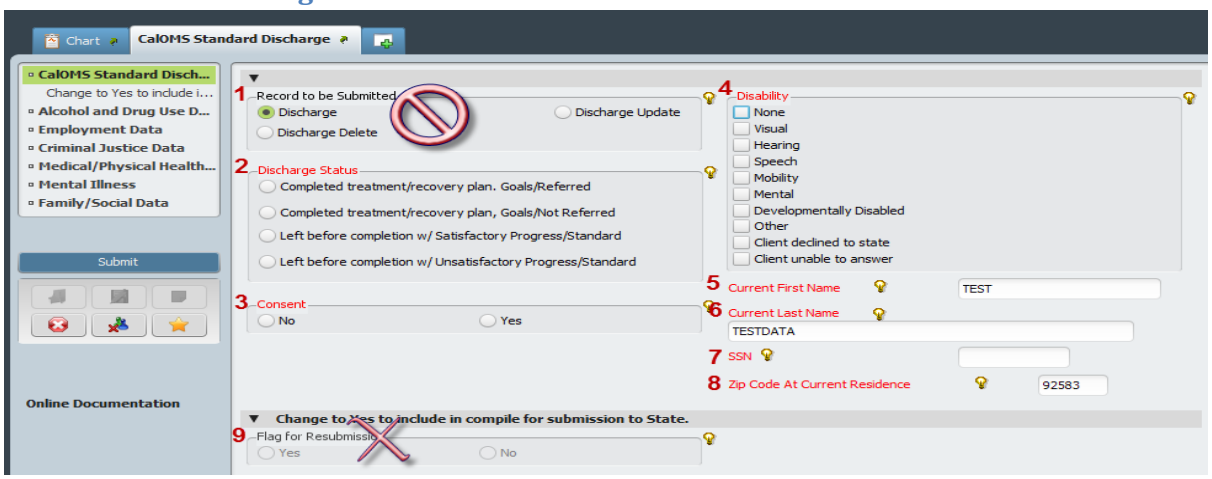
2. SU treatment providers must schedule and conduct a discharge interview with every client. A discharge interview is either in person (face-to-face) or via telephone. This interview includes, but is not limited to, asking each of the required CalOMS Tx standard discharge questions and documenting the responses. This date may be scheduled for some time prior to or on the client's planned last date of service, but may not be more than two weeks prior to the client's planned date of last service. – Reminder to use the last face-to-face as the date for the system/episode discharge date.

3. Providers should make every effort to ensure the discharge interview is a face-to-face interview. However, some clients may be unable to appear for the scheduled discharge interview, despite having made satisfactory progress in treatment. In these situations, providers are strongly encouraged to contact the client by phone to collect the CalOMS Tx standard discharge data.

4. Administrative discharges should only be reported in the event the client cannot be located, either in person or by telephone, to answer the CalOMS Tx questions. Such attempts to contact a client for a CalOMS Tx discharge interview must be documented in the client's file. Providers should never guess or complete responses on behalf of an absent client for the required CalOMS Tx discharge questions.

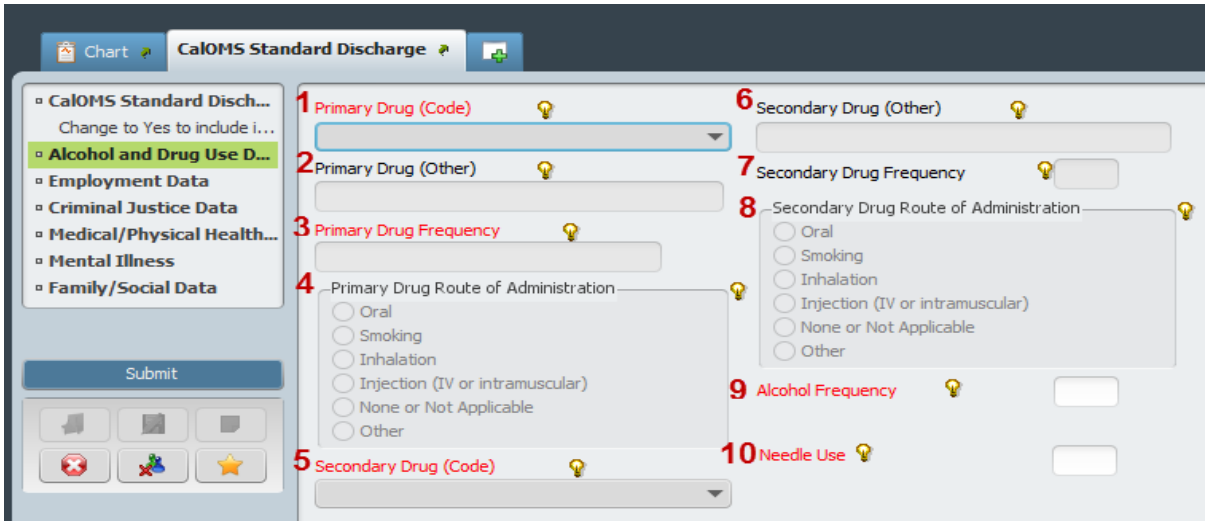
5. Detoxification does not constitute complete treatment. A successful detoxification service is measured in part by the engagement of the client in further treatment (e.g. residential or outpatient services). Providers are expected to make every effort to refer and connect clients to another level of treatment once they have completed detoxification. For clients who have gone through detoxification, as planned by the provider, and who are being referred for additional treatment services, providers must use discharge code 3 – Left Before Completion with Satisfactory Progress – Referred. Neither discharge code 1 nor discharge code 2 can be used for detoxification discharges.

CalOMS Standard Discharge



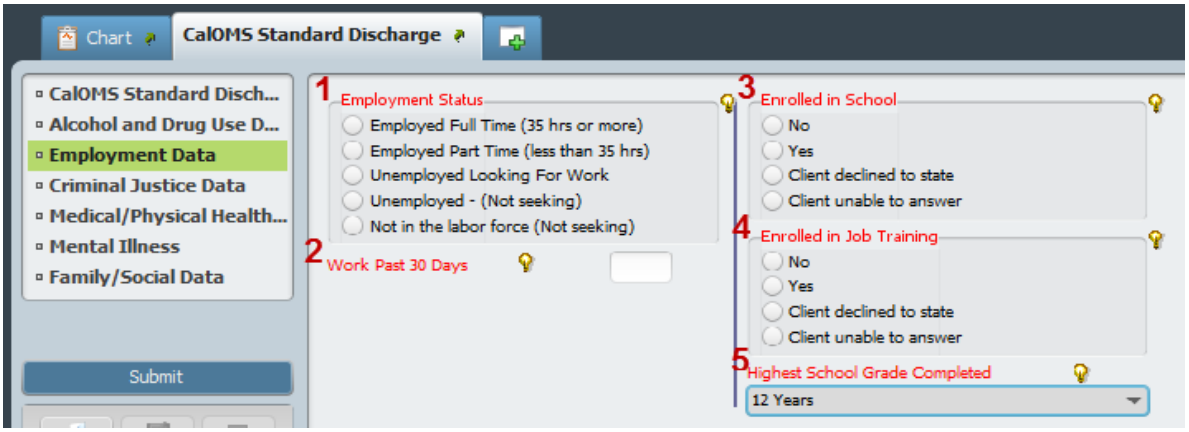
1. **Record to be Submitted**: **SKIP – Do not change the prepopulated selection**.
    a. *Discharge* ***Default***
    b. *Discharge Update* – *Default When the discharge to be edited has been submitted to the State the system will default to '*Discharge Update*'.
    c. *Discharge Delete* – Contact SU Administration if you require the CalOMS Discharge to be deleted.
2. **Discharge Status**: (*Radio Button – 4 Values*) Only the standard discharge reason will display. (*Review the DCG and Bulletins*)
    a. *Completed Treatment/Recovery Plan Goals – Referred*: (Status 1) Cannot be used for Detox discharge (see #5 above).
    b. *Completed Treatment/Recovery Plan Goals – Not Referred*: (Status 2) Cannot be used for Detox discharge (see #5 above).
    c. *Left Before Completion with Satisfactory Progress – Referred*: (Status 3)
    d. *Left Before Completion with Unsatisfactory Progress – Referred*: (Status 5)
3. **Consent**: (*Radio Button – 5 Values*) Since post discharge follow-up has been postponed, counties can default this field to '*no*'.
4. **Disability**: (*Multiple Selection – 7 Values, Other, Client Declined to State or Client Unable to Answer**) Select as many that apply. This field is linked to allowing the use of 99904* alternate valued throughout the form.
5. **Current First Name**: (*Free Text – No Special Characters*) Pulls from admission.
6. **Current Last Name**: (*Free Text – No Special Characters*) Pulls from admission.
7. **SSN**: (*Free Text – 9-digit number including dashes, 99900, 99902 or 99904**) Pulls from admission.
8. **Zip Code at Current Residence**: (*Free Text – 5-digit zip code, 00000, XXXXX or ZZZZZ**) Pulls from admission. Change if needed. This field is linked to the "*Current Living Arrangements*" question.
9. **Flag for Resubmission**: *System generated* - **SKIP**

Alcohol and Drug Use Data



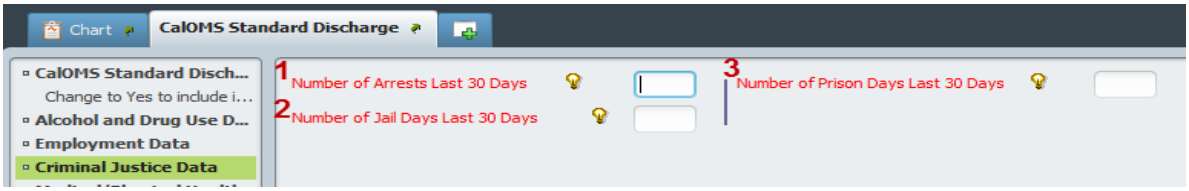
1. **Primary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) MUST match the "Primary Drug (Code)" reported at admission. This field is linked to #2, #3 and #4 below.
2. **Primary Drug (Other)**: (*Free Text – Up to 50 Characters)* Field will open if a name is required, based on "Primary Drug (Code)" selected. Otherwise, skip.
3. **Primary Drug Frequency**: (*Free Text – A number 0 to 30*) Number of days used in last 30 days.
4. **Primary Drug Route of Administration**: (*Radio Button – 4 Values, 'None or Not Applicable' or Other*) Some "*Primary Drug (Code)*" selections will default the route. Answer when applicable.
5. **Secondary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) MUST match the "*Secondary Drug (Code)*" reported at admission. This field is linked to #6, #7 and #8.
6. **Secondary Drug Name**: (*Free Text – Up to 50 Characters*) Field will open if a name is required, based on "*Secondary Drug (Code)*" selected. Otherwise, skip.
7. **Secondary Drug Frequency**: (*Free Text – A Number 0 to 30*) Number of days used in last 30 days.
8. **Secondary Drug Route of Administration**: (*Radio Button – 4 Values, 'None or Not Applicable' or Other*) Some "*Secondary Drug (Code)*" selections will default the route. Answer when applicable.
9. **Alcohol Frequency**: (*Free Text – A number 0 to 30, or 99902*) Defaults to '99902' if either "*Primary Drug (Code)*" or "*Secondary Drug (Code)*" is 'Alcohol'. This field is linked to the "*Primary and Secondary Drug (Code)*" questions.
10. **Needle Use**: (*Free Text – A number 0 to 30, 99900 or 99904**) How often the consumer used needles to inject drugs in past 30 days.

Employment Data



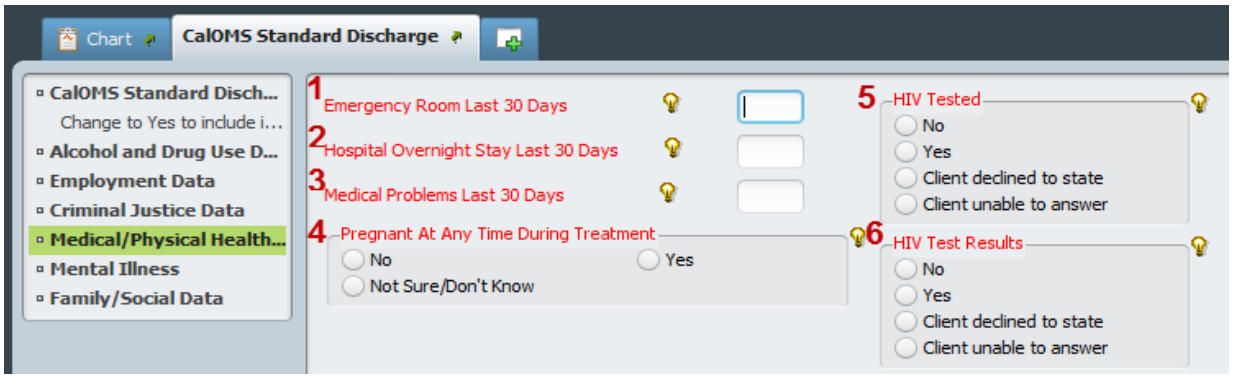
1. **Employment Status**: (*Radio Button – 5 Values*) Select One
2. **Work Past 30 Days**: (*Free Text – A number from 0 to 30, 99900 or 99904**) Paid days worked.
3. **Enrolled in School**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**)
4. **Enrolled in Job Training**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) Select One.
5. **Highest School Grade Completed**: (*Dropdown List – A number from 0 to 30, Client Declined to State or Client Unable to Answer**) Values pulls over from admission – review and change if consumer gives a different answer.

Criminal Justice Data



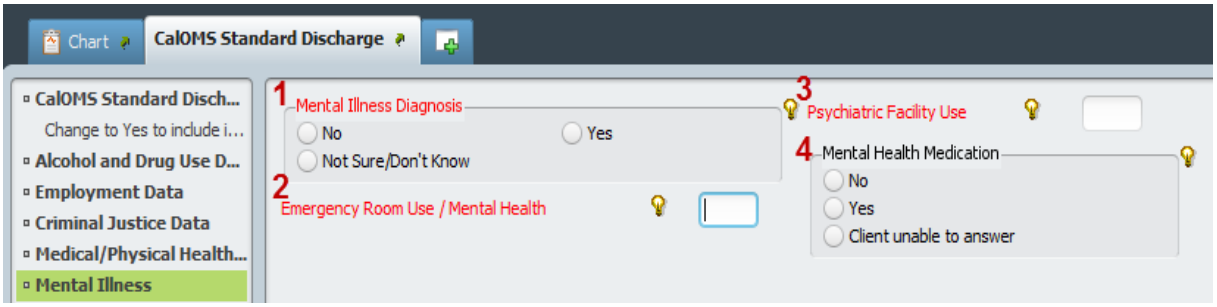
1. **Number of Arrests Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)
2. **Number of Jail Days Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)
3. **Number of Prison Days Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)

Medical / Physical Health Data



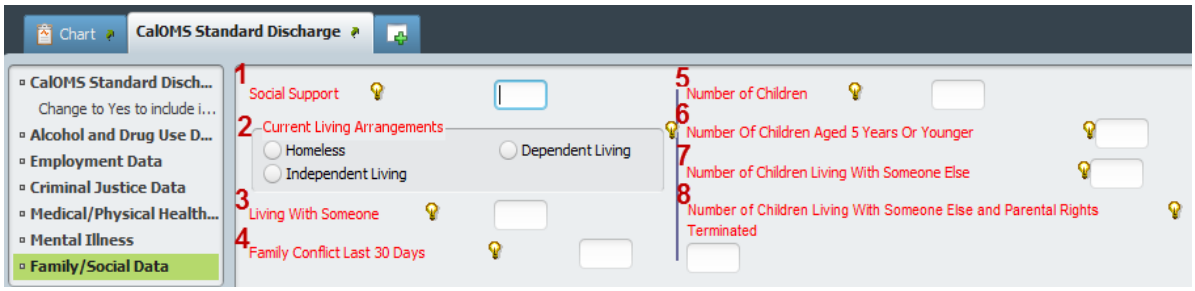
1. **Emergency Room Last 30 Days**: (*Free Text – A number from 0 to 99 or 99904**) This field is linked to the "*Medical Problems Last 30 Days*" question.
2. **Hospital Overnight Stay Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**) This field is linked to the "*Medical Problems Last 30 Days*" question.
3. **Medical Problems Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**) This field is linked to the "*Emergency Room Last 30 Days*" and "*Hospital Overnight Stay Last 30 Days*" questions. Must match or exceed the previous 2 questions (#1 or #2 Above) – (*See page 18 'Example for #4 Above'*).
4. **Pregnant At Any Time During Treatment**: (*Radio Button – Yes, No or Not Sure/Don't Know*) Defaults to '*No*' for male consumers.
5. **HIV Tested**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**)
6. **HIV Test Results**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**) This field is linked to the "*HIV Tested*" question.

Mental Illness

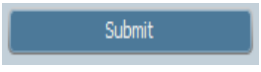


1. **Mental Illness Diagnosis**: (*Radio Button – Yes, No or Not Sure/Don't Know*)
2. **Emergency Room Use / Mental Health**: (*Free Text – A number from 0 to 99 or 99904**)
3. **Psychiatric Facility Use**: (*Free Text – A number from 0 to 30 or 99904**)
4. **Mental Health Medication**: (*Radio Button – Yes, No or Client Unable to Answer**) Prescribed Medication

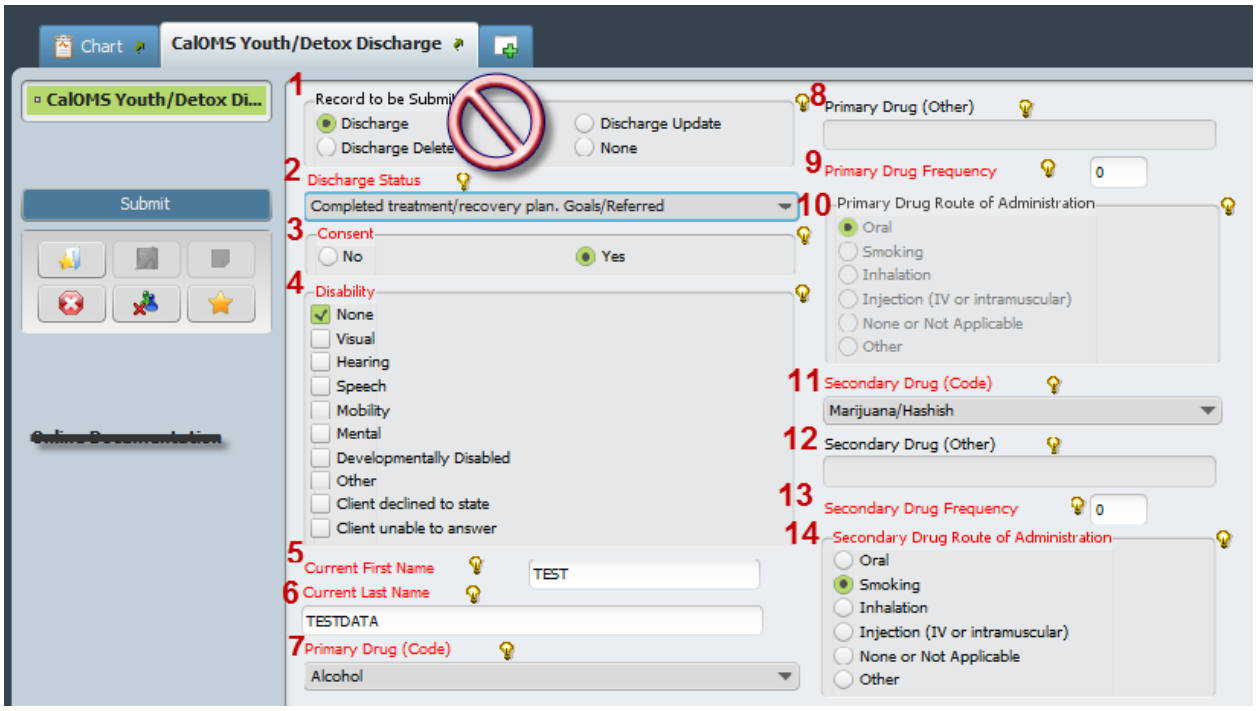
Family / Social Data



1. **Social Support**: (*Free Text – A number from 0 to 30*) Ex: 12-step meetings; Other self help meetings; Religious/Faith recovery or self-help meetings; Meetings of organizations other then those listed above; Interactions with family members and/or friend support of recovery.
2. **Current Living Arrangements**: (*Radio Button – 3 Values*) *Homeless* – consumers with no permanent residence. *Dependent Living* – Consumers living in a supervised setting or children (under age 18) living parent/family member/guardian. *Independent Living* – Individuals who contribute to their living arrangements. This field is linked to "*Zip Code at Current Residence*" question.
3. **Living with Someone**: (*Free Text – A number from 0 to 30, 99900 or 99904**) Someone who uses alcohol or other drugs.
4. **Family Conflict Last 30 Days**: (*Free Text – A number from 0 to 30, 99900 or 99904**)
5. **Number of Children Age 17 or Younger**: (*Free Text – A number from 0 to 30 or 99904**) Whether they live with the consumer or not. This field is linked to #6, #7 and #8 below and will default them to '*zero*' if this field has a value of '*0*'.
6. **Number of Children Age 5 or Younger**: (*Free Text – A number from 0 to 30 or 99904**) Of those 17 or younger, how many are 5 or younger. This field is linked to "*Number of Children Age 17 or Younger*" question.
7. **Number of Children Living with Someone Else**: (*Free Text – A number from 0 to 30 or 99904**) Due to a child protection court order. This field is linked to "*Number of Children Age 17 or Younger*" question.
8. **Number of Children Living with Someone Else and Parental Rights Terminated**: (*Free Text – A number from 0 to 30 or 99904**) Of those living with someone else, how many have the parental rights been terminated. This field is linked to "*Number of Children Age 17 or Younger*" and "*Number of Children Living with Someone Else*" question.

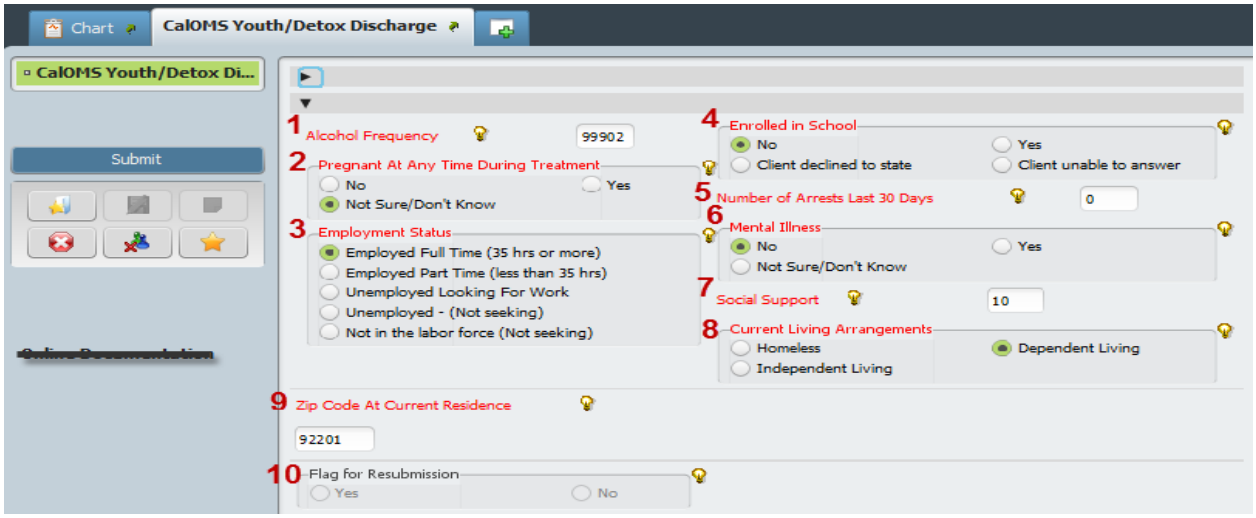
Submit CalOMS Standard Discharge when all fields have been completed. 

CalOMS Youth/Detox Discharge



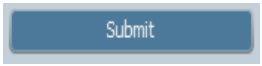
1. **Record to be Submitted**: **SKIP – Do not change the prepopulated selection**.
    a. *Discharge* ***Default***
    b. *Discharge Update* – *Default When the discharge to be edited has been submitted to the State the system will default to '*Discharge Update*'.
    c. *Discharge Delete* – Contact SU Administration if you require the CalOMS Discharge to be deleted.
    d. *None* - **SKIP**
2. **Discharge Status**: (*Radio Button – 4 Values*) Only the standard discharge reason will display. (*Review the DCG and Bulletins*)
    a. *Completed Treatment/Recovery Plan Goals – Referred*: (Status 1) Cannot be used for Detox discharge (see #5 above).
    b. *Completed Treatment/Recovery Plan Goals – Not Referred*: (Status 2) Cannot be used for Detox discharge (see #5 above).
    c. *Left Before Completion with Satisfactory Progress – Referred*: (Status 3)
    d. *Left Before Completion with Unsatisfactory Progress – Referred*: (Status 5)
3. **Consent**: (*Radio Button – 5 Values*) Since post discharge follow-up has been postponed, counties can default this field to '*no*'.
4. **Disability**: (*Multiple Selection – 7 Values, Other, Client Declined to State or Client Unable to Answer**) Select as many that apply. This field is linked to allowing the use of 99904* alternate valued throughout the form.
5. **Current First Name**: (*Free Text – No Special Characters*) Pulls from admission.
6. **Current Last Name**: (*Free Text – No Special Characters*) Pulls from admission.

7. **Primary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) MUST match the "Primary Drug (Code)" reported at admission. This field is linked to #2, #3 and #4 below.
8. **Primary Drug (Other)**: (*Free Text – Up to 50 Characters)* Field will open if a name is required, based on "Primary Drug (Code)" selected. Otherwise, skip.
9. **Primary Drug Frequency**: (*Free Text – A number 0 to 30*) Number of days used in last 30 days.
10. **Primary Drug Route of Administration**: (*Radio Button – 4 Values, 'None or Not Applicable' or Other*) Some "*Primary Drug (Code)*" selections will default the route. Answer when applicable.
11. **Secondary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) MUST match the "*Secondary Drug (Code)*" reported at admission. This field is linked to #6, #7 and #8.
12. **Secondary Drug (Other)**: (*Free Text – Up to 50 Characters*) Field will open if a name is required, based on "*Secondary Drug (Code)*" selected. Otherwise, skip.
13. **Secondary Drug Frequency**: (*Free Text – A Number 0 to 30*) Number of days used in last 30 days.
14. **Secondary Drug Route of Administration**: (*Radio Button – 4 Values, 'None or Not Applicable' or Other*) Some "*Secondary Drug (Code)*" selections will default the route. Answer when applicable.

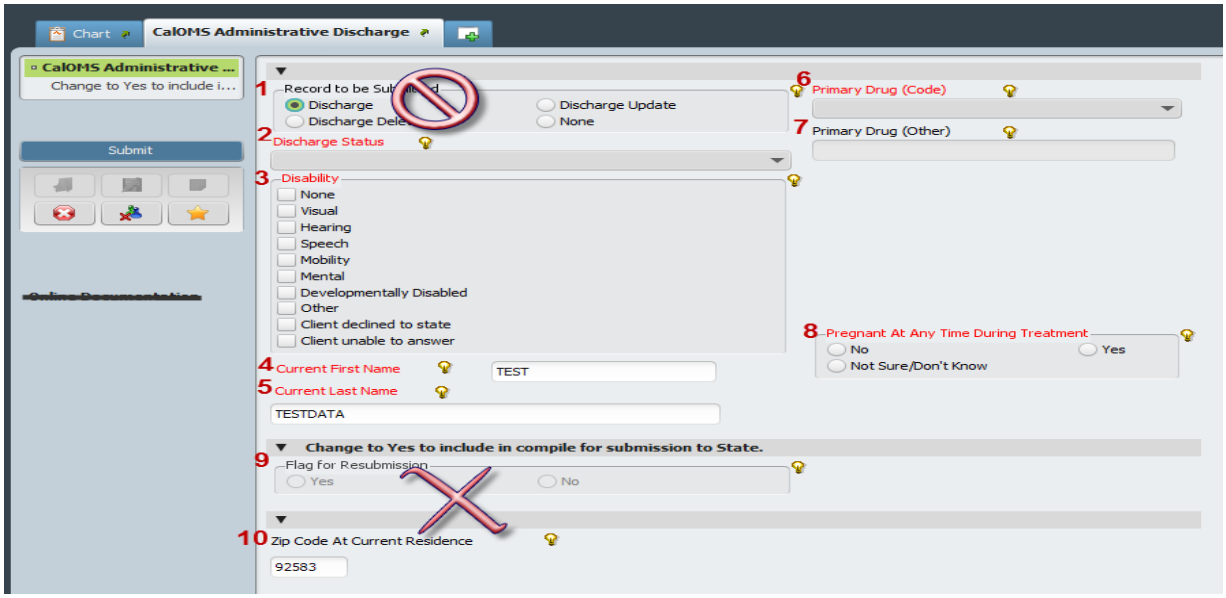


1. **Alcohol Frequency**: (*Free Text – A number 0 to 30, or 99902*) Defaults to '99902' if either "*Primary Drug (Code)*" or "*Secondary Drug (Code)*" is 'Alcohol'. This field is linked to the "*Primary and Secondary Drug (Code)*" questions.
2. **Pregnant At Any Time During Treatment**: (*Radio Button – Yes, No or Not Sure/Don't Know*) Defaults to '*No*' for male consumers.
3. **Employment Status**: (*Radio Button – 5 Values*) Select One
4. **Enrolled in School**: (*Radio Button – Yes, No, Client Declined to State or Client Unable to Answer**)
5. **Number of Arrests Last 30 Days**: (*Free Text – A number from 0 to 30 or 99904**)
6. **Mental Illness**: (*Radio Button – Yes, No or Not Sure/Don't Know*)
7. **Social Support**: (*Free Text – A number from 0 to 30*) Ex: 12-step meetings; Other self help meetings; Religious/Faith recovery or self-help meetings; Meetings of organizations other then those listed above; Interactions with family members and/or friend support of recovery.

8. **Current Living Arrangements**: (*Radio Button – 3 Values*) *Homeless* – consumers with no permanent residence. *Dependent Living* – Consumers living in a supervised setting or children (under age 18) living parent/family member/guardian. *Independent Living* – Individuals who contribute to their living arrangements. This field is linked to "*Zip Code at Current Residence*" question.
9. **Zip Code at Current Residence**: (*Free Text – 5-digit zip code, 00000, XXXXX or ZZZZZ*)* Pulls from admission. Change if needed. This field is linked to the "*Current Living Arrangements*" question.
10. **Flag for Resubmission**: *System generated* - **SKIP**

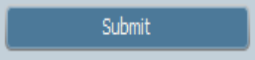
Submit CalOMS Youth/Detox Standard Discharge when all fields have been completed. 

CalOMS Administrative Discharge



1. **Record to be Submitted**: **SKIP – Do not change the prepopulated selection**.
    a. *Discharge* ***Default***
    b. *Discharge Update* – *Default When the discharge to be edited has been submitted to the State the system will default to '*Discharge Update*'.
    c. *Discharge Delete* – Contact SU Administration if you require the CalOMS Discharge to be deleted.
    d. None - **SKIP**
2. **Discharge Status**: Only the administrative discharge reason will display. (Review the DCG and Bulletins)
    a. *Left Before Completion with Satisfactory Progress – Not Referred*: (Status 4)
    b. *Left Before Completion with Unsatisfactory Progress – Not Referred*: (Status 6)
    c. *Death*: (Status 7)
    d. *Incarceration*: (Status 8)

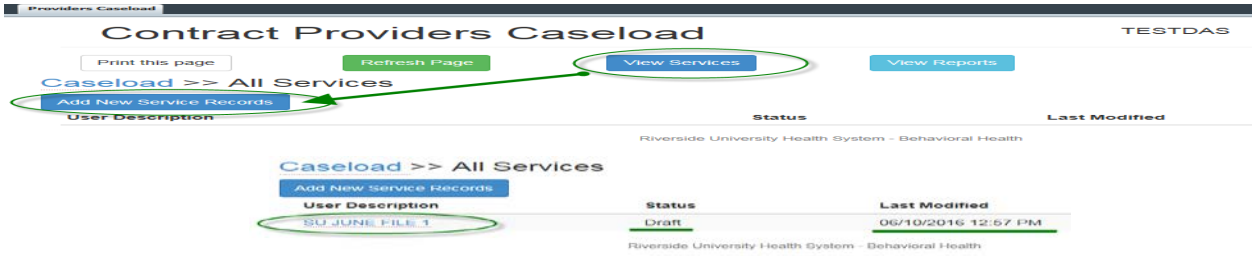
3. **Disability**: (*Multiple Selection – 7 Values, Other, Client Declined to State or Client Unable to Answer**) Select as many that apply. This field is linked to allowing the use of 99904* alternate valued throughout the form.
4. **Current First Name**: (*Free Text – No Special Characters*) Pulls from admission.
5. **Current Last Name**: (*Free Text – No Special Characters*) Pulls from admission.
6. **Primary Drug (Code)**: (*Dropdown List – 20 Values, None or Other (Specify)*) MUST match the "Primary Drug (Code)" reported at admission. This field is linked to #2, #3 and #4 below.
7. **Primary Drug (Other)**: (*Free Text – Up to 50 Characters)* Field will open if a name is required, based on "Primary Drug (Code)" selected. Otherwise, skip.
8. **Pregnant At Any Time During Treatment**: (*Radio Button – Yes, No or Not Sure/Don't Know*) Defaults to '*No*' for male consumers.
9. **Flag for Resubmission**: *System generated* - **SKIP**
10. **Zip Code at Current Residence**: (*Free Text – 5-digit zip code, 00000, XXXXX or ZZZZZ**) Pulls from admission. Change if needed. This field is linked to the "*Current Living Arrangements*" question.

Submit CalOMS Youth/Detox Standard Discharge when all fields have been completed. 

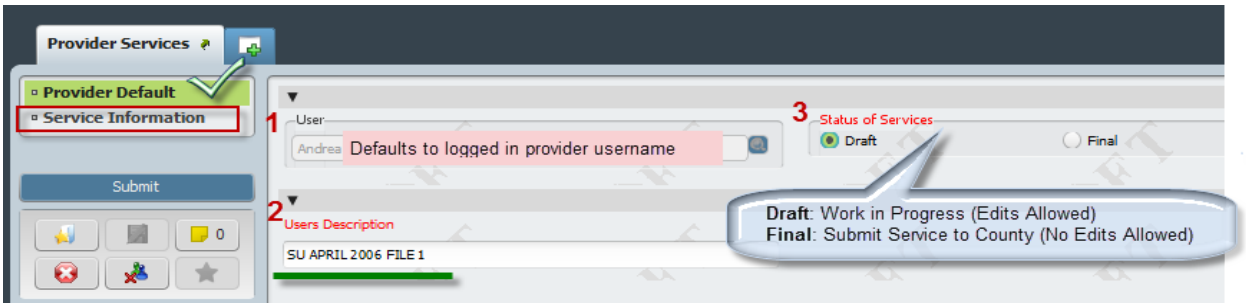
Section 3

Section Three: Billing / Services

From the Home Page select “View Services” command button, the service pre-display page will open. Either access a “User Description” in ‘draft’ “Status” to continue adding services to an existing file/form or select “Add New Service Records” to create a new file/form.

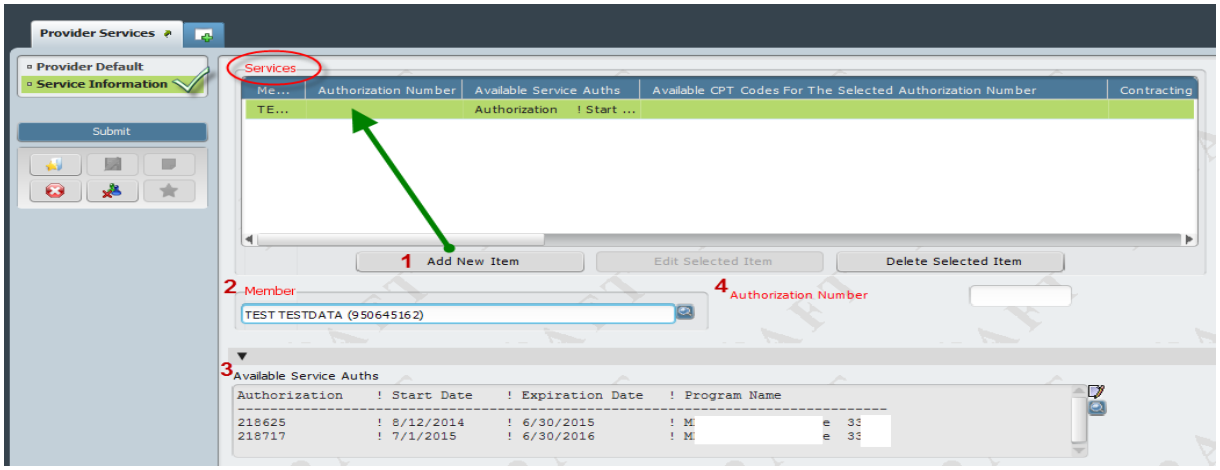


Provider Services

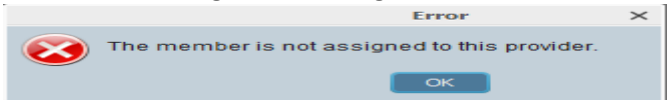


1. **User**: (Process Search) System generated – based on username logged in.
2. **Status of Services**: (Radio Button) Assign status for each file being worked. *Provider can submit services as often as needed, but must invoice only once a month for all services entered from last invoice date to current invoice date*.
    a. **Draft**: Provider to use ‘draft’ status when the file/form is a work in progress and the date range of services entered has yet to be reviewed and finalized for submission.
    b. **Final**: Provider to use ‘final’ status when the file/form has been reviewed and can now be submitted to the County for review/action.
        i. Provider can submit multiple files in final status and compile all final files in to one monthly invoice. (Reports are available to assist and later discussed in Section 4)
3. **Users Description**: (Free Text) Provider to name each service file to distinguish between the billing entries previously submitted vs. current data entry.
    a. **Naming Format**: **SU** MONTH YEAR **FILE #** (Ex: SU April 2016 File 1, SU APRIL 2016 FILE 2)

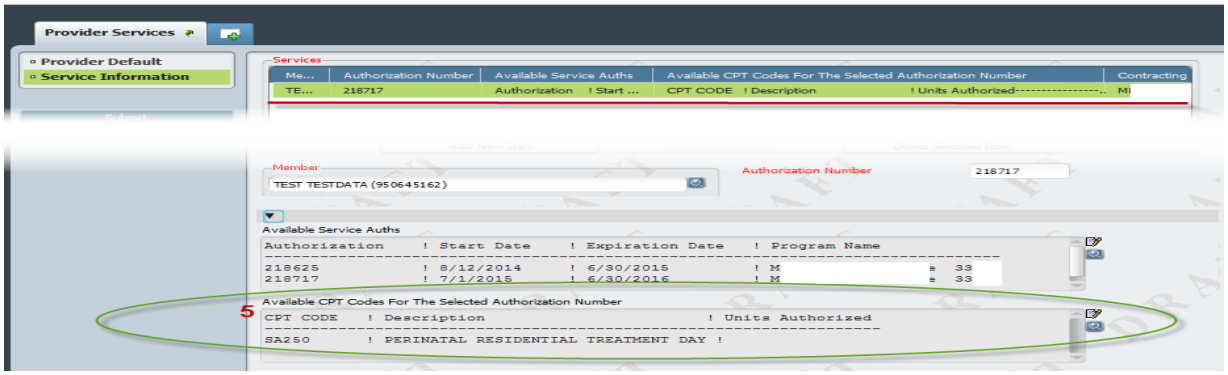
Choose “Service Information” section on the left if the form does not move to the next section.



1. **Add New Item**: (*Command Button*) In order to record an entry end user MUST first select to add a row. Once the row has been added the required fields will open for entry.
2. **Member**: (*Process Search*) Enter consumer PatID as assigned by the County or Last Name, First Name as registered. SU Administration will send each Provider an email with the PatID and Service Authorization number assigned to each episode/admission approved request.
    a. If you receive the following error message contact SU Administration for correction.

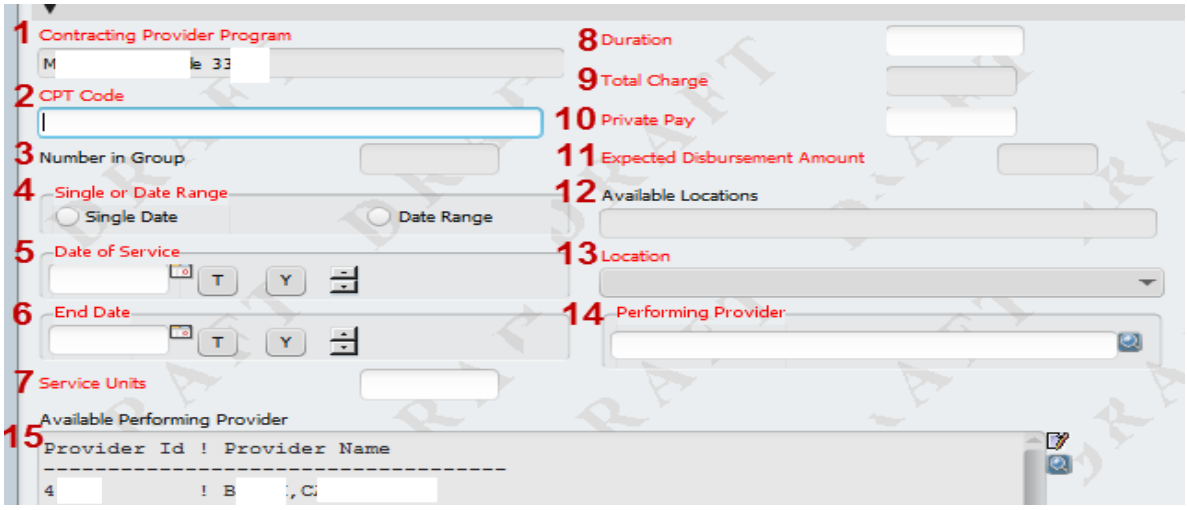


3. **Available Service Auths**: *Default – System generated*. Once the member is selected all applicable service authorizations for the provider logged in will display. Review that the appropriate program is assigned.
    a. Any errors contact SU Administration for correction.
4. **Authorization Number**: (*Free Text*) Enter the numeric service authorization number that applies from the “Available Service Auths”.



5. **Available Service Auths**: *Default – System generated*. Once the service authorization is entered the service detail information assigned to that service authorization will display. Review that the appropriate service codes are assigned. (*Remaining units are displayed in the View Auths Home Page – see Section 2, Page9*)

a. Any errors contact SU Administration for correction.



1. **Contracting Provider Program**: *Default – System generated*. - SKIP (Populates program based on service authorization number selected/entered).
2. **CPT Code**: (*Free Text*) Enter any service code to bill as displayed in "Available CPT Code For the Selected Authorization Number". (Ex: SA250)
   a. System will warn of invalid entry: 

3. **Number in Group**: (*Free Text – Numeric*) Field will open for entry based on a group type service code entered.
4. **Single or Date Range**: (*Radio Button*)
   a. '*Single Date*' only requires entry in "*Date of Service*"
   b. '*Date Range*' requires both "*Date of Service*" and "*End Date*". Date range is used for consecutive dates without a break/gap in service and that the service code, units, duration, location and performing provide are the same for each date within the date range.
5. **Date of Service**: (*Free Text – Date Format*)
6. **End Date**: (*Free Text – Date Format*)
7. **Service Units**: (*Free Text*) Enter number of units to assign per service code and/or duration. The unit amount populates the "Total Charges" based on unit to service code rates. (If entering date range unit entry is based on single service entry – Ex: 9 days = 1 unit each)

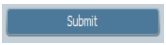
   a. ***Review Schedule I***.
      i. Most services are a one-to-one. Unit is considered a contact.
      ii. Some Providers enter units based on duration/time. (Ex: 10 minutes = 1 unit)
8. **Duration**: (*Free Text - Numeric*) Enter duration for service(s) entered in minutes. (Ex: 24 Hours = 1440 minutes)
9. **Total Charges**: *Default – System generated*. - **SKIP**

10. **Private Pay**: (*Free Text*) Enter dollar amount, if none enter '*0.00*'
11. **Expected Disbursement Amount**: *Default – System generated*. - **SKIP**
12. **Available Locations**: *Default – System generated*. – **SKIP** (This field will assist in selecting the appropriate value in "*Location*")
13. **Location**: (*Dropdown List*) Currently SU requires that '*Office*' be used for all entries.
14. **Performing Provider**: (*Process Search*) Available staff list found in "*Available Performing Provider*" view. Search using the Provider ID or Provider Name as shown – Select.

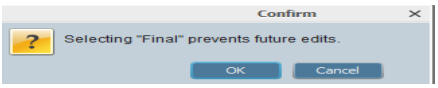
15. **Available Performing Provider**: *Default – System generated*. – **SKIP** (List of Staff assigned to Provider logged in)

Repeat 1 – 15 for each entry. One created file (**Provider Services Form**) can obtain multiple consumers and dates.

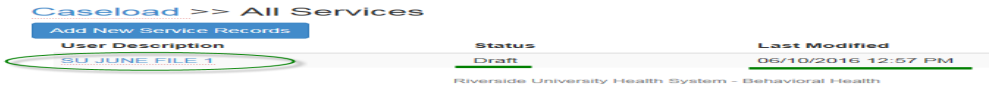
Confirm "*Status of Service*" is still in '*Draft*' prior to submitting if the file is still work in progress.



Only change to '*Final*' when ready to submit services to County for review/action. *Warning message will display*.



Once end user has submitted a file/form either in 'draft' or 'final' status a summary of the file can be viewed (all statuses) and accessed (draft status only) from the "View Services" pre-display page. Selecting the "User Description" in 'draft' will open the "Provider Services" form for additional entries and/or review for completion of the file before setting to 'final' and submitting to County for review/processing.



Invoice Submission

Enter services during the billing month, up till the 5th calendar day of the following month. After all submitted services have been verified, print and create the following:

- PVD 2003 ELMR Invoice Summary Report (see Section 4)
- Manual Invoice on agency letterhead – Use the information provided on the PVD 2003.
- Provider Integrity Form (PIF) – Substitute the Bill Enumerator with the Batch #(s).

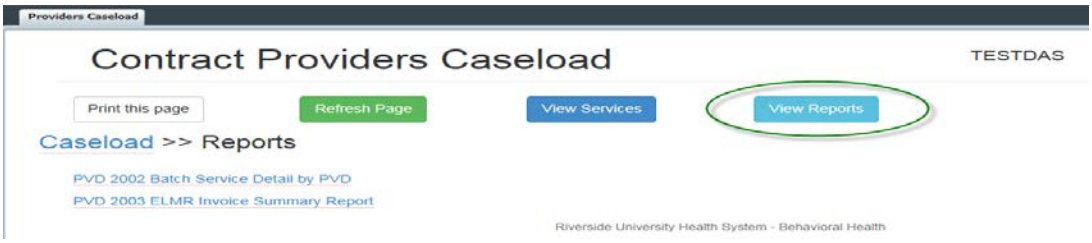
All three (3) documents should be sent via:

- Email (preferred) to **ELMR_PIF@rcmhd.org**
- Fax to 951-358-6868
- Mail to: Riverside University Health System – Behavioral Health
  Invoice Processing Unit
  P.O. Box 7549
  Riverside, CA 92513-7549

Section 4

Section Four: Reports

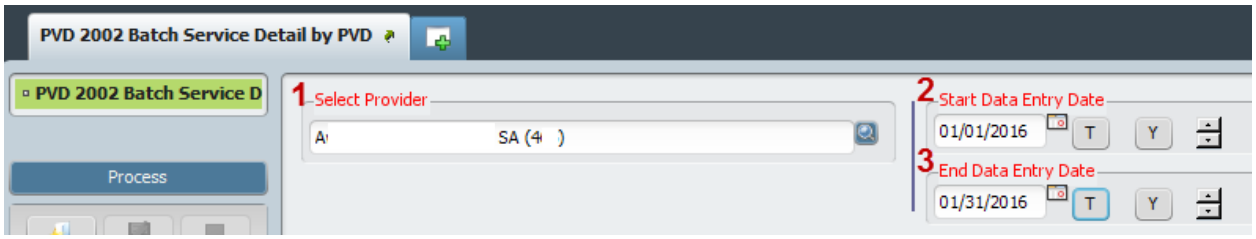
From the home page select the "View Reports" command button to open the reports page. Two reports have been assigned to assist in reconciling submitted services by date range.



- PVD 2002 Batch Services Detail by PVD: This report lists all Open and Closed services within the specified time frame.
    - Run this report monthly (by submission date range) to review all service detail submitted to county for review/action and assist in completing the monthly invoice and Provider Integrity Form (PIF).
    - Running this report for the entire fiscal year will allow you to easily reconcile services, which will assist during the year-end cost report settlement.

- PVD 2003 ELMR Invoice Summary Report: This report summarizes services billed at Contract Number and Department ID level within the specified time frame.
    - This report will be **required** as backup to the manual invoice submission, and MUST match the totals of the Provider's invoice. (*Run monthly utilizing the same date range as the PVD2002*).

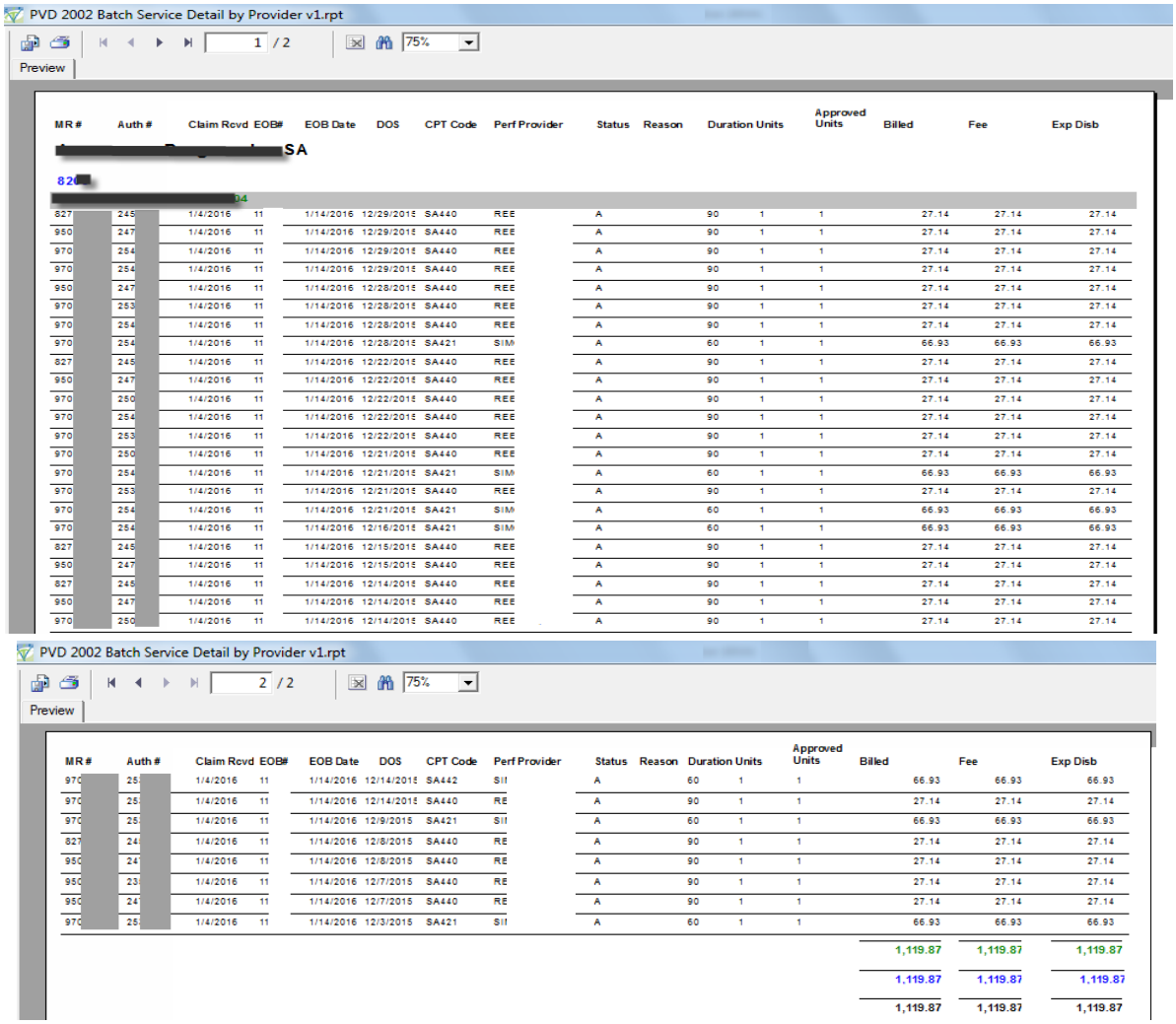
PVD 2002



1. **Select Provider**: (*Process Search*) *Default – System generated.* – **SKIP** (*if requiring entry use provider id or name to search*)

2. **Start Data Entry Date**: (*Free Text – Date Format*)
    a. **MONTHLY**: Use the first date that data for the current invoice month was submitted (*Ex: using file naming format of SU April 2016 File 1 – find the 'final' "status" submit date for the first file, this would be the 'Start Data Entry Date' for the current month report pull*).
    b. **YEARLY**: Use the July File 1 (First File) submitted date.
3. **End Data Entry Date**: (*Free Text – Date Format*)
    a. **MONTHLY**: Use the last date that data for the current invoice month was submitted (*Ex: using file naming format of SU April 2016 File 4 – find the 'final' "status" submit date for the last file, this would be the 'End Data Entry Date' for the current month report pull*).
    b. **YEARLY**: Use the June File 4 (Last File) submitted date.

PVD 2002 Sample



PVD 2002 Batch Service Detail by Provider v1.rpt

1 / 2 — 75% — Preview

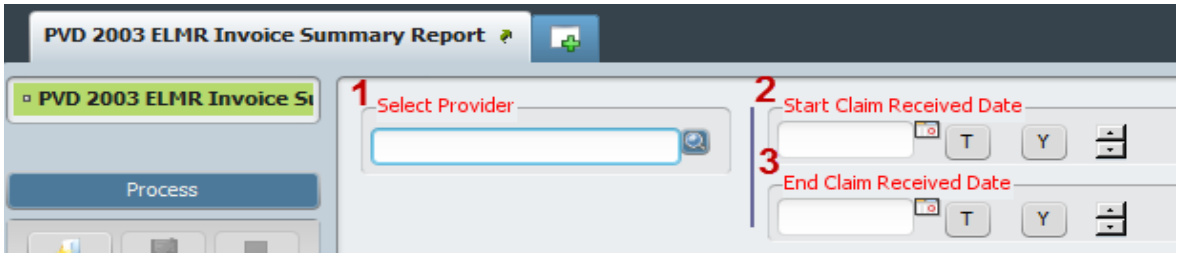
MR #	Auth #	Claim Rcvd	EOB#	EOB Date	DOS	CPT Code	Perf Provider	Status	Reason	Duration Units	Approved Units	Billed	Fee	Exp Disb
[redacted] SA														
820[redacted]														
[redacted]04														
827	245	1/4/2016	11	1/14/2016	12/29/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
950	247	1/4/2016	11	1/14/2016	12/29/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	254	1/4/2016	11	1/14/2016	12/29/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	254	1/4/2016	11	1/14/2016	12/29/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
950	247	1/4/2016	11	1/14/2016	12/28/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	253	1/4/2016	11	1/14/2016	12/28/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	254	1/4/2016	11	1/14/2016	12/28/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	254	1/4/2016	11	1/14/2016	12/28/2015	SA421	SIM	A		60	1	1	66.93	66.93	66.93
827	245	1/4/2016	11	1/14/2016	12/22/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
950	247	1/4/2016	11	1/14/2016	12/22/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	250	1/4/2016	11	1/14/2016	12/22/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	254	1/4/2016	11	1/14/2016	12/22/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	253	1/4/2016	11	1/14/2016	12/22/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	250	1/4/2016	11	1/14/2016	12/21/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	254	1/4/2016	11	1/14/2016	12/21/2015	SA421	SIM	A		60	1	1	66.93	66.93	66.93
970	253	1/4/2016	11	1/14/2016	12/21/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	254	1/4/2016	11	1/14/2016	12/21/2015	SA421	SIM	A		60	1	1	66.93	66.93	66.93
970	254	1/4/2016	11	1/14/2016	12/16/2015	SA421	SIM	A		60	1	1	66.93	66.93	66.93
827	245	1/4/2016	11	1/14/2016	12/15/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
950	247	1/4/2016	11	1/14/2016	12/15/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
827	245	1/4/2016	11	1/14/2016	12/14/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
950	247	1/4/2016	11	1/14/2016	12/14/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14
970	250	1/4/2016	11	1/14/2016	12/14/2015	SA440	REE	A		90	1	1	27.14	27.14	27.14

PVD 2002 Batch Service Detail by Provider v1.rpt

2 / 2 — 75% — Preview

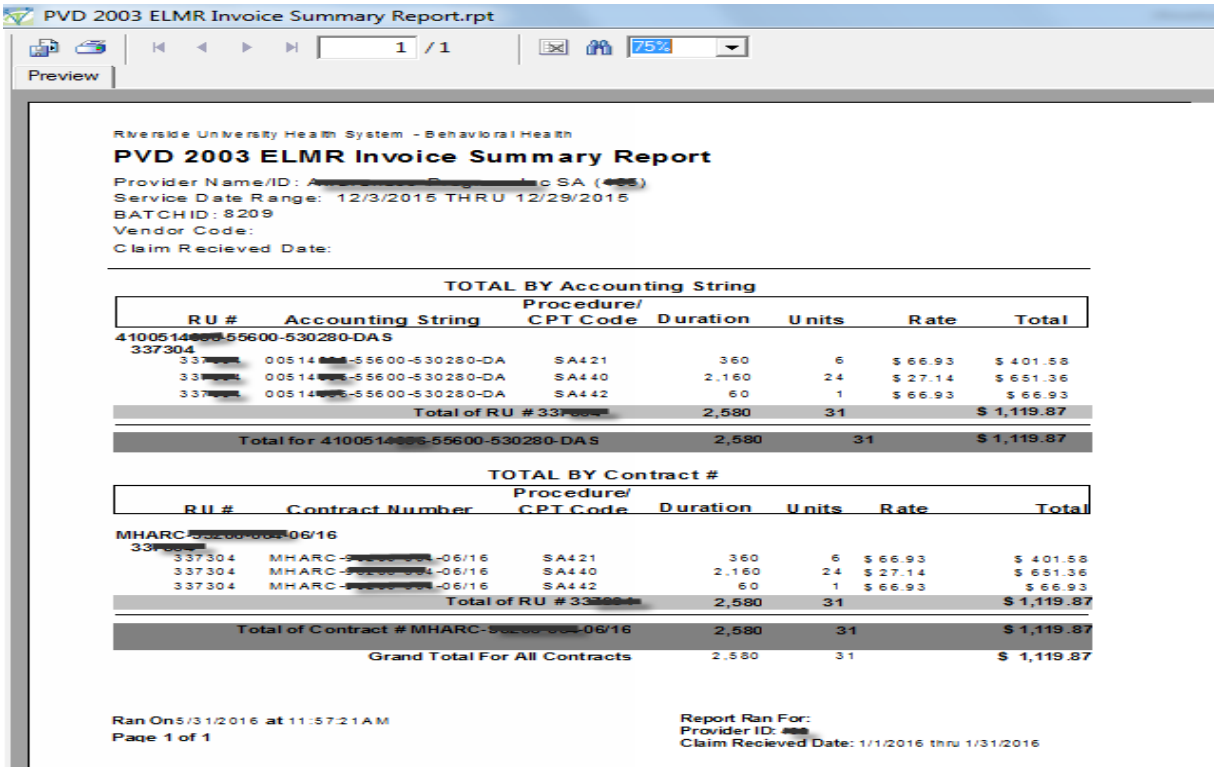
MR #	Auth #	Claim Rcvd	EOB#	EOB Date	DOS	CPT Code	Perf Provider	Status	Reason	Duration Units	Approved Units	Billed	Fee	Exp Disb
970	25	1/4/2016	11	1/14/2016	12/14/2015	SA442	SII	A		60	1	1	66.93	66.93	66.93
970	25	1/4/2016	11	1/14/2016	12/14/2015	SA440	RE	A		90	1	1	27.14	27.14	27.14
970	25	1/4/2016	11	1/14/2016	12/9/2015	SA421	SII	A		60	1	1	66.93	66.93	66.93
827	24	1/4/2016	11	1/14/2016	12/8/2015	SA440	RE	A		90	1	1	27.14	27.14	27.14
950	24	1/4/2016	11	1/14/2016	12/8/2015	SA440	RE	A		90	1	1	27.14	27.14	27.14
950	23	1/4/2016	11	1/14/2016	12/7/2015	SA440	RE	A		90	1	1	27.14	27.14	27.14
950	24	1/4/2016	11	1/14/2016	12/7/2015	SA440	RE	A		90	1	1	27.14	27.14	27.14
970	25	1/4/2016	11	1/14/2016	12/3/2015	SA421	SII	A		60	1	1	66.93	66.93	66.93
												1,119.87	1,119.87	1,119.87
												1,119.87	1,119.87	1,119.87
												1,119.87	1,119.87	1,119.87

PVD 2003



1. **Select Provider**: (*Process Search*) *Default – System generated.* – **SKIP** (*if requiring entry use provider id or name to search*)
2. **Start Claim Received Date**: (*Free Text – Date Format*)
    a. **MONTHLY**: Use the first date that data for the current invoice month was submitted (*Ex: using file naming format of SU April 2016 File 1 – find the 'final' "status" submit date for the first file, this would be the 'Start Data Entry Date' for the current month report pull*).
    b. **YEARLY**: Use the July File 1 (First File) submitted date.
3. **End Claim Received Date**: (*Free Text – Date Format*)
    a. **MONTHLY**: Use the last date that data for the current invoice month was submitted (*Ex: using file naming format of SU April 2016 File 4 – find the 'final' "status" submit date for the last file, this would be the 'End Data Entry Date' for the current month report pull*).
    b. **YEARLY**: Use the June File 4 (Last File) submitted date.

PVD 2003 Sample



PVD 2003 ELMR Invoice Summary Report.rpt

Preview

Riverside University Health System - Behavioral Health

PVD 2003 ELMR Invoice Summary Report

Provider Name/ID: [redacted]
Service Date Range: 12/3/2015 THRU 12/29/2015
BATCH ID: 8209
Vendor Code:
Claim Recieved Date:

TOTAL BY Accounting String

RU #	Accounting String	Procedure/ CPT Code	Duration	Units	Rate	Total
4100514[redacted]55600-530280-DAS						
337304						
337[redacted]	00514[redacted]-55600-530280-DA	SA421	360	6	$ 66.93	$ 401.58
33[redacted]	00514[redacted]-55600-530280-DA	SA440	2,160	24	$ 27.14	$ 651.36
337[redacted]	00514[redacted]-55600-530280-DA	SA442	60	1	$ 66.93	$ 66.93
	Total of RU # 33[redacted]		2,580	31		$ 1,119.87
	Total for 4100514[redacted]55600-530280-DAS		2,580	31		$ 1,119.87

TOTAL BY Contract #

RU #	Contract Number	Procedure/ CPT Code	Duration	Units	Rate	Total
MHARC-[redacted]06/16						
33[redacted]						
337304	MHARC-[redacted]-06/16	SA421	360	6	$ 66.93	$ 401.58
337304	MHARC-[redacted]-06/16	SA440	2,160	24	$ 27.14	$ 651.36
337304	MHARC-[redacted]-06/16	SA442	60	1	$ 66.93	$ 66.93
	Total of RU # 33[redacted]		2,580	31		$ 1,119.87
	Total of Contract # MHARC-[redacted]-06/16		2,580	31		$ 1,119.87
	Grand Total For All Contracts		2,580	31		$ 1,119.87

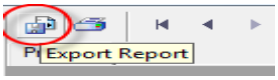
Ran On 5/31/2016 at 11:57:21 AM
Page 1 of 1

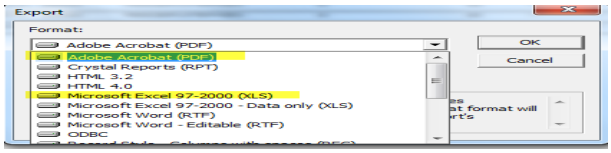
Report Ran For:
Provider ID: [redacted]
Claim Recieved Date: 1/1/2016 thru 1/31/2016

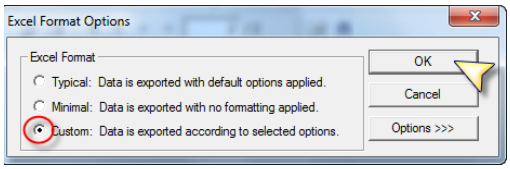
Report Retrieval

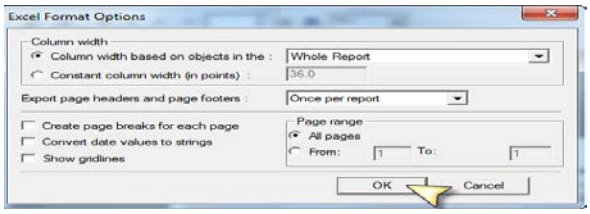
The Report Toolbar allows the end user to:

- Export the report

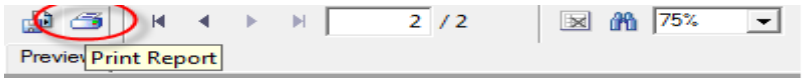




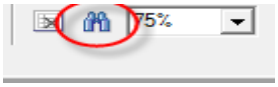




- Print the Report



- Find data within the pages of the report



Section 5

Section Five

Support

For ELMR System Questions:

- Phone: 951-955-7360
- Email: **ELMRSupport@rcmhd.org**

For Invoice Submission Inquiries:

- **ELMR_PIF@rcmhd.org**

Documents

- ELMR System Requirements User Guide
- SU Diagnosis Reference Guide
- ADP Bulletin 11-10: Procedures for Collection of Discharge Data for the California Outcome Measurement System – Treatment (CalOMS-Tx)
- Bulletin 10-08: Criteria for Discharging Treatment Clients using the CalOMS-Tx Completion Discharge Statuses
- Determining CalOMS Discharge Codes: Detox Programs
- Determining CalOMS Discharge Codes: Non-Detox Programs

Riverside University HEALTH SYSTEM
Behavioral Health

ELMR System Requirements

June
2016

Revised on
6/10/2016

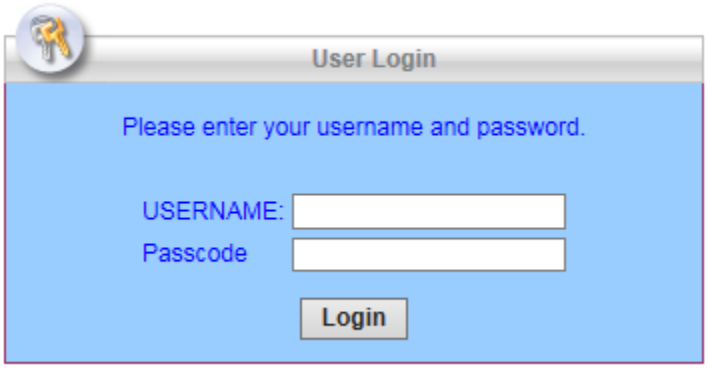
You must be on a Windows Operating System.
**** (Mac Users call ELMR Support for additional information) ****

VPN ACCOUNT ACCESS

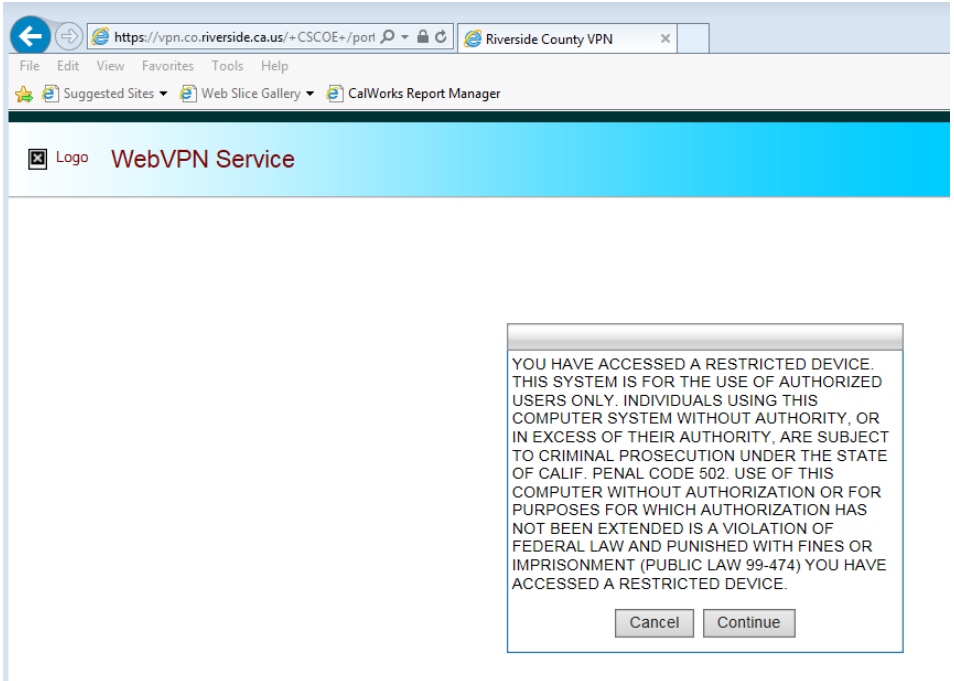
Once a VPN Account is created, a User Name and Password will be provided.

To access the virtual private network (VPN), from the Internet Explorer browser

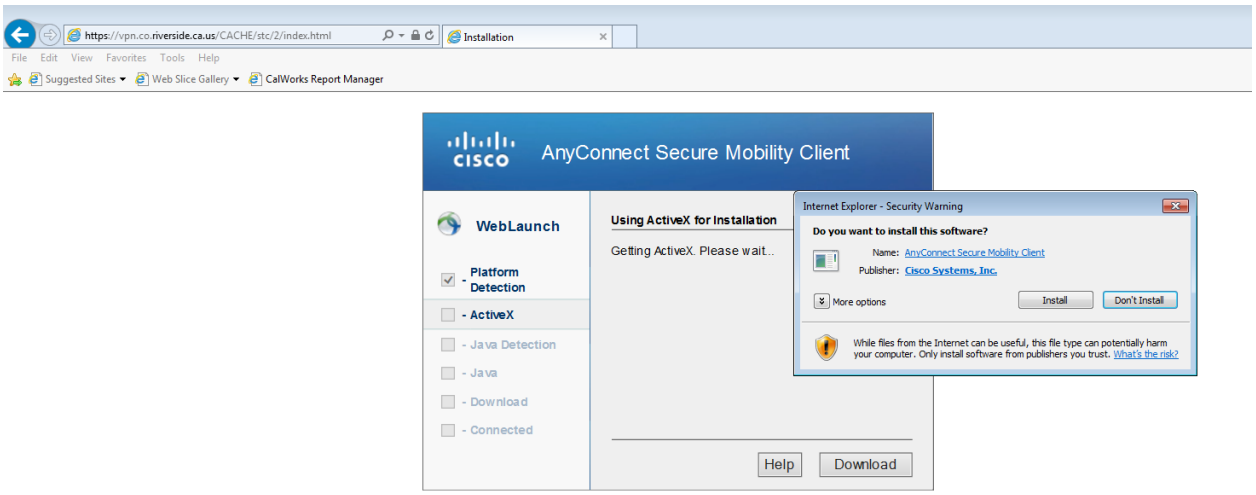
- Go to the web address https://vpn.co.riverside.ca.us/+CSCOE+/logon.html#form_title_text
- Enter your VPN User Name and Password



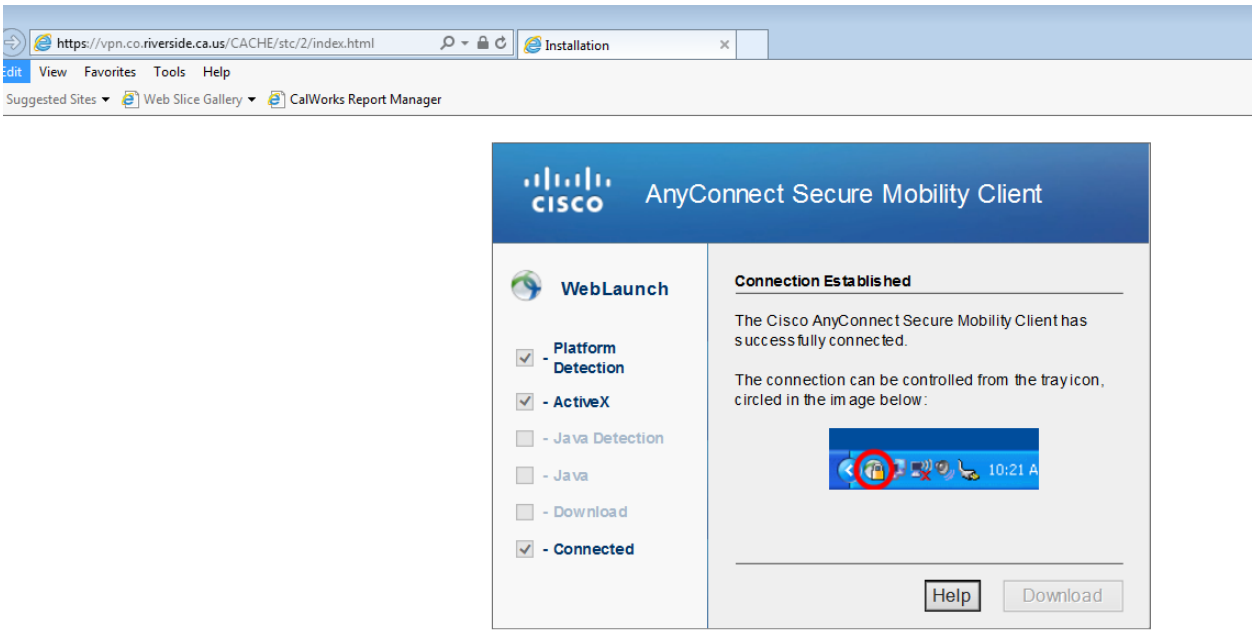
- Read User Disclosure and select **Continue**



- Select install



- Once the install is completed you will be connected to VPN



PROVIDER FAQ'S PAGE

From the Provider FAQ'S site you will have links to **ELMR LIVE**, **ELMR Report Distribution**, **FAQ's page**, and **Java** Link.

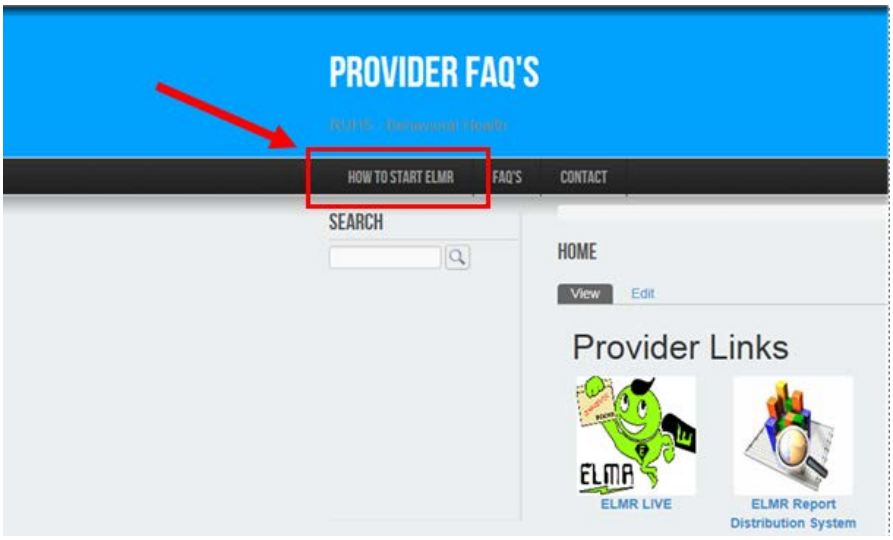
- Open Internet Explorer browser  *(**Note**: ELMR can only be used with the Internet Explorer browser).*

- Enter this URL: http://dylan.rcmh.local/provider/

NOTE: Java must be installed on computer first before ELMR LIVE can be accessed.

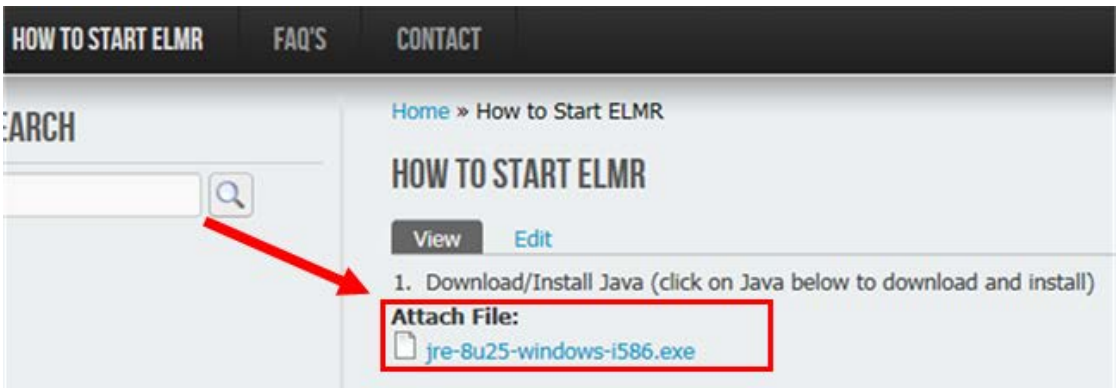
DOWNLOAD JAVA

▶ Select **How to Start ELMR** to access the page where the Java installation file is located.

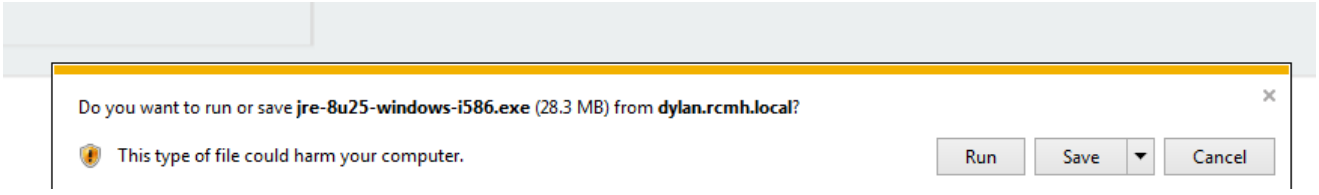


Note: *If a newer version of Java is already installed on your machine, please review the FAQ page to make sure your version will work with ELMR.*

▶ Select the jre-8u25-windows-i586.exe link to download Java

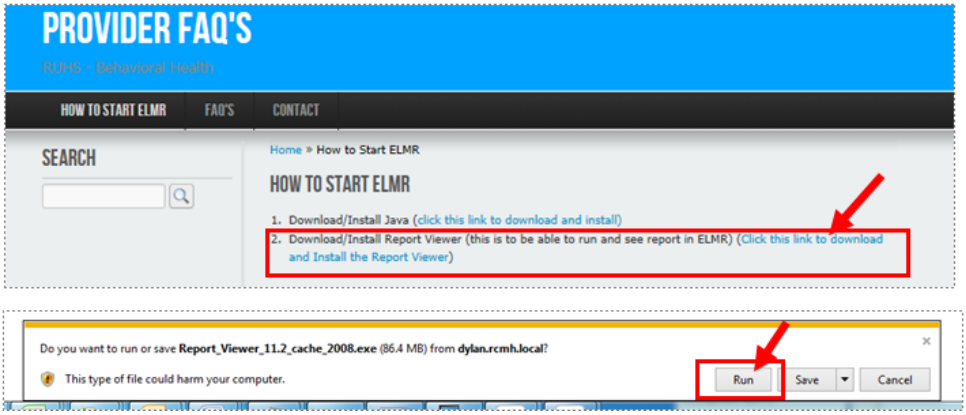


▶ Select Run

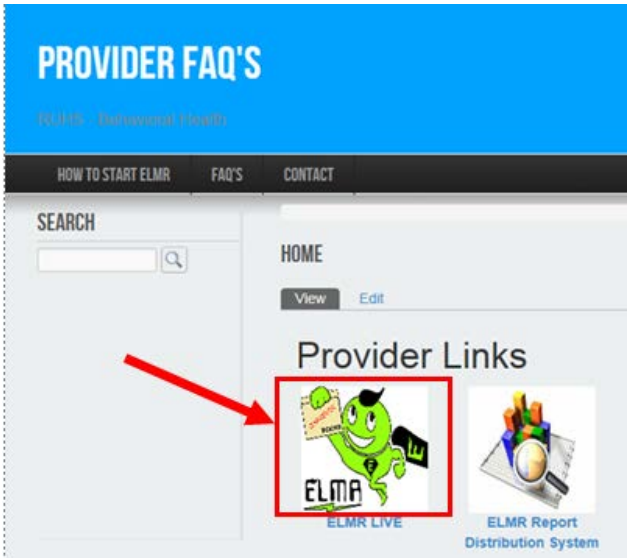


DOWNLOAD REPORT VIEWER

- Download and install the report viewer



- Once Java and the Report Viewer are installed, you can proceed with accessing ELMR from the link illustrated below:



This concludes instructions on System Requirements.

Please refer to **Provider Billing** User Guide.

How Can I Get Help

1. Review Training Materials
2. Visit the intranet site for the latest news/tips and FAQ: http://dylan.rcmh.local/provider/faq-page
3. Contact your Admission Support Staff
4. Call the Help Desk: 951.955.7360
6. Email Help Desk: ELMRSupport@rcmhd.org

SU Diagnosis Reference Guide

Searchable "SU" Name Value	ICD-9 (old value)	ICD-10 (new value)	DSM-IV Code Value	DSM-IV	DSM-V	SNOMED	Comments
Alcohol abuse	305.00	F10.10	305.00	Alcohol abuse	Alcohol use disorder, mild	15167005	
Alcohol dependence	303.90	F10.20	303.90	Alcohol dependence	Unspecified alcohol-related disorder	66590003	
Opioid abuse	305.50	F11.10	305.50	Opioid abuse	Opioid use disorder, mild	5602001	
Opioid dependence	304.00	F11.20	304.00	Opioid dependence	Unspecified opioid-related disorder	75544000	
Cannabis abuse	305.20	F12.10	305.20	Cannabis abuse	Cannabis use disorder, mild	37344009	
Cannabis dependence	304.30	F12.20	304.30	Cannabis dependence	Unspecified cannabis-related disorder	85005007	
Sedative, hypnotic or anxiolytic abuse	305.40	F13.10	305.40	Sedative, hypnotic or anxiolytic abuse	Sedative, hypnotic, or anxiolytic use disorder, mild	64386003	
Sedative, hypnotic or anxiolytic dependence	304.10	F13.20	304.10	Sedative, hypnotic or anxiolytic dependence	**BLANK**	427327003	
Cocaine abuse	305.60	F14.10	305.60	Cocaine abuse	Cocaine use disorder, mild	78267003	
Cocaine dependence	304.20	F14.20	304.20	Cocaine dependence	**BLANK**	31956009	
Amphetamine abuse	305.70	F15.10	305.70	Amphetamine abuse	Amphetamine-type substance use disorder, mild	84758004	
Amphetamine dependence	304.40	F15.20	304.40	Amphetamine dependence	Amphetamine-type substance use disorder, severe	21647008	
Hallucinogen abuse	305.30	F16.10	305.30	Hallucinogen abuse	Unspecified hallucinogen-related disorder	74851005	**NOTE: ICD-10 is shared with 305.90 Phencyclidine abuse**
Hallucinogen dependence	304.50	F16.20	304.50	Hallucinogen dependence	Unspecified hallucinogen-related disorder	38247002	**NOTE: ICD-10 is shared with 304.60 Phencyclidine dependence**
Phencyclidine abuse	305.90	**F16.10**	305.30	Phencyclidine abuse	Phencyclidine use disorder, mild	7071007	**NOTE: ICD-10 is shared with 305.30 Hallucinogen abuse**
Inhalant abuse		F18.10	305.90B	Inhalant abuse	Unspecified inhalant-related disorder	70340006	
Other or unknown substance abuse		F19.10	305.90C	Other or unknown substance abuse	Other (or unknown) substance use disorder, mild	66214007	
Phencyclidine dependence	304.60	**F16.20**	304.60	Phencyclidine dependence	Phencyclidine use disorder, severe	58727001	**NOTE: ICD-10 is shared with 304.50 Hallucinogen dependence**
Inhalant dependence		F18.20		Inhalant dependence	Unspecified inhalant-related disorder	5002000	
Other or unknown substance dependence	304.90	F19.20	304.90	Other or unknown substance dependence	Unspecified other (or unknown) substance-related disorder	2403008	
Pathological gambling	312.31	F63.0	312.31	Pathological gambling	Gambling disorder	18085000	**CANNOT USE IN AXIS-I AXIS-II (ONLY)**
Nicotine dependence	305.1	F17.200	305.1	Nicotine dependence	Unspecified tobacco-related disorder	56294008	**CANNOT USE IN AXIS-I AXIS-II (ONLY)**
Polysubstance dependence	**304.80**	**F19.20**	**N/A**	**Polysubstance dependence**	**BLANK**	**51339003**	**NO LONGER A VALID OPTION**

6/1/2016

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
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ADP BULLETIN

Criteria for Discharging Treatment Clients using the CalOMS-Tx Completion Discharge Statuses		Issue Date: June 29, 2010 Expiration Date: NA	Issue No. 10 - 08
Deputy Director Approval *Millicent Gomes* *Deputy Director* *Office of Criminal Justice Collaboration*	Function: [X] Information Management [ ] Quality Assurance [X] Service Delivery [ ] Fiscal [ ] Administration [ ]	Supersedes Bulletin/ADP Letter No. 10-04. This Bulletin clarifies several points made in the original.	

PURPOSE

This bulletin provides *minimum* criteria for conducting a "treatment completion" discharge in the California Outcomes Measurement System – Treatment (CalOMS-Tx). Assessment of any given client could reveal additional issues (criminal justice, risk behaviors such as needle use, health problems, or mental health issues) that must be addressed, in addition to these minimum completion criteria prior to treatment discharge. Therefore, providers are expected to include other important measures relevant to client functioning in determining treatment completion.

The completion criteria in this bulletin were developed by the Data/Outcomes Committee, which consists of representatives of the County Alcohol and Drug Program Administrators Association of California (CADPAAC), the University of California, Los Angeles' Integrated Substance Abuse Program (UCLA ISAP), and the Department of Alcohol and Drug Programs (ADP).

Treatment Completion Definition

For the purpose of consistent data reporting of treatment completion, each client must meet the minimum criteria identified in this bulletin: reduced drug use or abstinence; social support participation; and has achieved a length of stay sufficient for the client to have obtained the maximum possible benefit from participation in the treatment program. In general, a client has successfully completed treatment when these three criteria are met.

DISCUSSION

This bulletin expands on Bulletin 08-08, *Guidelines to Clarify Procedures for Collection of Admission and Discharge Data for the California Outcomes Measurement*

System – Treatment (CalOMS-Tx) by defining criteria for using the "Completed Treatment" CalOMS-Tx discharge codes under each of the following circumstances:

a. Completion of a single treatment service set where the client will be transferred to another level of treatment;

b. Completion of a single treatment service set where the client will not be transferred to another level of treatment; and

c. Completion of the last service of a treatment episode consisting of multiple planned treatment service sets where the client will not be transferred to another level of treatment due to completion of treatment goals.

Minimum Standards for Treatment Completion

The two "completed treatment" discharge status codes in CalOMS-Tx are:

- ✓ Code 1. Completed Treatment/Recovery Plan Goals – Referred
- ✓ Code 2. Completed Treatment/Recovery Plan Goals – Not Referred

The "completed treatment" discharge codes should only be used for discharging clients from the following types of services:

1. regular or intensive outpatient;
2. short-term residential;
3. long-term residential; and
4. narcotic replacement therapy(NRT)/outpatient methadone maintenance (OMM).

Detoxification does not constitute complete treatment. A successful detoxification service is measured in part by the engagement of the client in further treatment (e.g. residential or outpatient services). Providers are expected to make every effort to refer and connect clients to another level of treatment once they have completed detoxification. For clients who have gone through detoxification, as planned by the provider, and who are being referred for additional treatment services, providers must use discharge code 3 – Left Before Completion with Satisfactory Progress – Referred. Neither discharge code 1 nor discharge code 2 can be used for detoxification discharges.

Criteria for Using Discharge Code 1 – Applicable to "a" on Page 2

Discharge code 1 (complete and referred) should only be used for intensive outpatient, short-term residential, long-term residential, and NRT/OMM; code 1 should not be used for regular outpatient because regular outpatient is a less intense treatment that should occur as the client's final treatment service.

The criteria below apply to treatment completions where the client is being referred/transferred for further treatment:

1. The client reduced the number of days s/he used their primary drug from admission to discharge.

2. The client increased the number of days s/he participated in social support activities from admission to discharge.

3. The client has remained in the treatment level until s/he achieved the maximum possible benefit from that level; i.e. client is no longer benefiting from the current treatment level and will step up to a more intense level or step down to a less intense treatment level.

Criteria for using Discharge Code 2 – Applicable to "b" and "c" on Page 2

Discharge code 2 applies to these circumstances:

- The client's treatment plan only included one service type and the client has met the criteria for discharge code 2; or

- The client's treatment plan included multiple service sets, s/he is completing his/her last planned treatment service, and has met the criteria for discharge code 2.

The criteria for discharge code 2 are defined below:

1. The client has not used her/his primary drug, secondary drug, and alcohol (abstinence) in the 30 days prior to the discharge interview.

2. The client has increased the number of days s/he participated in social support activities from admission to discharge. This criterion may not always apply to discharges from NRT/OMM since such services span many years and clients may report a higher number of social support days at admission than discharge.

3. The client has remained in treatment until s/he achieved the maximum possible benefit from treatment; i.e. client is no longer in need of treatment. Research indicates that clients who remain in outpatient programs for an average of 90 days are more likely to have positive outcomes at discharge and maintain recovery. However, this does not apply to all treatment service types and some clients may realize their treatment plan goals in less than 90 days while others may require longer treatment stays.

If a regular outpatient client does not meet the minimum criteria identified for discharge code 2 then s/he should either: A) remain in the program until the completion criteria are met, or B) be referred and transferred (under a "left before completion" code) to a more intensive level of treatment such as intensive outpatient or residential.

If the criteria identified for discharge code 1 or 2 have not been met, then the discharge cannot be reported under these completion discharge codes in CalOMS-Tx. Rather, such discharges would be "left before completion" discharge codes. Refer to ADP Bulletin number 08-08 and select from discharge codes 3 to 8, whichever best reflects the circumstances under which the client was discharged from the treatment service set.

Note for clarification regarding specific funding:

A CalOMS-Tx discharge should not be reported if the funding used to provide treatment is changing and the client is continuing in the treatment service/level of care in which s/he has been enrolled. All clients should be discharged according to either the completion criteria identified in this bulletin or according to the discharge protocols provided in ADP Bulletin 08-08, whichever reflects the circumstances under which the client is being discharged.

Key Terms

A number of terms relevant to the criteria discussed in this bulletin are defined below.

Abstinence

Client ceases to use alcohol or other drugs completely. Abstinence is determined using the *primary drug frequency of use, secondary drug frequency of use,* and *alcohol use frequency* CalOMS-Tx data elements. Abstinence is achieved when the client reports zero (0) when asked the questions that correspond to each of these three data elements (refer to the CalOMS-Tx Data Collection Guide for question wording) during their discharge interview.

Abstinence and clients admitted to treatment from a controlled environment:

Clients who enter treatment from jail, prison, or some other controlled environment may report zero (0) when asked how many days they used (primary drug, secondary drug, and/or alcohol) in the thirty days preceding admission. Ask the client what his/her frequency of use was during the 30 days prior to admission; do not ask the client for frequency of use prior to entering a controlled environment. All CalOMS-Tx outcome questions must collect information about the 30 days immediately preceding the CalOMS-Tx interview. A client who reports zero (0) use days at admission meets the abstinence criteria for discharge if s/he reports zero (0) use days at the time of their discharge interview.

Reduced Alcohol and Other Drug (AOD) Use

Reduced AOD use is when the client has reduced the frequency of their primary drug use, but is not abstinent. Reduced use is to be determined using the *primary drug*

frequency of use CalOMS-Tx data element. A client has reduced use of their primary drug when the number of days they reported using their primary drug at admission to treatment is greater than the number of days they report using their primary drug at the time of their discharge interview.

Reduced Use or Abstinence and Clients who Have Prescriptions:

The criterion to either reduce AOD use or abstain from AOD use should be applied to substances the client is abusing or is addicted to. Each client's primary and secondary drug (if applicable) reported to CalOMS-Tx should be substances the client reports his/her use of as problematic. If a client is prescribed medication and is using his/her medication appropriately, then the medication should not be reported as the primary or secondary drug problem and should not be considered when determining if the client has reduced use of their primary and secondary drugs. If the client is abusing his/her prescription medication, then the prescription should be reported as the client's primary or secondary drug.

Social Support Participation

Participation in social support recovery activities means participating on one or more days in a given 30 day period in one of the following activities: twelve-step meetings, religious/faith-based recovery or self-help meetings, other self-help meetings, and/or interactions with family members or friends supportive of recovery. A client has increased participation in social support when the number of days they report participating in social support activities at admission is lower than the number of days they report participating in social support activities at the time of their discharge interview.

However, some clients enter treatment reporting a high number of days of social support participation at admission and maintain the same number of days in social support participation at discharge; other times clients report fewer days of social support at discharge. Therefore, the client has met the social support participation criterion if s/he had four or more days (weekly participation) of social support participation in the thirty days prior to their discharge.

Treatment Plan

Treatment providers are expected to develop a treatment plan based on an assessment of client needs during the treatment admission process. Every client should have a treatment plan based on his/her needs as identified from an assessment. The client should remain in treatment until s/he has achieved the maximum possible benefit from treatment; i.e. client is no longer in need of intensive treatment. The treatment plan may or may not include moving the client through various types and/or levels of treatment services. The treatment plan should include specific goals (e.g. detoxification, admission to outpatient treatment, group counseling once per week, and abstinent n days at discharge) that are necessary for the client to complete the intensive treatment

phase and move to a lower level of treatment or into recovery.

Treatment Service Set

A treatment service set is an admission to and discharge from one of the seven CalOMS-Tx service types (e.g. outpatient). A treatment service set is a component of a treatment episode.

Treatment Episode

As defined in the *CalOMS-Tx Data Collection Guide* and ADP Bulletin 08-08, a treatment episode is a planned series of treatment service sets occurring consecutively (no more than 30 days between service sets), e.g., admission to and discharge from detoxification, followed by admission to and discharge from outpatient services. However, a treatment episode may also be a single treatment service set, e.g., admission to and discharge from outpatient treatment with no further AOD treatment services planned for the client.

REFERENCES

1. ADP Bulletin 08-08: *Guidelines to Clarify Procedures for Collection of Admission and Discharge Data for the California Outcomes Measurement System – Treatment (CalOMS-Tx)*

2. CalOMS-Tx Data Collection Guide

3. CalOMS-Tx Web-Based Training http://www.adp.ca.gov/Data/wbt.shtml

4. CalOMS-Tx Data Compliance Standards

5. Treatment Improvement Protocol 45: Detoxification & Substance Abuse Treatment

QUESTIONS/MAINTENANCE

For further information related to CalOMS-Tx data collection refer to the CalOMS-Tx website through ADP's website:

1. Navigate to ADP's website: http://www.adp.ca.gov;

2. Click the green tab labeled "Data Systems" toward the top of ADP's homepage;

3. Click the "CalOMS Treatment" link, just below "Active Data Systems".

You may also contact ADP's CalOMS-Tx Help Desk by phone (toll free) at 1-877-517-3329 or at (916) 327-3010, or by e-mail at CalOMShelp@adp.ca.gov

EXHIBITS

Exhibit A: Example Scenarios for Application of CalOMS-Tx Completed Treatment Discharge Codes
Exhibit B: Frequently Asked Questions

DISTRIBUTION

County Alcohol and Drug Program Administrators
Strategic Local Government Services, LLC
Director's Advisory Council

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
1700 K STREET
SACRAMENTO, CA 95811-4037
TTY/TDD (800) 735-2929
(916) 323-8333

ADP BULLETIN

Title		Issue Date: August 16, 2011	Issue No.
Procedures for Collection of Discharge Data for the California Outcome Measurement System – Treatment (CalOMS-Tx)		Expiration Date:	11 - 10
Deputy Director Approval Millicent Gomes Deputy Director Office of Criminal Justice Collaboration	Function: [X]Information Management [ ]Quality Assurance [ ]Service Delivery [ ]Fiscal [ ]Administration [ ]	Supersedes Bulletin/ADP Letter No. ADP Bulletin 08-08 Effective September 1, 2011	

PURPOSE

This bulletin supersedes, and clarifies parts of, the Department of Alcohol and Drug programs (ADP) Bulletin 08-08 with the goal of collecting more accurate and complete discharge data. This bulletin provides CalOMS-Tx protocols for reporting both standard and administrative discharges from alcohol and other drug (AOD) treatment services to ADP. Specifically, this bulletin serves to simplify discharge Status Codes 3 through 6 for Discharge Status Data Element (DIS-2) found in Section 3.5.2 of the CalOMS Data Dictionary. (See Table 1)

DISCUSSION

The protocols in this bulletin were developed by a collaborative workgroup named the Data Outcomes Committee that consists of several county administrators representing the County Alcohol and Drug Program Administrators Association of California (CADPAAC), representatives of the University of California, Los Angeles' Integrated Substance Abuse Program (UCLA ISAP), and ADP staff.

Every treatment provider who receives funding for AOD treatment from ADP and every licensed narcotic treatment provider is required to collect CalOMS Tx data from every client served. Treatment providers must collect CalOMS-Tx data as follows:

- When a client is admitted to treatment (within seven days of their first service),
- On the one-year anniversary date of their admission (for clients in the same treatment service for one year or more), and
- When the client is discharged from the treatment service in which they have been participating.

Protocols for Discharging Clients

The following protocols clarify business rules for discharging clients from treatment in CalOMS-Tx.

1. A CalOMS-Tx discharge record must be submitted for every client for whom a CalOMS-Tx admission record has been submitted.

2. AOD treatment providers must attempt to schedule and conduct a discharge interview with every client. A discharge interview may be either in person (face-to-face) or via telephone. This interview includes, but is not limited to, asking each of the required CalOMS Tx standard discharge questions. Treatment providers are advised to include in each client's treatment plan a date to conduct a discharge interview. This date may be scheduled for some time prior to or on the client's planned last date of services, but may not be more than two weeks prior to the client's planned date of last service.

3. Providers should make every effort to ensure the discharge interview is a face-to-face interview. However, some clients may be unable to appear for the scheduled discharge interview. In these situations, providers are strongly encouraged to attempt to contact the client by phone to collect the CalOMS Tx standard discharge data.

4. Administrative discharges should only be reported in the event the client cannot be located, either in person or by telephone, to answer the CalOMS-Tx questions. Such attempts to contact a client for a CalOMS Tx discharge interview must be documented in the client's file. Providers should never guess or complete responses on behalf of an absent client for the required CalOMS-Tx discharge questions.

5. For all discharges marked "Death" (Status Code 7) or "Incarceration" (Status Code 8), report only the minimum discharge information.

Standard Discharge

Standard discharge requires a full set of questions be collected. A standard discharge must be reported when the client is interviewed by telephone or in person:

For standard discharges, providers are required to complete a full CalOMS Tx discharge record by interviewing the client and asking all of the required CalOMS Tx discharge questions as listed in Section 8.4.1 of the CalOMS-Tx Data Collection Guide. The date for a standard discharge is the date on which the client completes the CalOMS Tx discharge interview or the date of last treatment service, whichever is later.

Administrative Discharge

Administrative discharge requires a minimum set of questions be collected. An administrative discharge is reported when the client has stopped appearing for treatment services without leave from or notification to the AOD treatment program and the client cannot be located to be discharged and complete the CalOMS-Tx discharge interview. This circumstance should never occur for

discharges marked "completed treatment goals" (Completed Treatment, Referred and Completed Treatment, Not Referred).

For all administrative discharges the provider is required to complete the Administrative Discharge questions as listed in Section 8.5.3 of the CalOMS-Tx Data Collection Guide.

Simplification of Status Codes

In order to simplify the process and increase the accuracy of discharge data, ADP is removing any reference to client *referral* from the description of discharge Status Codes 3 through 6.

Status Codes 3 through 6 are used when the patient does *not complete treatment.*

- Treatment Status Codes 3 or 5 are to be used for a standard discharge where the provider is able to do an interview with the patient.
- Treatment Status Codes 4 or 6 are to be used only for administrative discharges when a patient interview is not possible.

Below is a list of the discharge Status Codes along with the new, simplified description for Status Codes 3 through 6. The descriptions for Status Codes 1, 2, 7 and 8 have not changed.

Table 1

Status Code	Previous Description	New Description
1	Completed Treatment / Recovery Plan Goals/ Referred/Standard (all questions)	Completed Treatment / Recovery Plan Goals/ *Referred*/**Standard** (all questions)
2	Completed Treatment / Recovery Plan Goals/ Not Referred/Standard (all questions)	Completed Treatment / Recovery Plan Goals/*Not Referred*/**Standard** (all questions)
3	Left Before Completion with Satisfactory Progress/Referred/Standard (all questions)	Left Before Completion with Satisfactory Progress/ **Standard** (all questions)
4	Left Before Completion with Satisfactory Progress/ Not Referred/Administrative (minimum questions)	Left Before Completion with Satisfactory Progress /**Administrative** *(minimum questions)*
5	Left Before Completion with Unsatisfactory Progress/Referred/Standard (all questions)	Left Before Completion with Unsatisfactory Progress /**Standard** (all questions)
6	Left Before Completion with Unsatisfactory Progress/Not Referred/Administrative (minimum questions)	Left Before Completion with Unsatisfactory Progress/**Administrative** *(minimum questions)*
7	Death/Administrative *(minimum questions)*	No change to description.
8	Incarceration/Administrative *(minimum questions)*	No change to description.

CONCLUSION

The discharge data are used to measure treatment outcomes for reporting purposes at the county, state, and federal levels. In addition, it is critical that counties and treatment providers collect accurate and complete client outcome data at discharge to continually improve the quality of services.

REFERENCES

CalOMS-Tx Data Collection Guide
CalOMS-Tx Data Compliance Standards

Refer to the *CalOMS Treatment Data Collection Guide* for detailed descriptions of data collection requirements. The *CalOMS Treatment Data Collection Guide* is on the ADP web site: http://www.adp.ca.gov/CalOMS/pdf/CalOMS_Data_Collection_Guide.pdf.

QUESTIONS/MAINTENANCE

Counties are encouraged to conduct provider trainings on how to implement discharge codes properly and on discharge interviewing methods, e.g., strategies to successfully complete the exit interview. UCLA's Addiction Technology Transfer Center (ATTC) can be utilized by counties as a resource to train providers on discharge interview protocols. In addition, a variety of CalOMS-Tx training materials are available on-line via the ADP web site.

For further information related to CalOMS-Tx data collection refer to the CalOMS web site through the ADP web site:

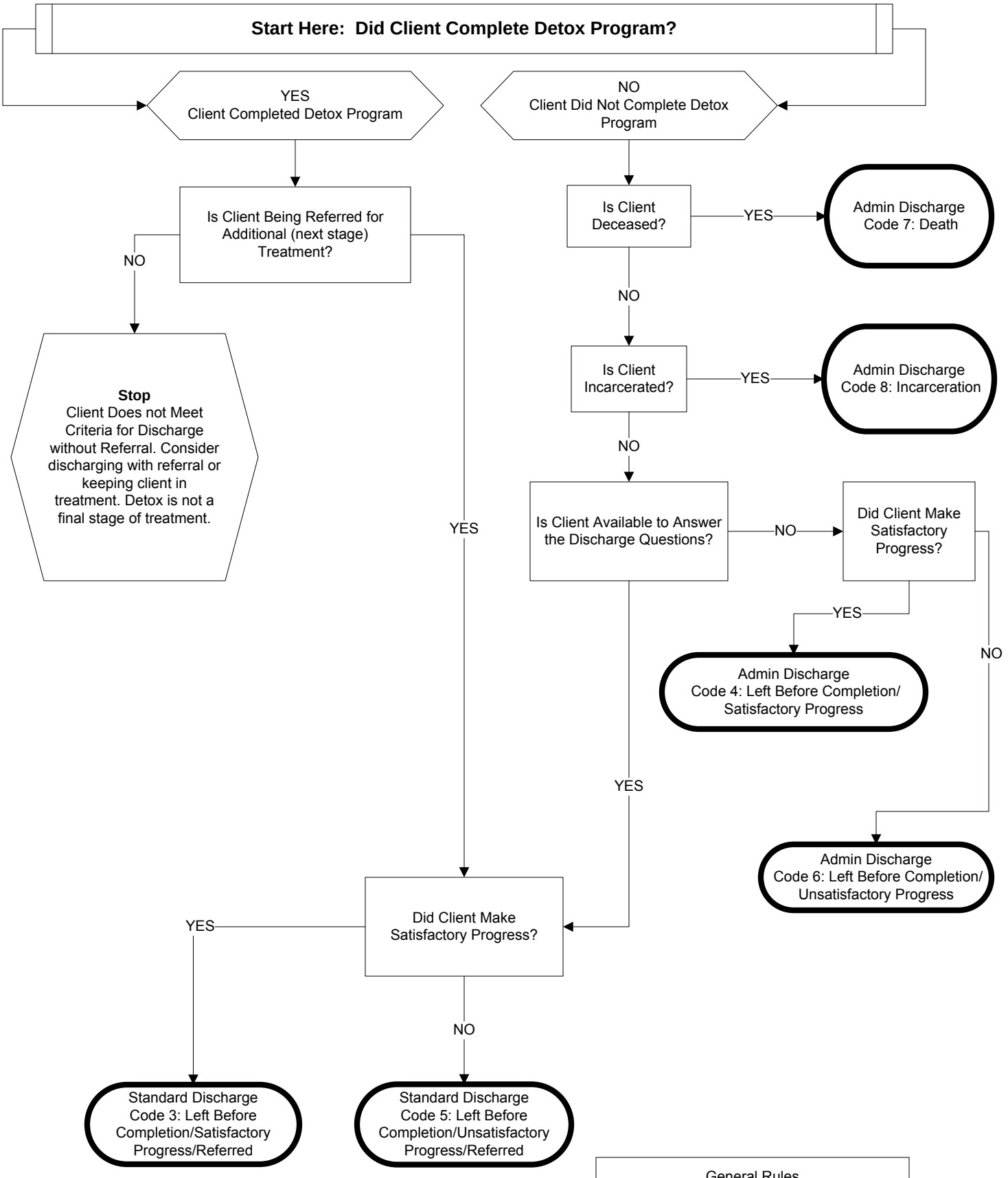
1. Navigate to ADP's web site: http://www.adp.ca.gov.
2. Click the green tab labeled "Data Systems" toward the top of ADP's homepage.
3. Click the "CalOMS Treatment" link, just below "Active Data Systems".

You may also contact the ADP CalOMS Tx Help Desk by phone (toll free): 1-877-517-3329, or at (916) 327-3010, or by e-mail at CalOMShelp@adp.ca.gov.

DISTRIBUTION

County Alcohol and Drug Program Administrators
Strategic Local Government Services, LLC
Director's Advisory Council

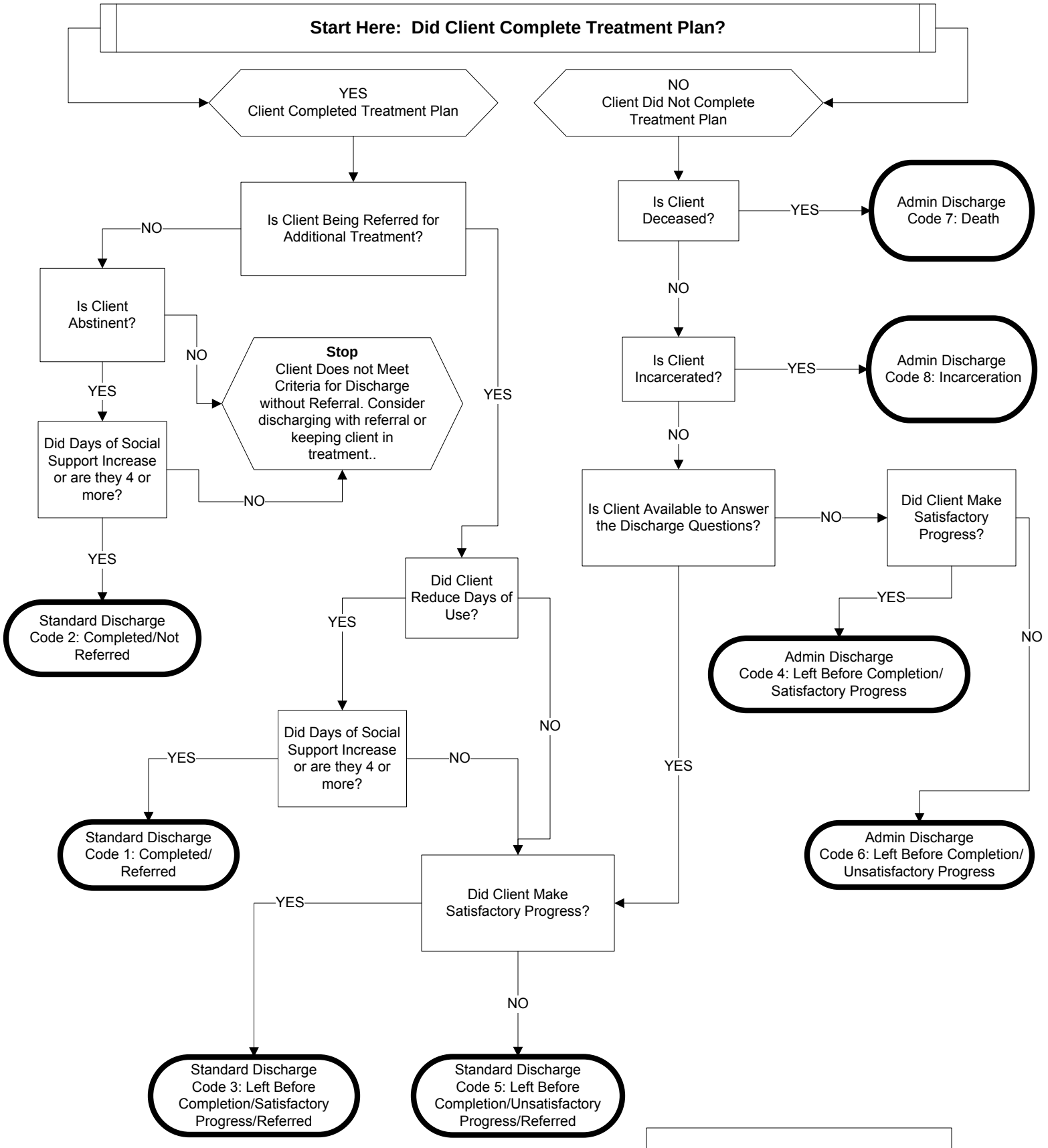
Determining CalOMS Discharge Codes: Detox Programs



General Rules

- Date of Discharge MUST BE Date of LAST FACE to FACE Service
- Do Not Use Discharge Code 1 or 2 for Detox Clients
- Refer Clients for Further Treatment Whenever Appropriate as Detox does not constitute treatment completion.

Determining CalOMS Discharge Codes: Non-Detox Programs



General Rules

- Date of Discharge MUST BE Date of LAST FACE to FACE Service
- Do Not Use Discharge Code 1 for Regular Outpatient Clients
- Refer Clients for Further Treatment Whenever Appropriate

Provider Name

Location Address: Address, City, State, Zip Code	Remit To Address: Address, City, State, Zip Code

License Number

Date: XX/XX/XXXX

Invoice No.: XXXXX

Riverside Universal Health System
Behavioral Health
Invoice Processing Unit
P.O. Box 7549
Riverside, CA 92503

RE: Contract No. : MHARC-XXXXX-XXX-06/17
Vendor Code: 0000XXXXX

Date Range: XX/XX/XXXX-XX/XX/XXXX

Dept. ID: 4100XXXXXX-XXXXX-XXXXXX

RU No. 33XXXX

TOTAL FOR RU NO. 33XXXX …… $

TOTAL INVOICE FOR *MONTH 2016*…….. $

Approval Signature & Date: _____

Print Name:

Contact Phone #: XXX-XXX-XXXX

Riverside University HEALTH SYSTEM Behavioral Health

Substance Abuse Prevention and Treatment Program

Procedure Code Manual

Effective: 02/01/2017

TABLE OF CONTENTS

SECTIONS:

PRIMARY PREVENTION

(ASAM: LEVEL 0.5 Early Intervention) = PRIMARY

Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-related disorder.
Screening, Brief Intervention, and Referral to Treatment (as needed).

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
861	Education	No	Practitioner	Indirect	20/13	1/600 FNL: 1/1440

This strategy involves two-way communication. Interaction between the educator/counselor and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, critical analysis (e.g., of media messages) and systematic judgment abilities. Example of activities conducted and method used for this strategy include, but are not limited to, the following:

* Classroom and/or small group sessions (all ages).
* Parenting and family management classes.
* Peer leader helper programs.
* Education programs for youth groups.
* Children of substance abuser.
* Waiting list group.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
862	Information Dissemination	No	Practitioner	Indirect	20/12	1/600

This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. This strategy is characterized by one-way communication from the Counselor to the audience, with limited contact between the two.

Examples of activities conducted and methods used for this strategy include, but are not limited to the following:

a. Clearinghouse/information resource centers.
b. Resource directories
c. Media campaigns
d. Brochures.
e. Radio/TV public service announcements.
f. Speaking engagements.
g. Health fairs/health promotion.
h. Information lines
i. Information calls from citizens.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
863	Problem Identification and Referral	No	Practitioner	Indirect	20/15	1/600

This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include, but are not limited to the following:

a. Employee assistance programs
b. Student assistance programs

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
864	Community Based Process	No	Practitioner	Indirect	20/16	1/600

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and working. Examples of activities conducted and methods used include, but are not limited to, the following:

* Community and volunteer training, e.g., neighborhood action training, training of key people in the system, staff/official training.
* Systematic planning.
* Multi agency coordination and collaboration.
* Accessing services and funding.
* Community team building.
* Capacity building training and activities.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
865	Alternatives	No	Practitioner	Indirect	20/14	1/600

This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and would, therefore, minimize or obviate resorting to the latter. Examples of activities conducted and methods used for this strategy include (but not limited to) the following:
a. Drug Free Dances and Parties;
b. Youth/Adult Leadership activities;
c. Community Drop-In Center, and;
d. Community Service Activities

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
866	Environmental	No	Practitioner	Indirect	20/17	1/600

This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy can be divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives. Examples of activities conducted and methods used for this strategy shall include, but not be limited to, the following:

a. Promoting the establishment and review of alcohol, tobacco and drug use policies in schools;
b. Technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use;
c. Modify alcohol and tobacco advertising practices; and
d. Product pricing strategies.

SECONDARY PREVENTION

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA805	Perinatal Outreach	No	Practitioner	Indirect	90/22	5/600

Those activities involved in identifying and encouraging eligible pregnant and parenting women in need of treatment services to take advantage of these services. This activity is also a means to make members of the professional community aware of perinatal services so that they become referral sources for potential consumers.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA880	Early Intervention	No	Practitioner	Indirect	30/18	1/600

This strategy is designed to come between a substance abuser and his/her actions in order to modify behavior. It includes a wide spectrum of activities, crisis counseling of non-consumer, user education to formal intervention and referral to appropriate treatment/recovery services. This code is used by County Providers and Contract Providers.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
882	Outreach / Intervention	No	Both	Indirect	30/19	1/600

Activities for the purpose of encouraging those individuals in need of treatment to undergo such treatment.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
883	California Mentor Initiative (CMI)	No	Both	Indirect	30/24	1/600

The CMI is designed to enhance and expand mentor service programs across the state. For the purposes of CMI, mentoring is defined as a relationship over a prolonged period of time between two or more people, where older, wiser, more experienced individuals provide constant, as needed support, guidance and concrete help to younger at-risk persons as they go through life. An “at-risk” youth is an individual under 19 years of age whose environment increases his/her chance of becoming a teen parent, school dropout, gang member, or user of alcohol or drugs.

OUTPATIENT SERVICES

(ASAM: Level 1, Outpatient Services)

Less than 9 hours of service/week (adult); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA421IND	Individual Counseling ODF				40/34	
	SA421INDP	Individual Counseling ODF (PERI)				90/34	
	SA421INDY	Individual Counseling ODF (Youth)				40/34	
POST	SA421INDPY	Individual Counseling ODF (P-Yth)	Yes	Both	Direct	90/34	1/120
PRE	SA421; SA421PERI; SA421YT; SA442; SA442PERI; SA442YT; SA443; SA443PERI; SA443YT; SA444; SA444PERI; SA444YT; SA445; SA445PERI; SA445YT; SA450; SA450PERI; SA450YT						

INTAKE: The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment. (STC: : Section 131, Part " a")

TREATMENT PLAN: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan. The treatment plan shall include:

a. A statement of problems to be addressed;

b. Goals to be reached which address each problem;

c. Action steps which will be taken by the provider and/or beneficiary to accomplish identified goals;

d. Target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to the be provided and the frequency thereof;

e. Treatment plans have specific quantifiable goal/treatment objectives related the beneficiary's substance use disorder diagnosis and multidimensional assessment;

f. The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration;

g. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director or LPHA. (STC: Section 131, Part "i")

CRISIS INTERVENTION: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation. (STC: Section 131, Part "h")

INDIVIDUAL COUNSELING: Contacts between a beneficiary 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. May include the following services: :

- Patient Education
- General Individual Counseling (STC: Section 131, Sections "b", "e", and "f")

COLLATERAL: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary. (STC: Part 131, Section "g")

DISCHARGE PLANNING: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. (STC: Part 131, Section "j")

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA440GRP	Group ODF				40/33	
	SA440GRPP	Group ODF (PERI)				90/33	
	SA440GRPY	Group ODF (Youth)				40/33	
POST	SA440GRPPY	Group ODF (P-Yth)	Yes	Both	Direct	90/33	1/120
PRE	SA440; SA440PERI; SA440YT; SA446; SA446PERI; SA446YT; SA447; SA447PERI; SA447YT						

Face-to-Face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in group, focusing on the needs of the individuals served. (STC: Section 131, Part "c")

PATIENT EDUCATION - Provide research based education on addiction, treatment, recovery and associated health risks. (STC: Part 131, Section "e").

FAMILY THERAPY - The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery as well as their own recovery can be conveyed. Family members can provide social support to the patient. help motivate their loved ones to remain in treatment, and receive help and support for their own family recovery as well. (STC: Past 131, Section "d")

INTENSIVE OUTPATIENT SERVICES

(ASAM: Level 2.1, Intensive Outpatient)

9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA220GRP	Group IOT				40/30	
	SA220GRPP	Group IOT (PERI)				90/30	
	SA220GRPY	Group IOT (Youth)				40/30	1/240 (Adult)
POST	SA220GRPPY	Group IOT (P-Yth)	Yes	Both	Direct	90/30	1/180 (Adol)
PRE	SA220; SA220PERI						

Face-to-face contacts in which one or more therapists or counselors treat clients in an group setting. Structured programming services are provided to beneficiaries at a minimum of 9 hours per week for adults and 6 hours per week for adolescents, with a maximum of 19 hours per week for both populations. Services may include the following:

- Group Counseling
- Patient Education
- Family Therapy (STC, Section 132)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA221IND	Individual Counseling IOT				40/30	
	SA221INDP	Individual Counseling IOT (PERI)				90/30	
	SA221INDY	Individual Counseling IOT (Youth)				40/30	
POST	SA221INDPY	Individual Counseling IOT (P-Yth)	Yes	Both	Direct	90/30	1/120
PRE	SA221; SA221PERI						

Contacts between a beneficiary and a therapist or counselor. Services can be provided in-person, by telephone or by telehealth. Services feature a minimum of 9 hours per week for adults and 6 hours per week for adolescents, with a maximum of 19 hours per week for both populations as specified by the patient's treatment plan . This includes the following services:

* Intake
* Individual Counseling
* Patient Education
* Family Therapy
* Collateral Services
* Crisis Intervention Services
* Treatment Planning
* Discharge Services (STC: Section 132)

OPIOID TREATMENT SERVICES (NTP)

(ASAM: Level 1, Opioid Treatment Programs) = NTP

Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA440NTPW	Group NTP				50/46	
	SA440NTPP	Group NTP (PERI)				90/46	
	SA440NTPY	Group NTP (Youth)				50/46	
POST	SA440NTPPY	Group NTP (P-Yth)	Yes	Both	Direct	90/46	10/200
PRE	SA440NTP						

Face-to-Face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in group, focusing on the needs of the individuals served. Services are provided in NTP licensed facilities. A patient must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity. (STC: Section 136)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA441NTPW	Individual Counseling NTP				50/47	
	SA441NTPP	Individual Counseling NTP (PERI)				90/47	
	SA441NTPY	Individual Counseling NTP (Youth)				50/47	
POST	SA441NTPPY	Individual Counseling NTP (P-Yth)	Yes	Both	Direct	90/47	10/200
PRE	SA441NTP						

Contacts between a beneficiary and a therapist or counselor. Services may be provided in-person, by telephone or by telehealth. Services are provided in a licensed NTP facility. A patient must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity. Services may include the following:

- Intake
- General Individual Counseling
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Medical Psychopharmacology
- Discharge Services (STC: Section 136)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA521NTPW	Dosing NTP				50/40	
	SA521NTPP	Dosing NTP (PERI)				90/40	
	SA521NTPY	Dosing NTP (Youth)				50/40	1-Unit
POST	SA521NTPPY	Dosing NTP (P-Yth)	Yes	Both	Direct	90/40	(Contact)
PRE	SA521NTP						

DMC-ODS Required MAT: Client dosing with methadone in an NTP licensed facility (STC: Section 136).

MEDICATION ASSISTED TREATMENT SERVICES (MAT)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA521MAT	Medication Assist Tx Non-NTP				40/36	
	SA521MATP	Medication Assist Tx Non-NTP (PERI)				90/36	
POST	SA521MATY	Medication Assist Tx Non-NTP (Youth)				40/36	
(NEW)	SA521MATPY	Medication Assist Tx Non-NTP (P-Yth)	Yes	Both	Direct	90/36	1/240

If a beneficiary receives any DMC services in a non-NTP setting, a physician working at the program may also prescribe MAT
The components of Additional MAT Includes:
a. The ordering, prescribing, administering, and monitoring of MAT
b. The use of FDA approved medications
c. Utilization of long-acting injectable naltrexone at DMC facilities
d. County proposed interim rates for additional MAT in residential and outpatient settings

Medication Assisted Treatment (MAT) is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of substance use disorders (SUD). Research shows that a combination of MAT and behavioral therapies is a successful method to treat SUD.

WITHDRAWAL MANAGEMENT SERVICES (DETOX)

(ASAM: Level 3.2-WM, Residential / Inpatient Withdrawal Management Monitoring)

Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA110DTX	Detox Inpatient					
	SA110DTXP	Detox Inpatient (PERI)					
	SA110DTXY	Detox Inpatient (Youth)					
POST	SA110DTXPY	Detox Inpatient (P-Yth)	Yes	Both	Direct	60/50	1440
PRE	SA110						

Clinically Managed Residential Withdrawal Management (sometimes referred to as “social setting detoxification”) is an organized service that may be delivered by appropriately trained staff who provide 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. Services are provided in a free-standing or integrated, appropriately licensed residential facility. Each beneficiary will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized treatment plan prescribed by a licensed physician. The components of withdrawal management services include:

- Intake
- Observation
- Medication Services
- Discharge Services (STC: Section 135)

RESIDENTIAL SERVICES

(ASAM: Level 3.1, Clinically Managed Low-Intensity Residential)
24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.

(ASAM: Level 3.3, Clinically Managed Population Specific High-Intensity Residential)
24-hour care with trained counselors to stabilize multidimensional imminent danger.
Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment. (Note: this level is not designated for adolescents).

(ASAM: Level 3.5, Clinically Managed High-Intensity Residential)
24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA210RES	Residential				60/51	
	SA210RESP	Residential (PERI)				90/51	
	SA210RESY	Residential (Youth)				60/51	
POST	SA210RESPY	Residential (P-Yth)	Yes	Both	Direct	60/51	1440
PRE	SA210						

Level 3.1: Clinically Managed Low-Intensity Residential treatment is a non-institutional, 24-hour non-medical, short term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis. Available to perinatal, non-perinatal, and adolescent beneficiaries. Has a 24-hour structure with available trained personnel. It offers a minimum of 5 hours of clinical service per week and preparation for transition to outpatient treatment.

Level 3.3: Clinically Managed Population Specific High-Intensity Residential treatment is a non-institutional, 24-hour non-medical, short term residential program that provides high intensity clinical services to beneficiaries with a substance use disorder diagnosis who also have severe cognitive deficiencies. Offers 24-hour care with trained counselors to stabilize multidimensional imminent danger. A less intense milieu and group treatment is offered for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for transition to outpatient treatment. This level is not intended for adolescent beneficiaries. This level provides a range of cognitive, behavioral and other therapies adapted to the patient's developmental stage and level of comprehension. The level provides daily scheduled professional addiction and mental health treatment.

Level 3.5: Clinically Managed High-Intensity Residential Services are offered in a 24-hour structured living environment with high-intensity clinical services for individuals who have multiple challenges to recovery and require a safe, stable recovery environment combined with a high level of treatment services. Provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for transition to outpatient treatment. Consumers receiving this level of care are able to tolerate and use the full milieu of the therapeutic community. Patients typically have multiple challenges in addition to addiction (trauma history, criminal/legal issues, psychological problems, etc). Services are available for perinatal, non-perinatal, and adolescent beneficiaries (NOTE: for adolescents, this is considered a Medium-Intensity service). The level provides daily scheduled professional addiction and mental health treatment designed to improve the patient's ability to structure and organize tasks of daily living and recovery.

The components of Residential Treatment services include the following:

- Intake
- Individual and Group Counseling
- Patient Education
- Family Therapy
- Safeguarding Medications
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Transportation Services
- Discharge Services

ROOM AND BOARD						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA190RAB	Room and Board					
SA190RABP	Room and Board (PERI)					
SA190RABY	Room and Board (Youth)					
SA190RABPY	Room and Board (P-Yth)	No	Both	Direct	90/60	1440
This services includes the cost for providing room and board at a residential facility or in a hospital setting to beneficiaries receiving residential withdrawal management (detoxification) or residential treatment services.						

POST (NEW)

PHYSICIAN / LPHA / CLINICAL THERAPIST SERVICES

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA600MDC	Physician Consultation MD-to-MD					
	SA600MDCP	Physician Consultation MD-to-MD (PERI)					
POST	SA600MDCY	Physician Consultation MD-to-MD (Youth)					
(NEW)	SA600MDCPY	Physician Consultation MD-to-MD (P-Yth)	Yes	Both	Direct	70/61	1/60

Physician consultation services include DMC physicians' consulting with addiction medicine physicians, addictions psychiatrists or clinical pharmacists. Consultations are to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. Physician consultation services can only be billed by and reimbursed to DMC providers.

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA602DX	Diagnosis Review				70/68	
	SA602DXP	Diagnosis Review (PERI)				90/68	
POST	SA602DXY	Diagnosis Review (Youth)				70/68	
(NEW)	SA602DXPY	Diagnosis Review (P-Yth)	No	Both	Direct	90/68	1/90

The review of the beneficiary diagnosis by LPHA in order to establish medical necessity of treatment This includes the review of intake report, review of diagnosis by counselor, and review of Medical Necessity note.

CASE MANAGEMENT SERVICES

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA468CM	Case Management				70/68	
	SA468CMP	Case Management (PERI)				90/68	
	SA468CMY	Case Management (Youth)				70/68	
POST	SA468CMPY	Case Management (P-Yth)	Yes	Both	Direct	90/68	1/60
	SA368RSCM	Case Management RS				70/68	
	SA368RSCMP	Case Management RS (PERI)				90/68	
POST	SA368RSCMY	Case Management RS (Youth)				70/68	
(NEW)	SA368RSCPY	Case Management RS (P-Yth)	Yes	Both	Direct	90/68	1/60
PRE	SA468; SA468PERI; SA468YT						

A service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
Case Management Services include:
* Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management services
* Transition to a higher or lower level of substance use disorder (SUD) care
* Development and periodic revision of a client plan that includes service activities
* Communication, coordination, referral, and related activities
* Monitoring service delivery to ensure beneficiary access to service and the service delivery system
* Monitoring the beneficiary's progress
* Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services
* Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California Law

NOTE: Recovery Service episodes require the use of the SA368 (Series). All other Levels of Care use SA468 (Series)

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA445INB	Non-Billable Case Mngt				70/68	
	SA445INBP	Non-Billable Case Mngt (PERI)				90/68	
POST	SA445INBY	Non-Billable Case Mngt (Youth)				70/68	
(NEW)	SA445INBPY	Non-Billable Case Mngt (P-Yth)	Yes	Both	Direct	90/68	1/60

Case Management Services include:
* Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management services
* Transition to a higher or lower level of substance use disorder (SUD) care
* Development and periodic revision of a client plan that includes service activities
* Communication, coordination, referral, and related activities
* Monitoring service delivery to ensure beneficiary access to service and the service delivery system
* Monitoring the beneficiary's progress
* Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services
* Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California Law

NOTE: Any SA468 (series) or SA368 (series) must be converted to a non-billable SA445 (equivalent series) when it is after the last face-to-face session. This is reviewed and edited (if applicable) when closing a non-present consumer chart, and the discharge date needs to be backdated to the last face-to-face session.

TESTING						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA475TEST	Testing				40/34	
SA475TESTP	Testing (PERI)				90/34	
SA475TESTY	Testing (Youth)				40/34	
POST SA475TSTPY	Testing (P-Yth)	No	Both	Direct	90/34	1/15
PRE	SA473; SA473PERI; SA473YT; SA474; SA474PERI; Sa474YT; SA475; SA475PERI; SA475YT; SA476; SA476PERI; SA476YT					
Services that include the use of substance use screening testing to determine whether or not a consumer has been using substances. **NOTE:** In an ODF Level of Care only.						

NO SHOW & EXCUSED ABSENCE

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
POST	SA400NS	No Show	No	Both	Direct	40/34	0/15
PRE	SA400; SA400PERI; SA200; SA200PERI						
	Services that a consumer has been scheduled to receive but does not physically show up to receive, nor call to cancel. **NOTE:** Can be used across all Levels of Care.						

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
POST	SA401EA	Excused Absence	No	Both	Direct	40/34	0/15
PRE	SA401; SA401PERI; SA201; SA201PERI						
	Services that a consumer has been scheduled to receive but does not physically show up to receive and calls with valid excuse for cancellation. **NOTE:** Can be used across all Levels of Care.						

RECOVERY SERVICES

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA321RSIN	Individual Counseling RS				42/34	
	SA321RSINP	Individual Counseling RS (PERI)				92/34	
	SA321RSINY	Individual Counseling RS (Youth)				42/34	
POST	SA321RSIPY	Individual Counseling RS (P-Yth)	Yes	Both	Direct	92/34	1/60
PRE	SA428						
	One-on-one contacts in which a beneficiary meets with a therapist or counselor to help stabilize the beneficiary and reassess if further care is needed. (Follow Outpatient Individual Guidelines)						

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA322RSGR	Group RS				42/33	
	SA322RSGRP	Group RS (PERI)				92/33	
	SA322RSGRY	Group RS (Youth)				42/33	
POST	SA322RSGPY	Group RS (P-Yth)	Yes	Both	Direct	92/33	1/90
PRE	SA448						
	Face-to-Face contacts in which one or more therapists or counselors meet with two or more clients at the same time to assist the beneficiary and reassess if further care is needed. (Follow Outpatient Group Guidelines)						

	CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
	SA323RSSP	Support Services RS				42/32	
	SA323RSSPP	Support Services RS (PERI)				92/32	
POST	SA323RSSPY	Support Services RS (Youth)				42/32	
(NEW)	SA323RSPPY	Support Services RS (P-Yth)	Yes	Both	Direct	92/32	1/120

Recovery support services are designed to emphasize the beneficiary's central role in managing their health, promote the use of effective self-management support strategies, and provide internal and community resources to support ongoing self-management. The components of recovery services include the following:

* Recovery Monitoring, including recovery coaching and monitoring via telephone/telehealth
* Substance Abuse Assistance, including peer-to-peer services and relapse prevention
* Support for Education and Job Skills, such as linkages to life skills, employment services, job training, and education services
* Family Support, such as 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, such as linkages to housing assistance, transportation, and case management

STAFF TIME (Indirect Services)

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA706	SU Documentation	No	Practitioner	Indirect	10/00	1/30

To be used for charting of consumer service, case management activity, or clinical reviews in the consumer chart that is not already part of the original service time. For example; A group service of 90 minutes and documentation time of 30 minutes for those 12 individuals that were in group.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA707	General Administration	No	Practitioner	Indirect	10/00	1/600

Staff meetings, supervisory meeting, and general supervision of staff including supervision of intern and students. Grant writing for federal funding and monthly reports. Riverside University Health System health promotion activities for County employees (blood drive, United Way). Morning and afternoon breaks (one half hour minimum per day in 15 min increments for all staff). Travel and paperwork associated with these activities.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA708	Paid and Unpaid Time Off	No	Practitioner	Indirect	10/00	1/600

All time used for all types of paid or unpaid leave, i.e., vacation, extra vacation, sick leave, comp time, jury duty, holiday leave, voting time, military leave, industrial injury, bereavement, AWOP, etc.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA709	Other Activities	No	Practitioner	Indirect	45/00	1/600

Other activities can include, but are not limited to the following:

* Information Calls (non-consumer based)
* Resource Calls (non-consumer based)
* Phone Calls for inactive/closed consumers (that does not fall under the Early Intervention criteria)
* Tracking of previously unzipped time not accounted for and where the staff is unable to verify what was rendered (plug time).
* Drive time (transportation, covering for MOMs transporting, etc.)

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA711	SU Screening	No	Practitioner	Indirect	45/00	1/60

Used to document consumer contact (in person or by phone) time spent screening and assessing ASAM level of care for potential prevention and treatment participants who do not have a current active episode in a SU Program.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA712	SU Case Management	No	Practitioner	Indirect	70/68	1/

Case management with consumer prior to entry or outside a treatment episode.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA719	AB109 Case Management	No	Practitioner	Indirect	70/88	1/

Used to document time spent in case management for AB109 participants. As well as direct services with AB109 participants who do not have a current active episode in a SU Program.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA720	AB109 Screening	No	Practitioner	Indirect	45/00	1/60

Used to document time spent in case managing duties for AB109 participants, screening and assessment. As well as direct services with AB109 participants who do not have a current active episode in a SU Program.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA760	Staff Training Received	No	Practitioner	Indirect	10/00	1/600

All training received by staff, literature reviews, etc.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA907	Clinical Supervision	No	Practitioner	Indirect		1/

Clinical supervision of unlicensed clinical therapists by licensed clinical therapists.

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
NEW SAPLCHLD	Appointment Placeholder	No	Practitioner	Indirect	N/A	N/A

Service Code designated to be utilized as a placeholder in the Scheduling Calendar as an appointment slot for scheduling availability and/or appointment assignment of a non-registered consumer.

NOTE: This service code is only utilized as a placeholder and MUST be overridden and NEVER posted. If posted in error edit or delete the SAPLCHLD service code in CalPM.

DRINKING DRIVER PROGRAM (DDP)

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA438	AB762 Initial Intake Assessment		Practitioner	Indirect	80/90	60 – 90
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA454	Group Orientation/Initial Structuring Group		Practitioner	Indirect	80/90	30 – 90
Face to Face contact in which one or more counselors orient identified consumers at the same time, focusing on short term behaviors and responsibilities of the consumer in order for a successful completion of court ordered DUI requirements.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA455	Group Orientation/Initial Structuring Group		Practitioner	Indirect	80/90	90 – 240
Face to Face contact in which one or more counselors orient identified consumers at the same time, focusing on short term behaviors and responsibilities of the consumer in order for a successful completion of court ordered DUI requirements. Group Orientation is at a higher level and more in-depth process due to consumers convicted of multiple DUI.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA456	Initial Structuring Individual		Practitioner	Indirect	80/90	15 – 60
Face to Face contact between a consumer and counselor focusing on treatment needs of the individual served.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA457	Restructure		Practitioner	Indirect	80/90	15 – 60
Face to Face contact between a consumer and counselor focusing on treatment needs of the individual due to DUI program termination. This service entails more in-depth case management in order to determine whether a higher level of service may be required and or may require a return to court of jurisdiction due to improper behavior.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA458	Reinstatement		Practitioner	Indirect	80/90	15 – 60
Face to Face contact between a consumer and counselor focusing on treatment needs of the individual whom has previously been sent back to court of jurisdiction and re-referred by the courts for continuing DUI case management services.						

DRIVING UNDER the INFLUENCE (DUI) & PC1000

CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA410	No Show/Absence DUI/PC1000		Practitioner	Indirect	80/90	5
A service that the consumer has been scheduled to receive but does not physically show up to receive.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA411	AB541 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA412	AB1353 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA413	SB38 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA414	AB1176 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the DUI: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA415	DUI Group Counseling		Practitioner	Indirect	80/90	150
Face to Face contact in which one or more counselors treat identified consumers at the same time, focusing on short term personal, family, job/school, and other problems and their relationship to DUI related behavior.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA416	DUI Educational Group Counseling		Practitioner	Indirect	80/90	150
The delivery of information on issues pertinent to DUI educational strategies in a group setting as a lecture without therapeutic interaction.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA417	SB38 DUI Phase II Educational Group Counseling		Practitioner	Indirect	80/90	90
Face to Face contact in which one or more counselors treat identified consumers at the same time, focusing on short term personal, family, job/school, and other problems and their relationship to DUI related behavior.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA418	DUI Individual Face to Face Counseling		Practitioner	Indirect	80/90	15
Face to Face contact between the consumer and counselor focusing on treatment needs of the individual served.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA419	DUI Breathalyzer/Urinalysis Test		Practitioner	Indirect	80/90	5
Services that include the use of breathalyzer or urinalysis test to determine if the consumer is under the influence of a mind-altering substance.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA430	DUI/PC1000 Transfer of Program/Provider		Practitioner	Indirect	80/90	15
The process of transferring a consumer to a different provider for continuing services or a modality change.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA431	PC1000 Initial Intake Assessment		Practitioner	Indirect	80/90	60
The evaluation or analysis of the behavioral cause of the Deferred Entry of Judgment Drug Diversion program: This includes intake and evaluation of educational needs.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA432	PC 1000 Group Counseling		Practitioner	Indirect	80/90	150
Face to Face contact in which one or more counselors treat identified consumers at the same time, focusing on short term personal, family, job/school, and other problems and their relationship to DUI related behavior.						

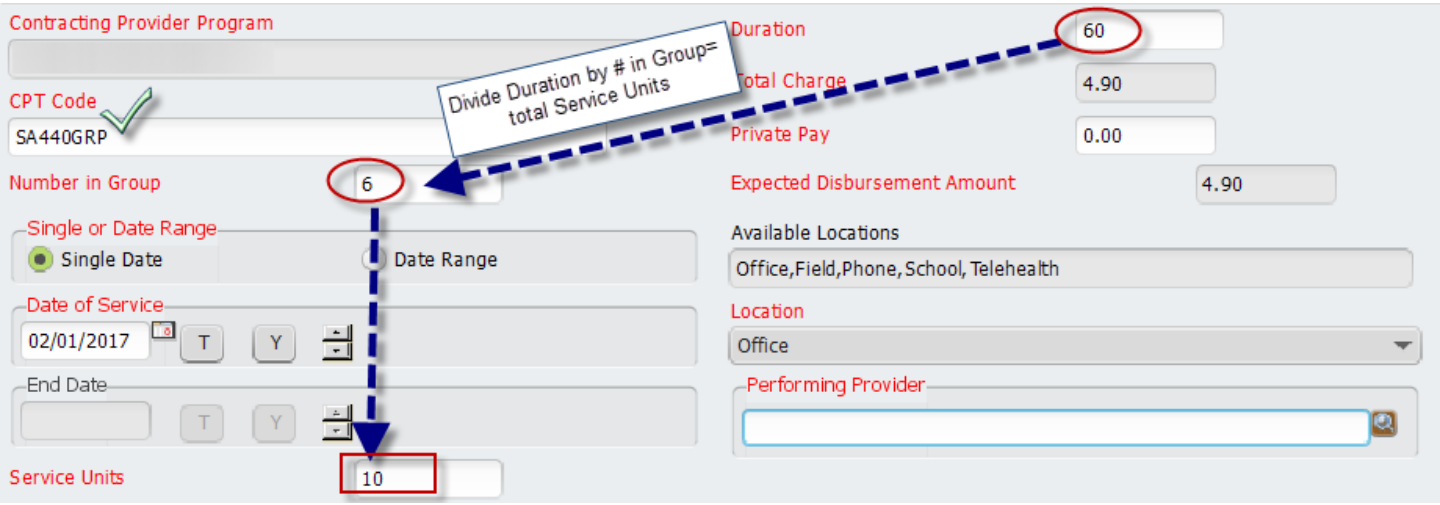
CODE	CODE NAME	DMC Billable	PRACTITIONER / CONSUMER / BOTH	DIRECT / INDIRECT	MODE / SFC	DURATION
SA433	PC 1000 Educational Group Counseling		Practitioner	Indirect	80/90	150
This group focuses on the delivery of information on issues pertinent to DUI educational strategies in a group setting as a lecture without therapeutic interaction.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA434	PC 1000 Individual Face to Face Counseling		Practitioner	Indirect	80/90	30
Face to Face contact between a consumer and counselor focusing on treatment needs of the individual served.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA435	PC 1000 Exit Interview		Practitioner	Indirect	80/90	30
Face to Face service between consumer and counselor focusing on reinforcing newly developed recovery. Skills and development of a plan to maintain those skills upon completion of Deferred Entry of Judgment program.						
CODE	**CODE NAME**	**DMC Billable**	**PRACTITIONER / CONSUMER / BOTH**	**DIRECT / INDIRECT**	**MODE / SFC**	**DURATION**
SA437	Reinstatement of DUI/PC1000 Program Consumer		Practitioner	Indirect	80/90	5
The process of reinstating the consumer back into program services following program termination. *Consumers cannot be reinstated if out of the program for two years or more, and will be assigned new initial intake assessment.						

Contracted Providers ODF and IOT Group Service Entry Instructions

When entering units for ODF or IOT group services, the following formula must be applied:

Number of minutes for the group divided by Number of beneficiaries= Total units per beneficiary.
Example: 60 minute group/6 beneficiaries = 10 units per beneficiary (Formula: 60/6=10)
The duration will stay the same for all beneficiaries in the group.

Using example and formula above, when entering services in ELMR each consumer entry would note UNITS=10 and DURATION=60:



The units must be entered as whole numbers; in some cases calculation will need to be rounded.
Example: 60 minute group/11 beneficiaries = 5.45 units per beneficiary- MUST be rounded to 5 units per beneficiary.
Example: 60 minute group/9 beneficiaries= 6.66 units per beneficiary- MUST be rounded to 7 units per beneficiary.
If the calculation is a percentage of 0.49 or lower round down to the nearest whole number, if percentage is 0.50 or higher round up to the nearest whole number.

Example of calculations:

	Number of Client in Group										
Duration	2	3	4	5	6	7	8	9	10	11	12
60	30	20	15	12	10	9	8	7	6	5	5
90	45	30	23	18	15	13	11	10	9	8	8
120	60	40	30	24	20	17	15	13	12	11	10

Exhibit C
"Attachment A"

CERTIFICATION OF CLAIMS AND PROGRAM INTEGRITY FORM

Billing/Service Period:		**Amount Certified:**	
DeptID:			
Provider Name:			
Contract Name/Region:			
Service Location (Address):			
RU's Certified:			
Bill Enumerator:			

Medi-Cal and/or Medicare Eligible Certification of Claims and Program Integrity (ONLY)

I, as an authorized representative of _____ , **HEREBY CERTIFY** under penalty of perjury to the following: An assessment of the beneficiaries was conducted by _____ in compliance with the requirements as set forth and established in the contract with the Riverside County Department of Mental Health (RCDMH) and as stipulated by all applicable Federal, State and/or County laws for Medi-Cal and Medicare beneficiaries. The beneficiaries were eligible to receive Medi-Cal and/or Medicare services at the time the services were provided to the beneficiaries. The services included in the claim were actually provided to the beneficiaries in association with and as stipulated by the claim. Medical necessity was established by my organization for the beneficiaries as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the time frame in which the services were provided, and by a certified and/or licensed professional as stipulated by all applicable Federal, State and County laws and regulations. A client plan was developed and maintained for the beneficiaries that met all client plan requirements established in the contract with the RCDMH and as stipulated by all applicable Federal, State and/or County law.

_____ _____

Signature of Authorized Provider Printed Name of Authorized Provider

Date: _____

Non-Medi-Cal and/or Medicare Eligible Certification of Claims and Program Integrity (ONLY)

I, as an authorized representative of _____, **HEREBY CERTIFY** under penalty of perjury to the following: An assessment of the beneficiaries was conducted by _____in compliance with the requirements as set forth and established in the contract with the Riverside County Department of Mental Health (RCDMH) and as stipulated by all applicable Federal, State and/or County laws for consumers who are referred by the County to the Provider for mental health specialty services. The beneficiaries were referred to receive services at the time the services were provided to the beneficiaries in association with and as stipulated by the claim. The services included in the claim were actually provided to the beneficiaries and for the time frame in which the services were provided, and by a certified and/or licensed professional as stipulated by all applicable Federal, State and County laws and regulations. A client careplan was developed and maintained for the beneficiaries that met all client careplan requirements established in the contract with the RCDMH and as stipulated by all applicable Federal, State and/or County law.

_____ _____

Signature of Authorized Provider Printed Name of Authorized Provider

Date: _____

RCDMH Admin. Use Only

BATCH #'s: _____

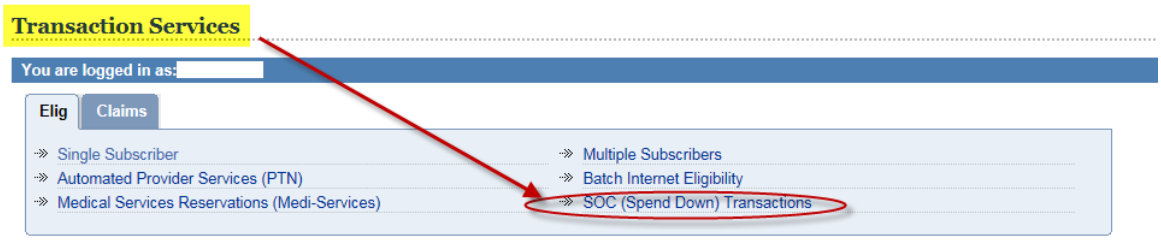
Share of Cost Description: Some Medi-Cal recipients must pay, or agree to be obligated to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). Example: A Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible.

Share of Cost Clearance Transaction

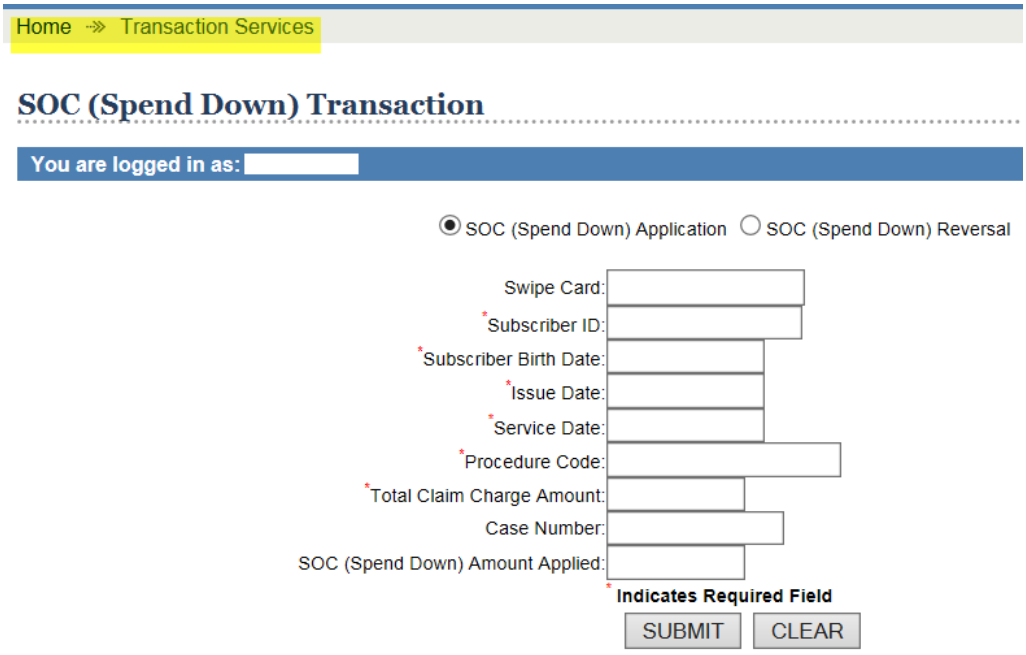
Providers access the Medi-Cal eligibility verification system via www.medi-cal.ca.gov. to determine if a recipient must pay, or agree to be obligated to pay, a SOC.

Providers should perform a SOC clearance transaction immediately upon receiving payment or accepting obligation from the recipient for the service rendered. Delays in performing the SOC clearance transaction may prevent the recipient from receiving other medically needed services.

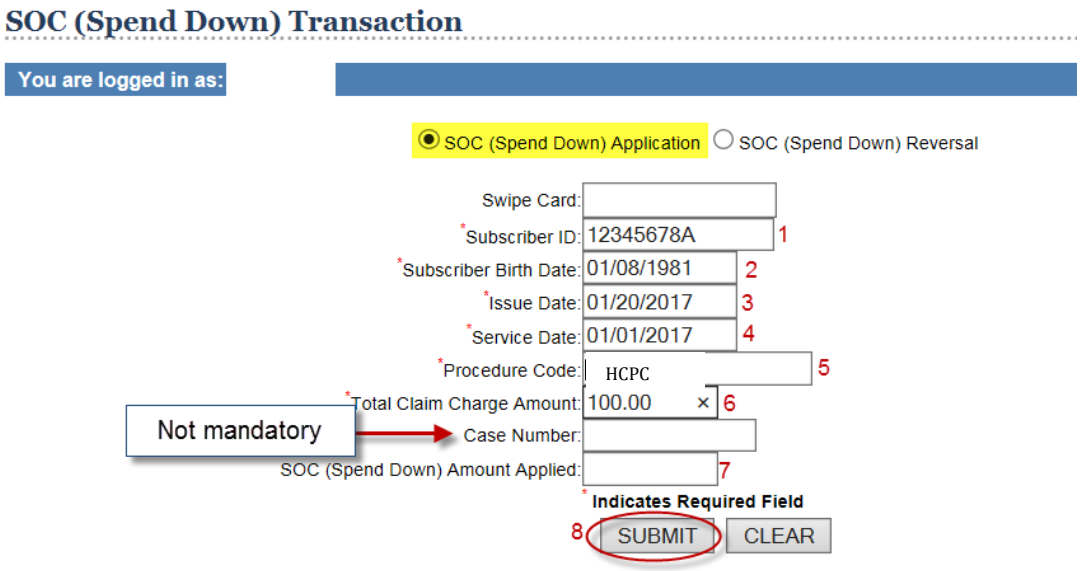
- After logging into Medi-Cal eligibility verification system, to complete SOC clearance click on "Transactions" tab, then select "SOC (Spend Down) Transactions."



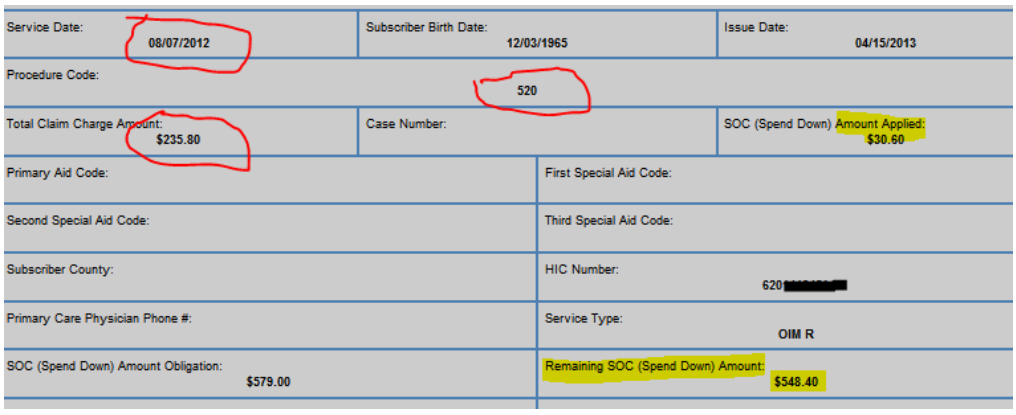
- The following screen will appear:



1. Enter the client's 9-digit SSN or CIN number in the "Subscriber ID" box with no hyphens.
2. Enter clients' DOB in "Date of Birth" box as 2-digit month, 2-digit day, and 4-digit year, separated by slashes.
3. Enter today's date in "Card Issue Date" box as 2-digit month, 2-digit day, 4-digit year, separated by slashes.
4. Enter the first date of service used to clear the SOC as a 2-digit month, 2-digit day, and 4-digit year, separated by slashes.
5. Enter the service code provided for the date of service.
6. Enter "Total Claim Charge Amount"field.
7. If a portion of the charge was applied to the SOC amount, enter it in the "SOC (Spend Down) Amount Applied" field Otherwise leave the field blank.
8. Click "Submit"

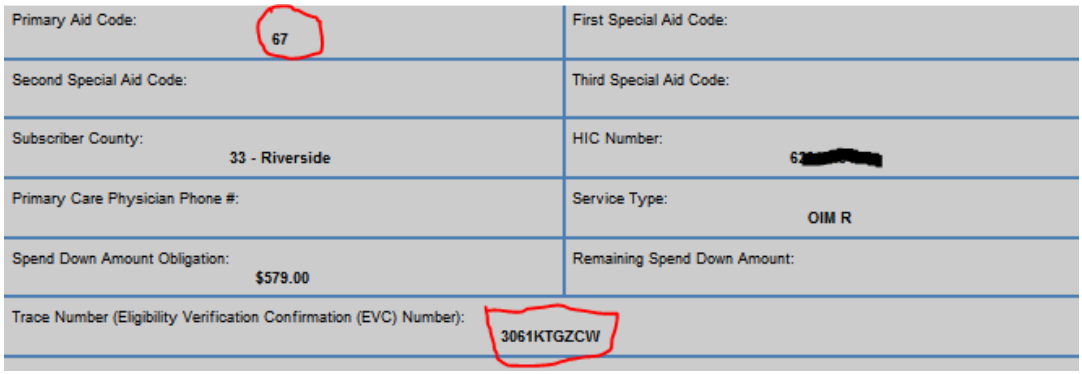


- Once submitted, the Service Date, Procedure Code, Total Claim Charge Amount, Amount Applied and Remaining Spend Down Amount (should be decreased by the amount cleared) will appear on the screen.



- **File copy of transaction in consumer chart.** Click the back arrow on the browser and repeat the process until all services client submitted payment for have been cleared on the Medi-cal website. ***Submit copies of all SOC Clearance Transactions to SAPT Administration. Fax: 951-683-4904**

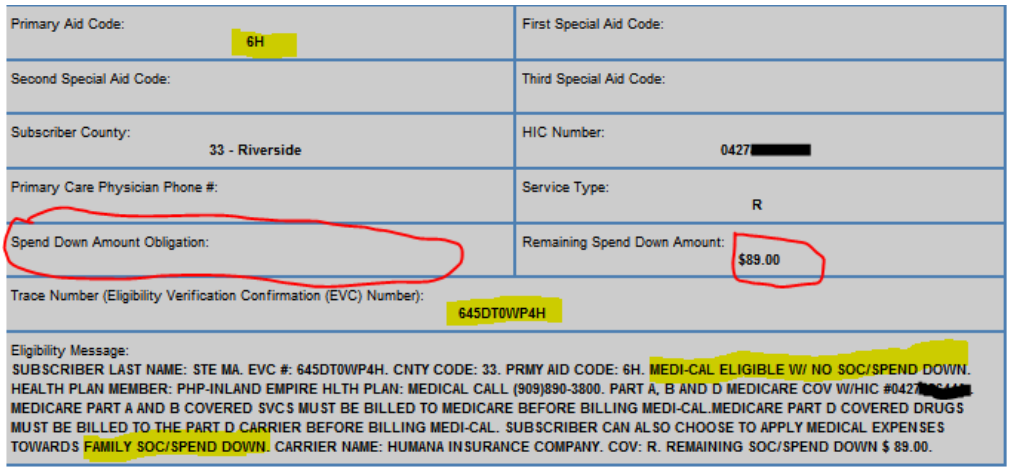
- When the SOC is cleared in full, a Primary Aid code and an EVC number will be displayed. The Remaining Spend Down field will be **blank**



Primary Aid Code: 67	First Special Aid Code:
Second Special Aid Code:	Third Special Aid Code:
Subscriber County: 33 - Riverside	HIC Number: 62[redacted]
Primary Care Physician Phone #:	Service Type: OIM R
Spend Down Amount Obligation: $579.00	Remaining Spend Down Amount:
Trace Number (Eligibility Verification Confirmation (EVC) Number): 3061KTGZCW	

- If the "Spend Down Amount Obligation" is blank, but there is a Remaining Spend Down amount (e.g. $89.00 in example below), it is likely due to a "Family" SOC obligation and not the clients' SOC obligation. Note in the example below:

  a. A Primary Aid Code *and* EVC # were returned. This indicates the client is Medi-cal eligible with no conditions.
  b. The Medi-cal response indicates "MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN."
  c. The Medi-cal response indicates "FAMILY SOC/SPEND DOWN."
  d. The "Family" has a Remaining SOC, but the client has no SOC obligation. The client does not have a SOC for the month/year in question. Therefore, no SOC should be cleared for the client.



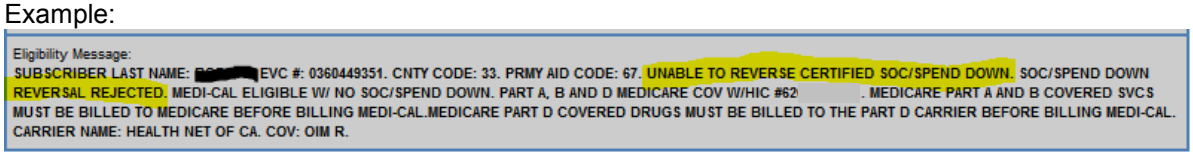
Primary Aid Code: 6H	First Special Aid Code:
Second Special Aid Code:	Third Special Aid Code:
Subscriber County: 33 - Riverside	HIC Number: 0427[redacted]
Primary Care Physician Phone #:	Service Type: R
Spend Down Amount Obligation:	Remaining Spend Down Amount: $89.00
Trace Number (Eligibility Verification Confirmation (EVC) Number): 645DT0WP4H	

Eligibility Message:
SUBSCRIBER LAST NAME: STE MA. EVC #: 645DT0WP4H. CNTY CODE: 33. PRMY AID CODE: 6H. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-INLAND EMPIRE HLTH PLAN: MEDICAL CALL (909)890-3800. PART A, B AND D MEDICARE COV W/HIC #0427[redacted]. MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. SUBSCRIBER CAN ALSO CHOOSE TO APPLY MEDICAL EXPENSES TOWARDS FAMILY SOC/SPEND DOWN. CARRIER NAME: HUMANA INSURANCE COMPANY. COV: R. REMAINING SOC/SPEND DOWN $ 89.00.

Reversing the Share of Cost Cleared on the Medi-cal Website

- If the Share of Cost transaction was completed in error and must be corrected, the transaction should be "reversed" as soon as the error is discovered. Otherwise you risk the SOC becoming "certified" and cannot be reversed.

  Example:


Eligibility Message:
SUBSCRIBER LAST NAME: [redacted]EVC #: 0360449351. CNTY CODE: 33. PRMY AID CODE: 67. UNABLE TO REVERSE CERTIFIED SOC/SPEND DOWN. SOC/SPEND DOWN REVERSAL REJECTED. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. PART A, B AND D MEDICARE COV W/HIC #62[redacted]. MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. CARRIER NAME: HEALTH NET OF CA. COV: OIM R.

- After logging into Medi-Cal eligibility verification system, to complete SOC reversal click on "Transactions" tab, select "SOC (Spend Down) Transactions", then "SOC (Spend Down) reversal :

1. Enter the client's 9-digit SSN or CIN number in the "Subscriber ID" box with no hyphens.
2. Enter clients' DOB in "Date of Birth" box as 2-digit month, 2-digit day, and 4-digit year, separated by slashes.
3. Enter today's date in "Card Issue Date" box as 2-digit month, 2-digit day, 4-digit year, separated by slashes.
4. Enter the first date of service used to clear the SOC as a 2-digit month, 2-digit day, and 4-digit year, separated by slashes.
5. Enter the service code provided for the date of service.
6. Enter "Total Claim Charge Amount"field.
7. Click "Submit".
8. The Remaining Spend Down Amount should be "increased" by the amount of the reversal.
9. Repeat the steps and e-enter the correct SOC Clearance information if necessary.

County of Riverside ACH Enrollment Form

Mail to: County of Riverside Auditor-Controller's Office General Accounting Division Attn: Vendor Code Section P.O. Box 1326 Riverside, CA 92502-1326 ☐ NEW ☐ CHANGE	**If you have any questions completing this form, please contact the Auditor-Controller's Office:** Email questions to: ACOVendorProcessing@rivco.org Phone: 951-955-3841
The information below should be completed by the vendor. A separate form must be completed for each Vendor Number.	It is the vendor's responsibility to assure the accuracy of the following banking information.

Vendor Information	Financial Institution Information
Vendor Number:	
District Number: Not Applicable	Financial Institution Name:
Vendor Name:	Address:
Remit to Address:	ACH Coordinator:
	Phone#:
Federal Tax ID# :	Fax#:
(Last four digits only) Contact Person:	Nine Digit Routing Transit#:
Phone #:	Depositor Account#:
Fax#:	Depositor Account Title:
Email: (Email address will be used for notification of ACH payment)	Type of Account: ☐ Checking ☐ Savings ☐ Check here if bank is outside of the United States

It is the responsibility of the vendor to obtain the ACH payment related remittance information from their financial institution. The County of Riverside sends this information through the ACH network in the Addenda Records. ACH Rules state the financial institution is required to provide this information to the vendor by the opening of business on the second banking day following the Settlement Date of the payment. Please contact the ACH department at your financial institution regarding the services your bank provides to obtain the payment information.

Note: Upon receipt of a levy, the ACH election will become void and a warrant will be issued for all goods and/or services rendered to the County of Riverside.

(Please Print or Type - Signature Required) Vendor Signature:	Please attach the following items when submitting form:
Name:	1. **Business Card** of authorizing signer
Title:	2. **Voided Blank Check** for referenced account
Date:	

Receipt and Verification (FOR INTERNAL USE ONLY)

Received By: _____ Via: _____ Date: _____

A/P Verification/Approval: _____ Date: _____

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
1700 K STREET
SACRAMENTO, CA 95811-4037
TTY/TDD (800) 735-2929
(916) 322-7012

ADP BULLETIN

Title		Issue Date: January 13, 2011 Expiration Date: N/A	Issue No. 11 - 01
Update - Processing Drug Medi-Cal Claims for Clients with Other Heath Coverage			
Deputy Director Approval dave neilsen Deputy Director Program Services Division	Function: [ ]Information Management [ ]Quality Assurance [ ]Service Delivery [X]Fiscal [ ]Administration [ ]Other	Supersedes Bulletin/ADP Letter No. 10-09 and July 28, 2010 letter regarding Drug Medi-Cal and Other Health Coverage	

PURPOSE

This bulletin consolidates the content of two previous communications that have been sent regarding the Drug Medi-Cal (DMC) claim process for clients who have Other Health Coverage (OHC). It combines and revises the information first provided in the Department of Alcohol and Drug Programs (ADP) Bulletin 10-09, and a related letter dated July 28, 2010, to County Administrators and DMC Providers.

This bulletin also provides additional information regarding an appropriate denial/response letter from the OHC, and DMC claim submission for Minor Consent services provided to Medi-Cal Full Scope eligible clients.

DISCUSSION

Federal Medicaid rules and the California Code of Regulations (CCR), Title 22, Section 51005(a) require billing a client's OHC before billing Medi-Cal. For clients whom the Medi-Cal Eligibility Determination System (MEDS) indicates have OHC, the Short-Doyle Medi-Cal (SDMC) billing system denies the DMC claim payment if the service provider does not bill the OHC carrier first and does not indicate the results of that billing in the submitted DMC claim. The results of billing the OHC may be received in electronic or written form. The sections below address several considerations that apply to billing for services provided to clients that are identified by MEDS as having OHC available.

Criteria for Billing DMC Without Billing OHC

1. A county or service provider may submit the DMC claim without having to bill the OHC first in the following two instances:

   a. Client's OHC is Vision, Dental, Hospital Inpatient or Prescription Only: The county or provider may submit the DMC claim without having to bill the OHC first

if a client's OHC is vision, dental, hospital inpatient or prescription only - which does not cover substance use disorder services on an outpatient basis.

b. Minor Consent Program Services: The county or provider may submit the DMC claim without having to bill the OHC first for minor consent services. The Minor Consent program permits youth under 21 years of age who are living with their parent(s) or guardian(s) access to confidential, limited alcohol and other drug treatment services without regard to the parental income and resources. This is in accordance with Family Code Section 6929; Welfare and Institutions Code Section 14010; and Title 22 of the CCR Section 51473.2. The Minor Consent program is funded by the State General Fund.

The SDMC system was modified to allow the above two exceptions as of July 2, 2010.

Delayed or No OHC Response

ADP implemented the following changes to the existing procedures to permit a more efficient process for submitting claims and issuing reimbursement:

1. Providers may presume that a claim for reimbursement submitted to an OHC carrier has been denied, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
    a. The provider has billed the service to the other carrier as required, and
    b. At least 90 calendar days have elapsed since the submission of the claim to the OHC carrier, and
    c. The provider has received none of the following:
        i. Payment for the claim,
        ii. A report (whether in hardcopy, electronic, or other form) of the results of the OHC carrier's adjudication of the claims,
        iii. Any communication, in any form, indicating that the claim submission was in an unacceptable form or otherwise in need of correction prior to adjudication by the OHC carrier.

2. When billing for DMC reimbursement based on a presumed denial as described in #1, above, providers shall report the presumed denial as follows for up to 12 months:
    a. Enter adjustment group code "OA" ("Other Adjustments"),
    b. Enter adjustment reason code "192".

3. Providers may consider a claim for reimbursement for particular services denied by the OHC carrier without submitting a billing claim to the OHC carrier, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
    a. The provider has billed the OHC carrier in the past 12 months, and
    b. In response to the previous attempt to bill the carrier, the provider has received a dated notification in written or electronic form that clearly indicates that the claim

for reimbursement is denied for an appropriate denial reason (see below, under "Appropriate OHC Denial or Adjustment Reasons") and that, for some specified span of time after the notification, claims for services provided under similar circumstances will not be accepted by that carrier, and

c. The services are within the scope of services for which the OHC carrier has indicated that they will not accept claims from the provider in the notification described in #3(b), and
d. The services were provided within the span of time identified in the notification described in #3(b) during which the OHC carrier would not accept the claims.

4. When billing for DMC reimbursement based on denial from a notification as described in #3, above, providers shall prepare their claims by mapping the justification for denial identified in the notification on which they are relying to the most appropriate combination of the following using the standard code sets in force at the time the claim is created or as submitted by the OHC carrier:
   a. Adjustment group code,
   b. Adjustment reason code, and,
   c. If necessary for the adjustment reason code given, health remarks code.

Appropriate OHC Denial or Adjustment Reasons

The Department of Health Care Services (DHCS) is the lead agency for administering California's Medicaid (Medi-Cal) Program. As the lead agency, DHCS provides Medi-Cal claim processing and payment guidance to other state departments. DHCS requires that Medi-Cal providers bill a client's OHC prior to billing Medi-Cal to receive either payment from the OHC, or a notice of denial from the OHC indicating that:

- The recipient's OHC coverage has been exhausted, or
- The specific service is not a benefit of the OHC.

There is another possible outcome of claims submitted to OHC providers. The OHC may cover the service, but only if the client obtains that service from the OHC's facility or through an OHC-approved provider. In such a case, a DMC provider submitting a claim to the OHC may receive a response indicating that the billing is denied because the services were not rendered by an in-network provider and/or because the services were not authorized according to the OHC's coverage requirements. Such a notice of denial may contain statements similar to the following:

- "HMO eligible, but services were not rendered by an HMO facility/provider; therefore, patient is not eligible for HMO benefits", or
- "The claim is denied. The procedure or services performed were not ordered or authorized by a Kaiser Permanente physician."

These are not acceptable denial reasons for submitting claims for DMC reimbursement as required by DHCS because they do not indicate that the OHC coverage has been exhausted, or that the service provided is not a benefit of the OHC. If a client has OHC,

and that OHC covers substance use disorder services, the client must exhaust the benefits available to them from the OHC before submitting the DMC claim for reimbursement.

Counties and providers that submitted DMC claims on or after January 1, 2010, and that were approved for such claims based on an OHC denial reason other than that the OHC coverage has been exhausted, or that the specific service is not a benefit of the OHC, must void those claims. If specific services within the approved claim (but not the entire claim) involved an OHC denial reason other than that the OHC coverage has been exhausted, or that the specific service is not a benefit of the OHC, then the claim should be resubmitted without those specific services. Failure to do so could result in an audit finding.

Clients with Multiple OHC Carriers

ADP has received inquires regarding whether DMC providers must bill all OHC carriers when a client has more than one OHC carrier identified in MEDS. As previously stated, DMC providers may bill DMC if they have a denial letter from the OHC stating that the recipient's OHC coverage has been exhausted. This means that each of the client's OHC carriers have been billed and the OHC coverage has been exhausted.

Claim to OHC Receiving Partial Payment

If a county or provider has submitted a claim to an OHC and received partial payment of the claim, they may submit the claim to ADP and are eligible to receive payment up to the maximum DMC rate for the service, less the amount of the payment made by the OHC.

Provider Responsibility to Identify and Bill OHC

It is the responsibility of DMC providers to assess whether the client's OHC includes substance use disorder services before providing a DMC reimbursable service to the client. This can be done by referring the client to the OHC or contacting the OHC on behalf of the client. If a DMC provider chooses to provide the service without assessing OHC first, then it does so at the risk of not being able to obtain DMC reimbursement.

DMC Claim Submission for Confidential Minor Consent Services Provided to Clients Without Minor-Consent-Only Aid Codes and Who Have Other Health Coverage

Minor Consent Medi-Cal aid codes are only assigned to clients that do not already have full scope, no-share-of-cost Medi-Cal eligibility. When a Minor Consent service is provided to a client without a Minor-Consent-Only aid code who has OHC and the OHC carrier is not billed first, the SDMC system will deny the DMC claim because the system treats only those claims submitted for clients with Minor Consent-Only aid codes as claims for confidential Minor Consent services (for which OHC need not be billed.)

ADP is investigating mechanisms to allow providers to specifically identify that DMC claims are for minor consent services. In the interim, for Minor Consent services provided to a client without a Minor-Consent-Only aid code, the DMC provider should submit the DMC claim without billing the OHC carrier first. These claims should be submitted to ADP as if denied by the OHC carrier, with the reason for denial reported as follows:

1. Enter adjustment group code “OA” (“Other Adjustments”),
2. Enter adjustment reason code “192”.

Counties and providers that submitted DMC claims for services provided as confidential Minor Consent services to clients without Minor-Consent-Only aid codes, which were denied because the OHC carrier was not billed, may submit replacement claims for those claims, following the procedure described above for reporting them as if denied by the OHC carrier.

Counties and providers that chose not to submit DMC claims for services provided as confidential Minor Consent services to clients without Minor-Consent-Only aid codes with OHC because they would have been denied, may now submit these claims following the procedure described above for reporting them as if denied by the OHC carrier. If the claim is submitted more than 30 days after the service date, the claim should use delay reason code “7”.

Records Retention

Trading partners shall retain all records relevant to the application of the rules communicated in this bulletin consistent with the records retention requirements identified in the State Administrative Manual and the trading partner’s DMC or Net Negotiated Amount/DMC contract with the State. This includes retaining documentation in the client files to support when confidential Minor Consent services are provided to clients without Minor-Consent-Only Aid Codes and who have other health coverage.

REFERENCES

California Code of Regulations, Title 22, Section 51005

QUESTIONS / MAINTENANCE

Questions concerning this bulletin may be directed to:

Tom Walker, Fiscal Analyst
Program and Fiscal Policy Branch
Department of Alcohol and Drug Programs
1700 K Street, 4th Floor
Sacramento, CA 95811-4037
(916) 323-2089
thwalker@adp.ca.gov

EXHIBITS

DISTRIBUTION

County Alcohol and Drug Program Administrators
Strategic Local Government Services, LLC
Director's Advisory Council
Drug Medi-Cal Direct Contract Providers
Drug Medi-Cal Certified Providers

Guarantors Address List
November, 20 2015

ID	Guarantor Name	Address 1	Address 2	ZIP	City	STATE	PHONE	Contract Effective Date	Contract Expiration Date
1241	AARP CLAIM UNIT	PO BOX 740819		30374	ATLANTA	GA	800-227-7789	1/1/2009	
3065	AB3632 NO CONSENT			92503	Riverside	CA		7/1/2011	
3122	ABRAZO ADVANTAGE HEALTH PLAN CLAIMS	P.O. BOX 81200		85069	Phoenix	AZ	888-864-1114	7/1/2011	
3179	Access IPA	880 S ATLANTIC BLVD	#201	91754	Monterey Park	CA	626-457-5579	7/1/2011	
3148	ACCOUNTABLE HEALTHCARE IPA	2525 CHERRY AVE SUITE 225		90755	Signal Hill	CA	562-435-3333	7/1/2011	
505	ADP Cal-Works							1/1/2009	
506	ADP Grant							1/1/2009	
502	ADP NNA					CA		1/1/2009	
601	ADP OHC - Not Required	P.O. Box 7549		92513	Riverside	CA		7/1/2011	
600	ADP SELF PAY					CA		1/1/2009	
3028	ADVANTRA FREEDOM	P O BOX 7154		40742	London	KY	800-713-5095	1/1/2009	
2437	ADVENTIST HEALTHCARE	3602 INLAND EMPIRE	SUITE C110	91764	Ontario	CA	800-400-3361	1/1/2009	
2761	AETNA	PO BOX 14586		40512	Lexington	KY	800-441-8664	1/1/2009	
2951	AETNA	P O BOX 981106		79998	EL PASO	TX	888-632-3862	1/1/2009	
2740	AETNA BEHAVIORAL HEALTH	P O BOX 14079		40512	Lexington	KY	800-424-1601	1/1/2009	
2924	AETNA PPO	P O BOX 981204		79998	EL PASO	TX	888-802-3862	1/1/2009	
2981	AETNA SUPPLEMENT PLAN	P O BOX 14426		50306	DES MOINES	IA	800-557-5078	1/1/2009	
1715	AETNA US HEALTHCARE	P O BOX 24019		93779	FRESNO	CA	800-282-5366	1/1/2009	
2807	AETNA US HEALTHCARE PPO	P O BOX 14079		40512	Lexington	KY	800-844-5562	1/1/2009	
3194	Affiliate Doctors of Orange County MG	PO Box 371000		91337	Reseda	CA	714-539-3100	7/1/2011	
3005	AIG	P O BOX 3726		98124	SEATTLE	WA	800-493-4240	1/1/2009	
2963	AIG INSURANCE	P O BOX 25977		66225	SHAWNEE	KS	714-436-5334	1/1/2009	
2768	ALLIANCE CLAIM PROCESSING	PO BOX 34585		98124	SEATTLE	WA	800-442-4038	1/1/2009	
3149	Allied Administrators	P O box 2500		94126	San Francisco	CA	800-736-0401	7/1/2011	
3091	Allied Benefit Systems	P.O. Box 90978		60690	Chicago	IL	800-288-2078	7/1/2011	
3161	ALOHACARE	1357 Kapiolani Blvd	Suite 1250	96801	Honolulu	HI		7/1/2011	
3177	ALPHA CARE MEDICAL GROUP	PO BOX 2002		91754	Monterey Park	CA	213-406-2600	7/1/2011	
3101	Amberiben	PO BOX 7186		83707	Boise	ID	800-723-2901	7/11/2011	
3114	AMERICAN MEDICAL SERVICE	PO Box 31375		84131	Salt Lake City	UT	800-232-5432	7/1/2011	
1019	AMERICAN POSTAL WORKERS UNION PLAN	P O BOX 1358		21060	GLEN BURNIE	MD	800-222-2798	1/1/2009	
3085	American Specialty Healthcare	P.O. Box 509002		92106	San Diego	CA	800-977-3568	7/1/2011	
3095	Americhoice LHIP Claims Office	P.O. Box 23667		92193	San Diego	CA	866-262-9881	7/1/2011	
3040	AMERIGROUP COMMUNITY CARE	P O BOX 61010		23466	VIRGINIA BEACH	VA	800-454-3730	1/1/2009	
2802	ANTHEM BLUE CROSS	P O BOX 60007		90060	LOS ANGELES	CA	800-288-6921	1/1/2009	
2968	APS HEALTHCARE	P O BOX 99		21090	Linthicum Heights	MD	800-431-5036	1/1/2009	
3046	APS HEALTHCARE	P O BOX 1440		20849	ROCKVILLE	MD	877-229-1458	1/1/2009	
3060	ARCADIAN HEALTH PLAN	P O BOX 4946		91723	Covina	CA	800-699-5125	1/1/2009	
3041	ARIZONA BENEFIT OPTIONS - UMR	P O BOX 30538		84130	SALT LAKE CITY	UT	888-999-1459	1/1/2009	
3059	ARIZONA MEDICAL NETWORK	1600 W BROADWAY RD	STE 300	85282	Tempe	AZ	888-690-2020	1/1/2009	
2096	ARIZONA PHYSICIANS IPA INCORPORATED	3141 NORTH THIRD AV		85013	Phoenix	AZ	800-445-1638	1/1/2009	
3110	Arrow Care	400 NO. PEPPER AVE		92324	Colton	CA	800-442-4978	7/1/2011	
3055	ARTA	P O BOX 370		90720	Los Alamitos	CA	866-376-8294	1/1/2009	
3032	ASI	P O BOX 2510		20847	ROCKVILLE	MD	301-816-0045	1/1/2009	
3014	ASSURANT HEALTH	P.O. BOX 91604		79490	Lubbock	TX	888-853-3267	1/1/2009	
3172	ASSURANT HEALTH	P.O. BOX 91604		79490	Lubbock	TX	800-379-3239	7/1/2011	
1638	B/C B/S OF TEXAS	P.O. BOX 660044		75266	Dallas	TX		7/1/2011	
1683	B/C B/S OF TEXAS	P.O. BOX 660044		75266	Dallas	TX	800-676-2583	7/1/2011	
3008	BANKERS LIFE AND CASUALTY	P O BOX 1935		46082	CARMEL	IN	800-773-4760	1/1/2009	
2913	Beaver Medical Group HMO	P.O. Box 10757		92423	San Bernardino	CA	909-793-3311	7/1/2011	
1106	BEAVER MEDICAL GROUP PPO	PO BOX 2200		92373	Redlands	CA	909-793-3311	1/1/2009	
3189	Benefit Advantage	PO Box 1567		91730	Rancho Cucamonga	CA	877-527-6030	7/1/2011	
2946	BENEFITS AND RISK MANAGEMENT SERVICES	P O BOX 2140		95763	FOLSOM	CA	888-326-2555	1/1/2009	
1039	BLUE CROSS OF CA	PO BOX 70000		91470	Van Nuys	CA	818-703-2345	1/1/2009	
1974	BLUE CROSS OF CA	P O BOX 4239	POINT OF SERVICE	91365	WOODLAND HILLS	CA	800-888-2916	1/1/2009	
1036	BLUE CROSS/BLUE SHIELD OF CA	P O BOX 272510		95927	CHICO	CA	800-824-8839	1/1/2009	
2525	BLUE CROSS/BLUE SHIELD OF CA PPO PLANS	P O BOX 272570		95927	CHICO	CA	800-241-4896	1/1/2009	
1476	BLUE CROSS/BLUE SHIELD OF UTAH	PO BOX 30270		84130	SALT LAKE CITY	UT	801-487-6441	1/1/2009	
2314	BLUE SHIELD 65 PLUS	6300 CANOGA AVE		91367	Woodland Hills	CA	877-654-6500	1/1/2009	

Guarantors Address List
November, 20 2015

ID	Guarantor Name	Address 1	Address 2	ZIP	City	STATE	PHONE	Contract Effective Date	Contract Expiration Date
1722	BLUE SHIELD 65 PLUS	P O BOX 5014		91365	WOODLAND HILLS	CA	800-776-4466	1/1/2009	
2404	BLUE SHIELD HMO PLAN	P O BOX 272600		95927	CHICO	CA	800-424-6521	1/1/2009	
2655	BLUE SHIELD MENTAL HEALTH ADMINISTRATOR	P.O. BOX 272540		95927	Chino	CA	877-263-8827	1/1/2009	
1048	BLUE SHIELD OF CA	P O BOX 272560		95927	CHICO	CA	800-331-2001	1/1/2009	
2325	BLUE SHIELD OF CA	P O BOX 272540		95927	CHICO	CA	800-351-2465	7/1/2011	
1047	BLUE SHIELD OF CA PREFERRED PLAN	P O BOX 272540		95927	CHICO	CA	800-424-6521	1/1/2009	
2306	BLUE SHIELD OF CALIFORNIA	P O BOX 1505		96080	Red Bluff	CA	800-622-0632	1/1/2009	
2863	BLUE SHIELD OF CALIFORNIA	P O BOX 272610		95927	CHICO	CA	800-351-2465	1/1/2009	
3153	BLUECARE	1 CAMERON HILL CIR	ST 2	97402	Chattanooga	TN		7/1/2011	
2347	BOON-CHAPMAN BENEFIT ADMINISTRATORS	P O BOX 9201		78766	AUSTIN	TX	800-252-9653	1/1/2009	
501	CALIFORNIA DEPT OF ALCOHOL AND DRUG PROG	P.O. Box 1004		95814	Sacramento	CA		1/1/2009	
1269	CALIFORNIA IRONWORKERS FIELD WELFARE	131 N EL MOLINO AV	SUITE 330	91101	Pasadena	CA	800-527-4613	1/1/2009	
3100	Caloptima OneCare	P.O. Box 11065		92865	Orange	CA	888-587-7277	7/1/2011	
2999	CARE FIRST	601 POTRERO GRANDE		91755	MONTEREY PARK	CA	323-889-6638	1/1/2009	
3094	Care Source	P.O. Box 8730		45401	Dayton	OH	800-488-0134	7/1/2011	
3044	CARE WEST INSURANCE	P O BOX 5038		95552	MODESTO	CA	209-236-7449	1/1/2009	
3068	CAREMORE HEALTH PLAN	P O BOX 366		90702	ARTESIA	CA	800-300-7011	1/1/2009	
2847	CBSA	P.O. Box27267		55427	New Hope	MN	888-259-7022	7/1/2011	
3105	CCSTPA	P.O. Box 64008		55164	Saint Paul	MN	866-528-0934	7/1/2011	
3071	CENTRAL HEALTH PLAN	1540 BRIDGEGATE DR	MAIL STOP 3000	91765	POMONA	CA	866-314-2427	1/1/2009	
1834	CHAMPVA CENTER	P O BOX 469064		80246	Glendale	CO	303-331-7599	1/1/2009	
3075	CHILDREN'S PHYSICIANS MEDICAL GROUP	P O BOX 11067		92856	ORANGE	CA		1/1/2009	
2541	CIGNA	P O BOX 46270	11095 VIKING DR	55344	Eden Prairie	MN	800-866-6534	1/1/2009	
2839	CIGNA	P O BOX 182223		37422	CHATTANOOGA	TN	800-244-6224	1/1/2009	
2864	CIGNA	P O BOX 6010		18505	Scranton	PA	800-638-6589	1/1/2009	
3049	CIGNA	P O BOX 5909		18505	Scranton	PA		1/1/2009	
3067	CIGNA BEHAVIORAL HEALTH	P O BOX 182223		37422	CHATTANOOGA	TN	800-866-6534	1/1/2009	
3186	CIGNA BEHAVIORAL HEALTH	P.O. BOX 188022		37422	Chattanooga	TN	800-244-6224	7/1/2011	
2697	CIGNA BEHAVIORAL HEALTH	P O BOX 46270		55344	Eden Prairie	MN	800-442-2353	1/1/2009	
3115	Cigna Behavioral Health Disney	P O BOX 188019		37422	Chattanooga	TN	800-753-0540	7/1/2011	
3111	CIGNA BEHAVIORAL HEALTH-DISNEY	P.O. BOX 188019		37422	Chattanooga	TN	800-753-0540	7/1/2011	
1709	Cigna Healthcare	P.O. Box 188004		37422	Chattanooga	TN	800-396-5899	1/22/2013	
2181	CIGNA INTERNATIONAL	P O BOX 15050		19850	Wilmington	DE	800-441-2668	1/1/2009	
3070	CIGNA MEDICARE ACCESS PLANS	P O BOX 696018		78269	SAN ANTONIO	TX	800-577-9410	1/1/2009	
2615	Cigna PPO	P.O. Box 188007		37422	Chattanooga	TN	800-882-4462	7/1/2011	
3062	CITIZENS CHOICE HEALTH PLAN	P.O. BOX 127		90702	Artesia	CA	323-728-7232	1/1/2009	
2446	COLLEGE HEALTH IPA	5665 Plaza drive	SUITE 400	90630	Cypress	CA	800-779-3825	7/1/2011	
3170	Community Care Health Plan	P O BOX 45020		93718	Fresno	CA	559-228-5410	7/1/2011	
3174	Community Health Group	PO Box 210157		91921	Chula Vista	CA	800-404-3332	7/1/2011	
3123	COMMUNITY HEALTH PLAN OF WASHINGTON	720 Olive Way #300		98101	Seattle	WA	800-942-0247	7/1/2011	
2993	COMPREHENSIVE BEHAVIORAL CARE	2770 Centennial Ave		43617	Toledo	OH	419-794-0567	7/1/2011	
1995	CONNECTICUT GENERAL	P O BOX 5132		48086	SOUTHFIELD	MI	800-523-4626	1/1/2009	
3042	CONSOLIDATED HEALTH PLAN	2077 ROOSEVELT AVE		01104	Springfield	MA	800-633-7867	1/1/2009	
3099	CONSTITUTION STATE SERVICES	P.O. Box 3001		72913	Fort Smith	AR	800-842-5612	7/1/2011	
8200	CONTRACTOR COMMERCIAL INSURANCE	4095 County Circle Dr		92503	Riverside	CA		7/1/2013	
8999	CONTRACTOR MEDICARE PART B	4095		92503	Riverside	CA		7/1/2013	
1981	CORPORATE HEALTH ADMINISTRATORS	P O BOX 1858		58502	BISMARCK	ND	800-235-0123	1/1/2009	
7000	COUNTY PAY					CA		1/1/2009	
3109	Coventry HealthCare	P.O. Box 7802		40742	London	KY	877-227-3520	7/1/2011	
99999	CSM Default Payor							1/1/1990	
2983	DELTA HEALTH SYSTEMS	P O BOX 80		95201	STOCKTON	CA	800-807-0820	1/1/2009	
1074	DESERET MUTUAL	PO BOX 45530	10 S. MAIN	84145	SALT LAKE CITY	UT	800-821-5133	1/1/2009	
1882	Desert Medical Group/Oasis IPA	275 N El Cielo Palm Springs		92262	Palm Springs	CA		7/1/2011	
3019	DESIGN BENEFITS	P O BOX 1209		92878	CORONA	CA	866-202-0505	1/1/2009	
5000	DMH	701 GATEWAY BLVD		95814	Sacramento	CA		1/1/2009	
5001	DMH	701 GATEWAY BLVD		95814	Sacramento	CA		1/1/2009	
5004	DMH	701 GATEWAY BLVD		95814	Sacramento	CA		10/1/2013	
3084	Easy Choice Health Plan	PO Box 260519		75026	Plano	TX	866-999-3945	7/1/2011	

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1606	EBA&M CORP	PO BOX 5079		91359	WESTLAKE VILLAGE	CA	800-776-1545	1/1/2009	
2361	ECS PLUS	P O BOX 30018		92607	LAGUNA NIGUEL	CA	800-638-9313	1/1/2009	
1474	EMPIRE PHYSICIANS MEDICAL GROUP	PO BOX 10699		92423-0699	San Bernardino	CA	760-699-6388	1/1/2009	
2451	EMPLOYEE BENEFIT ADMINISTRATORS	424 N FIRST AVE		91006	Arcadia	CA	818-294-2800	7/1/2011	
3104	ESIS	P.O. Box 6569		18505	Scranton	PA	702-892-8785	7/1/2011	
3098	Evercare	P.O. Box 30304		84130	Salt Lake City	UT	877-842-3210	7/1/2011	
2545	EXCLUSIVE CARE	P O BOX 1508		92502	RIVERSIDE	CA	800-962-1133	1/1/2009	
3142	FACULTY PHYS & SURG OF LLUSM-PEDIATRICS	101 REDLAND BLVD		92408	San Bernardino	CA	909-651-4100	7/1/2011	
3160	FACULTY PHYSICIANS AND SURGEONS OF LLUSM	PO BOX 54701		90074-4701	Los Angeles	CA	909-651-4300	7/1/2011	
3156	FAMILY SENIORS MEDICAL GROUP	PO BOX 12018		92546	Hemet	CA		7/1/2011	
3145	FAMILY SENIOR'S MEDICAL GROUP	21250 BOX SPRINGS RD		92557	Moreno Valley	CA	951-369-8036	7/1/2011	
3119	FAMILY SERVICES MEDICAL GROUP	1545 West Florida Ave		92543	Hemet	CA	888-966-8297	7/1/2011	
3126	FARMERS WORK COMP	P.O. BOX 108843		73101	Oklahoma City	OK	818-540-2239	7/1/2011	
2085	First Choice Health Network	2323 Eastlake Avenue East		98102	Seattle	WA	800-443-0425	7/1/2011	
3073	FIRST HEALTH NETWORK	P O BOX 18948		92623	IRVINE	CA	800-345-8643	1/1/2009	
2904	FOR YOUR CHOICE	P O BOX 1209		92878	CORONA	CA	866-202-0505	1/1/2009	
6001	FULL PAY					CA		1/1/2009	
3147	GALLAGHER BASSETT	PO BOX 22348		85734	Tucson	AZ	916-403-1524	7/1/2011	
3015	GALLAGHER BASSETT SERVICES	P O BOX 23812		85734	TUCSON	AZ	909-581-1919	1/1/2009	
3125	GEORGIA DEPT OF COMMUNITY HEALTH	P.O. Box 3214		60532	Lisle	IL	800-766-4456	7/1/2011	
2559	GOLDEN RULE INSURANCE CO	712 ELEVENTH ST		62439	Lawrenceville	IL	618-943-5465	1/1/2009	
1099	GOVERNMENT EMPLOYEE HOSPITAL ASSOC	P O BOX 4665		64051	INDEPENDENCE	MO	800-821-6136	1/1/2009	
2816	GREAT WEST LIFE AND ANNUITY INSURANCE CO	1000 GREAT WEST DR		63857	Kennett	MO	800-664-4559	1/1/2009	
3165	GWH-Cigna	P.O. Box 188061		37422	Chattanooga	TN	866-494-2111	7/1/2011	
3176	H O V Incorporated/OPTIMA BH	P O BOX 1440		48099	Troy	MI	877-687-6297	7/1/2011	
2965	HARMONY	1701 WEST CHARLESTON	SUITE 300	89102	Las Vegas	NV	800-363-4874	1/1/2009	
3136	HARRINGTON HEALTH	P O BOX 30537		84130	Salt Lake City	UT	800-216-2166	7/1/2011	
3079	HAWAII STATE COMP	235 S BERETANIA ST	STE 1300	96813	Honolulu	HI	808-587-0900	1/1/2009	
3116	HEALTH CARE PARTNERS NEVADA	P.O. BOX 94017		89193	Las Vegas	NV	800-457-4708	7/1/2011	
3086	Health Choice Generations	410 N 44th St. Suite 510		85008	Phoenix	AZ	800-656-8991	7/1/2011	
2815	Health Comp PPO	P.O. Box 45018		93718	Fresno	CA	800-442-7247	7/1/2011	
2840	HEALTH NET	P O BOX 14702		40512	Lexington	KY	800-641-7761	1/1/2009	
3166	Health Net SR HMO (H0562)	P.O. Box 14703		40512	Lexington	KY		7/1/2011	
3061	HEALTH SPRING	P O BOX 20000		37202	Nashville	TN	800-230-6138	1/1/2009	
3159	HEALTHCARE LA IPA			91357	Tarzana	CA	818-702-0100	7/1/2011	
3056	HEALTHCARE MANAGEMENT ADMINISTRATION	P O BOX 85008		98015	BELLEVUE	WA	800-668-6004	1/1/2009	
3155	HEALTHCARE PARTNERS	PO BOX 6099		90504	Torrance	CA	800-403-4160	7/1/2011	
3097	Healthy Way LA	1000 S. Freemont Ave #A-9	East 2nd Floor Unit 4	91803	Alhambra	CA	877-333-4952	7/1/2011	
1751	HEMET COMMUNITY MEDICAL GROUP - KMSM	P O BOX 12018		92546	HEMET	CA	951-791-1111	1/1/2009	
3058	HIGH DESERT PRIMARY CARE	17095 MAIN ST		92345	HESPERIA	CA	760-956-4114	1/1/2009	
3069	HM CARE ADVANTAGE	P O BOX 519		29716	FORT MILL	SC	866-255-9030	1/1/2009	
3184	HMC HEALTH WORKS	PO BOX 981605		79998	El Paso	TX	800-461-9179	7/1/2011	
1111	HOLMAN GROUP	9451 CORBIN AV	SUITE 100	91324	Northridge	CA	800-321-2843	1/1/2009	
3077	HORIZON BLUE CROSS BLUE SHIELD OF NJ	P O BOX 5172		21045	COLUMBIA	MD	800-626-2212	1/1/2009	
3146	HORIZON NJ HEALTH	P O BOX 7117		40742	London	KY	800-682-9091	7/1/2011	
3074	HTH WORLDWIDE	P O BOX 30259		33630	TAMPA	FL	877-865-5979	1/1/2009	
1113	HUMANA CARE PLUS	PO BOX 14610		40512	Lexington	KY	800-285-8800	1/1/2009	
3035	HUMANA CLAIMS	P O BOX 14601		40512	Lexington	KY	800-760-3263	1/1/2009	
8600	IAR							7/1/2013	
2967	IEHP/DUAL CHOICE (H5640)	P.O. BOX 4349		91729	Rancho Cucamonga	CA	866-223-4347	7/1/2011	
3134	IEHP/Medi-Connect (H5355)	P.O. Box 4349		91729	Rancho Cucamonga	CA	909-890-0036	7/1/2011	
2820	ILWU - PMA COASTWISE INDEMNITY	814 Mission Ste 300		94103	San Francisco	CA	800-955-7376	7/1/2011	
6004	IMD Self Pay							6/30/2010	
3185	IMG INTERNATIONAL MEDICAL GRP	P.O. BOX 88500		46208	Indianapolis	IN	800-628-4664	7/1/2011	
3182	Imperial Health Holding Medical Group	2295 Huntington Dr #D		91108	San Marino	CA	626-656-2370	7/1/2011	
1481	INDIAN HEALTH SERVICES	1555 1/2 POTRERO RD		92220	Banning	CA	909-849-4761	1/1/2009	
2960	INDIAN HEALTH SERVICES	1607 PLANTATON DR		86440	MOJAVE VALLEY	AZ	928-346-4680	1/1/2009	
3106	Inland Medical Group IPA	P.O. Box 2002		91754	Monterey Park	CA	888-285-9676	7/1/2011	

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3093	INLAND VALLEYS IPA	1200 CORPORATE CENTER DR. STE 200		91754	Monterey Park	CA	888-285-9676	7/1/2011	
3081	INTEGRA BMS	P O Box 1178 Matthew		28106	Matthew	NC	800-228-1803	7/1/2011	
1117	INTER VALLEY HEALTH PLAN	P O BOX 6002	300 S PARK #300	91769	POMONA	CA	800-251-8191	1/1/2009	
3154	INTERCARE HOLDINGS INS SVCS	PO BOX 14243		92863	Orange	CA	866-221-2968	7/1/2011	
3150	IPA INLAND FACULTY	1860 COLORADO AV	STE 200	90041	Los Angeles	CA	323-257-7637	7/1/2011	
1119	IPM HEALTH & WELFARE TRUST OF CA	1168 E LA CADENA		92507	Riverside	CA	909-684-1791	1/1/2009	
3064	KAISER	P O BOX 30547		84130	SALT LAKE CITY	UT	800-533-1833	1/1/2009	
1125	KAISER PERMANENTE CLAIMS ADMINISTRATION	P O BOX 7004		90242	Downey	CA	800-390-3510	1/1/2009	
3192	KEYSTONE HEALTH PLAN	1901 MARKET ST 45TH FLOOR		19103	Philadelphia	PA	800-645-3965	7/1/2011	
3108	L.A. Care Claims Department	PO Box 811580		90081	Los Angeles	CA	888-452-2273	7/1/2011	
1890	LABORERS TRUST FUNDS FOR SOUTHERN CA	P O BOX 23812		94623	OAKLAND	CA	626-442-5300	1/1/2009	
3190	Lakeside Comm Healthcare	PO Box 371390		91337	Reseda	CA	818-637-2000	7/1/2011	
3178	Laundry &Dry Cleaners Union	13191 Crossroads Parkway North	#205	91716	City of Industry	CA	800-524-8687	7/1/2011	
3053	LIBERTY MUTUAL	P O BOX 7203		40742	London	KY	800-281-1120	1/1/2009	
1824	LINECO	2000 SPRINGER DR		60148	Lombard	IL	800-323-7268	1/1/2009	
3054	MAGALLEN	P O BOX 2276		63043	Maryland Heights	MO	800-424-4143	1/1/2009	
3096	Magellan	P.O. Box 710400		92171	San Diego	CA	800-541-6652	1/1/2012	
2788	MAGELLAN	P O BOX 1837		63043	Maryland Heights	MO	888-314-4017	1/1/2009	
3037	MAGELLAN	P O BOX 2067		63043	Maryland Heights	MO	877-543-3875	1/1/2009	
2929	MAGELLAN BEHAVIORAL HEALTH	P O BOX 2243		63043	Maryland Heights	MO	800-889-4033	1/1/2009	
2931	MAGELLAN BEHAVIORAL HEALTH	P O BOX 2093		63043	Maryland Heights	MO	800-261-3992	1/1/2009	
1790	MANAGED HEALTH NETWORK	P O BOX 14621		40512	Lexington	KY	800-444-4281	1/1/2009	
2445	MANAGED HEALTH NETWORK	INSIGHT TEAM	2370 KERNER BLVD	94901	San Rafael	CA	800-526-6478	1/1/2009	
3157	Mckinley Medical Group	PO Box 7969		92513	Riverside	CA	951-359-0779	7/1/2011	
3039	MD CARE INC	P O BOX 14601		40512	Lexington	KY	888-285-9676	7/1/2011	12/31/2012
3173	MEDICAL MUTUAL	P O BOX 6018		44101	Cleveland	OH	800-525-5957	7/1/2011	
9997	MEDICARE PART A	P O BOX 669		30903-066	AUGUSTA	GA		1/1/2009	
9995	MEDICARE PART A SECONDARY					CA		1/1/2009	
9996	MEDICARE PART B SECONDARY					CA		1/1/2009	
2596	MEMORIAL HEALTHCARE IPA OF LONG BEACH	P O BOX 20890		92728	FOUNTAIN VALLEY	CA	562-981-9500	1/1/2009	
3188	Menifee Valley Community Medical Group	PO BOX 12018		92546	Hemet	CA	951-791-1111	7/1/2011	
2530	MERCY CARE PLAN	P O BOX 52089		85072	Phoenix	AZ	602-230-9921	1/1/2009	
3152	Meritain Health	PO Box 27267		55427	Minneapolis	MN	800-925-2272	7/1/2011	
7001	MH DO NOT USE							1/1/2009	
2791	MIDWEST NATIONAL LIFE	P O BOX 981606		79998	El Paso	TX	888-756-3534	1/1/2009	
3163	Molina Dual Opt MediConnect (H8677)	P.O. Box 22702		90801	Long Beach	CA		7/1/2011	
3133	Molina Marketplace Covered CA	P.O. Box 22702		90801	Long Beach	CA	888-665-4621	7/1/2011	
2926	Molina Medicare of CA (H5810) (2926)	P O BOX 22811		90801	LONG BEACH	CA	888-665-4621	1/1/2009	
3144	MONARCH HEALTHCARE MEDICAL GROUP	11 TECHNOLOGY DR		92618	Irvine	CA	949-923-3200	7/1/2011	
3129	MSI CLAIMS	P O BOX 30248		90853	Long Beach	CA	714-247-0300	7/1/2011	
3187	MSO INC OF CALIFORNIA	2295 HUNTINGTON DR	STE D	91108	San Marino	CA	626-656-2370	7/1/2011	
1147	Mutual of Omaha	Claims Dept Mutual of Omaha Plaza		68175	Omaha	NE	800-354-3289	7/1/2011	
3082	MVP Healthcare	P.O. Box 1480 Latham		12110	West Latham	NY	888-868-2368	7/1/2011	
3140	My Family Medical Group	5475 Walnut Av		91710	Chino	CA	888-230-7338	7/1/2011	
3171	NALC	20547 WAVERLY CT					888-636-6252	7/1/2011	
3181	National Foundation Life Insurance Company	P O Box 1468		75001	Arlington	TX	800-221-9039	7/1/2011	
3083	National Resources Consultants	P.O. Box 600188		92160	San Diego	CA	800-999-7222	7/1/2011	
3010	NETWORK MEDICAL MANAGEMENT LA SALLE MEDICAL ASSOCIATES IPA	1680 S. GARFIELD AVE SUITE 205		91801	Alhambra	CA	888-554-4562	1/1/2009	
3112	NIPPON LIFE INSURANCE COMPANY OF AMERICA	P.O. BOX 25951		66225	Shawnee Mission	KS		7/1/2011	
9999	NORIDIAN MEDICARE	900 42nd STREET SOUTH		58103-214	FARGO	ND		1/1/2009	
2519	OFTEDAL	PO BOX 21367		59104	Billings	MT	406-869-5556	7/1/2011	
3158	OLYMPUS MHC INC	777 BRICKELL AVE	#410	33131	Miami	FL	800-250-3271	7/1/2011	
2945	ONE CARE - WINDSTONE HEALTHCARE	P.O. BOX 3941 S BRISTOL ST	SUITE D503	92704	Santa Ana	CA	800-577-4701	1/1/2009	
3103	One Care-Windstone	P.O. Box 11065		92865	Orange	CA	800-577-4701	7/1/2011	
1161	OPERATING ENGINEERS HEALTH & WELFARE	PO BOX 7067		91109	Pasadena	CA	626-356-1004	1/1/2009	
1687	OPERATING ENGINEERS TRUST FUND	PO BOX 7065		91109	Pasadena	CA	818-356-1004	1/1/2009	
2822	ORANGE COUNTY FOUNDATION/MEDICAL CARE	P O BOX 11066		92856	ORANGE	CA	800-345-8643	1/1/2009	
1485	OUT OF COUNTRY CLAIMS			99999	RIVERSIDE	CA		1/1/2009	

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1277	PACIFICARE	PO BOX 6006	5995 PLAZA DRIVE	90630	Cypress	CA	877-842-3210	1/1/2009	
1984	PACIFICARE BEHAVIORAL HEALTH	P O BOX 31053		92654	LAGUNA HILLS	CA	800-999-9585	1/1/2009	
3025	PACIFICARE BEHAVIORAL HEALTH	P O BOX 30602		84130	SALT LAKE CITY	UT	800-716-1166	1/1/2009	
2859	PARKER INDIAN HEALTH CENTER	12033 AGENCY RD		85344	Parker	AZ	928-669-3150	1/1/2009	
2887	PCSD	P O BOX 609001		92160	SAN DIEGO	CA	888-840-4747	1/1/2009	
1173	PENNSYLVANIA LIFE INSURANCE CO	PO Box 7676		94120	San Francisco	CA		7/1/2011	
2885	PERSONAL INSURANCE ADMINISTRATORS	P O BOX 6040		91376	AGOURA HILLS	CA	800-468-4343	1/1/2009	
3063	PHOENIX HEALTH PLAN	P O BOX 81000		85069	PHOENIX	AZ	800-747-7997	1/1/2009	
2758	PHYSICIANS CARE OF CA	PO BOX 15165		92735	SANTA ANA	CA	800-990-7262	1/1/2009	
3135	PINNACLE	P O BOX 2220		92658	Newport Beach	CA	800-777-7898	7/1/2011	
3143	PINNACLE MEDICAL GROUP	P O BOX 12089		92423	San Bernardino	CA	909-799-1818	7/1/2011	
3072	PLANNED ADMINISTRATORS INC	P O BOX 6702		29260	COLUMBIA	SC	800-440-3068	1/1/2009	
3089	POM CO GROUP	P O BOX 6329		13217	Syracuse	NY	800-898-9715	7/1/2011	
3164	POMONA VALLEY MEDICAL GROUP	PO BOX 2399		91729	Rancho Cucamonga	CA	800-281-8886	7/1/2011	
3127	POSITIVE HEALTHCARE PARTNERS	P.O. BOX 7490		91750	La Verne	CA	800-263-0067	7/1/2011	
3107	PRE-EXISTING CONDITION INSURANCE PLAN	P O BOX 30783		84130	Salt Lake City	UT	800-220-7898	7/1/2011	
3169	Primary Care Associates of CA	4909 Lakewood Bl.		90712	Lakewood	CA	562-602-1563	7/1/2011	
2811	PRIMARY PHYSCIAN CARE	P.O. BOX 11088		28220	Charlotte	NC	800-446-5439	7/1/2011	
2647	PRIMECARE MEDICAL GROUP INLAND VALLEY	P.O. Box 6903		91729	Rancho Cucamonga	CA	909-476-1575	7/1/2011	
3001	PRIMECARE MEDICAL GROUP OF CITRUS VALLEY	P O BOX 6903		91729	RANCHO CUCAMONGA	CA	909-476-1575	1/1/2009	
2299	PRIMECARE MEDICAL GROUP OF CORONA	P O BOX 6903		91729	RANCHO CUCAMONGA	CA	909-476-1575	1/1/2009	
2324	PRIMECARE MEDICAL GROUP OF HEMET	P O BOX 6903		91729	RANCHO CUCAMONGA	CA	909-476-1575	1/1/2009	
2296	PRIMECARE MEDICAL GROUP OF MORENO VALLEY	P O BOX 6903		91729	RANCHO CUCAMONGA	CA	909-476-1575	1/1/2009	
2385	PRIMECARE MEDICAL GROUP OF RIVERSIDE	P O BOX 6903		91729	RANCHO CUCAMONGA	CA	909-476-1575	1/1/2009	
2405	PRIMECARE MEDICAL GROUP OF SUN CITY	P O BOX 6903		91729	RANCHO CUCAMONGA	CA	909-476-1575	1/1/2009	
2311	PRIMECARE MEDICAL GROUP OF TEMECULA	P O BOX 6903		91729	RANCHO CUCAMONGA	CA	909-476-1575	1/1/2009	
3057	PRIMECARE MEDICAL GROUP SAN BERNARDINO	P O BOX 6903		91729	Rancho Cucamonga	CA	909-792-5375	1/1/2009	
3087	Principal Financial Group	P.O. Box 14079		40512	Lexington	KY	800-800-8121	1/1/2011	
1763	PRINCIPAL MUTUAL LIFE INSURANCE CO	P O BOX 39710		80949	COLORADO SPRINGS	CO	800-533-5044	1/1/2009	
3193	PROMED HEALTH NETWORK	PO BOX 11466		92711	Santa Ana	CA	800-281-8886	7/1/2011	
3139	PROSPECT MEDICAL GROUP	P O BOX 11466		92711	Santa Ana	CA	714-796-5900	7/1/2011	
3027	PROVIDENCE	P O BOX 3125		97208	PORTLAND	OR	800-878-4445	1/1/2009	
2974	PRUDENT BUYER/THE PLAN HANDLERS	P O BOX 619059		75261	DALLAS	TX	877-288-0840	1/1/2009	
6003	Public Guardian/Conservator	PO Box 1150		92502	Riverside	CA		6/30/2010	
6002	Public Guardian/MHRP	PO Box 1405		92502-140!	Riverside	CA		6/30/2010	
8000	RCRMC Commercial Insurance	4095 County Circle Dr		92503	Riverside	CA		7/1/2011	
3162	REDLANDS COMMUNITY	P O Box 3391		92373	Redlands	CA	909-335-5500	7/1/2011	
3003	Redlands Yucaipa Medical Group	P.O. Box 12029		92423	San Bernardino	CA	909-799-1818	7/1/2011	
2868	REGAL MEDICAL GROUP	P O BOX 371330		91337	RESEDA	CA	818-654-3423	1/1/2009	
2936	REGAL MEDICAL GROUP	8510 BALBOA BLVD	SUITE 275	91325	Northridge	CA	818-654-3461	1/1/2009	
1375	RISK MANAGEMENT	PO BOX 1770	11161 ANDERSON #2	92354	Loma Linda	CA	909-558-4386	1/1/2009	
5002	Riverside County HealthCare							1/1/2012	
3137	RIVERSIDE MEDICAL CLINIC	7117 BROCKTON AVE		92506	Riverside	CA		7/1/2011	
1857	RIVERSIDE MEDICAL GROUP	3660 ARLINGTON AVE	PREPAID CLAIMS DEI	92506	Riverside	CA	909-782-3060	1/1/2009	
2627	RIVERSIDE PHYSICIANS NETWORK	P O BOX 59957		92517	RIVERSIDE	CA	951-788-9800	7/1/2011	
2784	RIVERSIDE PHYSICIANS NETWORK	1650 IOWA STREET	SUITE 220	92507	Riverside	CA	800-424-6521	1/1/2009	
3113	ROBERTSON READY MIX	PO Box 1659		92878	Corona	CA	800-560-1150	7/1/2011	
2381	San Bernardino Medical Group	1700 N Waterman Ave		92404	San Bernardino	CA	800-542-8789	7/1/2011	
3138	San Francisco Mental Health Plan	P O BOX 423180		94142	San Francisco	CA	800-638-6589	7/1/2011	
2458	SCAN HEALTH PLAN	P O BOX 22698	ATTN CLAIMS	90801	LONG BEACH	CA	800-247-5091	1/1/2009	
3078	SCIENCE CARE	P O BOX 2909		85062	PHOENIX	AZ	952-896-9102	1/1/2009	
3080	SCOTT AND WHITE HEALTH PLAN	P O BOX 269006		75026	PLANO	TX	800-321-7947	1/1/2009	
1351	SECURE HORIZONS	5796 CORPORATE AVE	PO BOX 489 CY38-14	90630	Cypress	CA	800-542-8789	1/1/2009	
3024	SECURE HORIZONS	P O BOX 30968		84130	SALT LAKE CITY	UT	800-542-8789	1/1/2009	
3102	Sedwick CMS	PO BOX 14421		40512	Lexington	KY	800-228-0454	7/11/2011	
3191	Select Benefits Administrators	P.O. Box 3245		53201	Milwaukee	WI	800-497-3699	7/1/2011	
3180	SHARP HEALTH PLAN	P O BOX 609001		92160	San Diego	CA	800-359-2002	7/1/2011	
3131	SHEETMETAL WORKERS	P O BOX 10067		90266	Manhattan Beach	CA	800-647-4338	7/1/2011	

Guarantors Address List
November, 20 2015

ID	Guarantor Name	Address 1	Address 2	ZIP	City	STATE	PHONE	Contract Effective Date	Contract Expiration Date
3018	SMITH ADMINISTRATORS	P O BOX 853937		75085	RICHARDSON	TX	800-867-2582	1/1/2009	
3128	SOBOBA HEALTH CLINIC	604 DONNA WY		92583	San Jacinto	CA	800-851-5816	7/1/2011	
3183	Southern Calif. Lumber Industry Health & Welfare Fund	13191 Crossroads Pkwy North Suite 205		91746	City of Industry	CA	562-463-5080	7/1/2011	
2441	SOUTHWEST ADMINISTRATOR-RETIREE PLAN	P O BOX 1121		91802	ALHAMBRA	CA	213-386-3300	1/1/2009	
1245	SOUTHWEST ADMINISTRATORS	P O BOX 470459		90047	Los Angeles	CA	800-777-9276	1/1/2009	
3036	SOUTHWEST CATHOLIC HEALTH	4350 E COTTON CENTER		85040	Phoenix	AZ	602-263-3000	1/1/2009	
1061	SRC CLAIMS DEPARTMENT	ATTN: MEDICAL CLAIMS	P O BOX 14079	40512	Lexington	KY	800-736-0360	1/1/2009	
3141	St Joseph Heritage Medical Group	1515 E Orangewood Av		92805	Anaheim	CA	888-313-4373	7/1/2011	
2563	ST JOSEPH HOSPITAL AFFLIATE CLAIMS	PO BOX 70014		92825	ANAHEIM	CA	888-881-3136	1/1/2009	
2759	STAR BRIDGE	P O BOX 55270		85078	PHOENIX	AZ	800-308-5948	1/1/2009	
1212	STATE COMPENSATION INSURANCE FUND	P O BOX 92622		90009	LOS ANGELES	CA	951-656-8300	1/1/2009	
2977	STATE COMPENSATION INSURANCE FUND	P O BOX 65005		93650	Pinedale	CA	714-565-5060	1/1/2009	
2923	STATE DEPT OF INDUSTRIAL RELATIONS UEF	320 W 4TH STREET	SUITE 600	90013	Los Angeles	CA	213-576-7324	7/1/2011	
3045	STATE FUND COMPENSATION	P O BOX 59901		92517	RIVERSIDE	CA	714-560-1647	1/1/2009	
3168	STAYWELL	P O BOX 31372		33631	Tampa	FL	866-334-7927	7/1/2011	
3092	Teacher Health Trust	P.O. Box 96238		89193	Las Vegas	NV	800-432-5859	7/1/2011	
2915	TEMECULA VALLEY PHYSICIANS MEDICAL GROUP	P O BOX 12018		92546	HEMET	CA	951-791-1111	1/1/2009	
3130	THE LOOMIS CO	P O BOX 7011		19610	Wyomissing	PA	888-826-5769	7/1/2011	
3196	TOTAL LONGTERM CARE INC	8950 E LOWRY BLVD		80230	Denver	CO	303-869-4664	7/1/2011	
3034	TPSC TRUSTED PLANS	P O BOX 2950		98401	TACOMA	WA	800-426-9786	1/1/2009	
1250	TRANSWESTERN	P.O. Box 45019		93718	Fresno	CA	800-221-8942	7/1/2011	
3175	TRAVELERS	P O BOX 6510		91765	Diamond Bar	CA	909-612-3000	7/1/2011	
1783	TRI CARE PRIME/WPS	P O BOX 77028		53707	MADISON	WI	888-874-9378	1/1/2009	
3090	Tri Valley Medical Group	39765 Date St.	Suite 102	92563	Murrieta Hot Springs	CA	951-894-4665	7/1/2011	
2755	TRICARE NORTH CLAIMS	PO BOX 870140		29587	Surfside Beach	SC	877-874-2273	7/1/2011	
2908	TRICARE FOR LIFE	P O BOX 7890		53708	MADISON	WI	866-773-0404	1/1/2009	
3038	TRICARE SOUTHERN REGION	P O BOX 7064		29020	Camden	SC	800-700-8646	1/1/2009	
2990	TRISTAR	P O BOX 512028		90051	LOS ANGELES	CA	562-506-0321	1/1/2009	
3050	TRISTAR RISK MANAGEMENT	P O BOX 600630		92160	SAN DIEGO	CA	858-715-8800	1/1/2009	
6000	UMDAP SELF PAY					CA		1/1/2009	
3051	UMR	P O BOX 30541		84130	SALT LAKE CITY	UT	877-233-1800	1/1/2009	
8500	UNDER BILLING REVIEW							7/1/2013	
3052	UNION ROOFERS HEALTH & WELFARE FUND	9901 PARAMOUNT BLVD		90240	Downey	CA	562-927-1434	1/1/2009	
2494	UNITED AMERICAN INSURANCE COMPANY	P.O. BOX 8080		75070	Mc Kinney	TX	972-529-5085	1/1/2009	
3088	UNITED BEHAVIORAL HEALTH	P O BOX 30760		84130-076(	Salt Lake City	UT	888-440-8225	7/1/2011	
2857	UNITED BEHAVIORAL HEALTH	P O BOX 30755		84130	SALT LAKE CITY	UT	877-620-6186	1/1/2009	
1225	UNITED FOOD & COM WORKERS BENEFIT FUND	PO BOX 6010	MENTAL HEALTH CL/	90630	Cypress	CA	714-220-2297	1/1/2009	
3117	UNITED HEALTH CARE	P.O. BOX 30884		84130	Salt Lake City	UT	877-842-3210	7/1/2011	
2411	UNITED HEALTH CARE	P O BOX 30551		84130	SALT LAKE CITY	UT	877-842-3210	1/1/2009	
2729	UNITED HEALTH CARE	PO BOX 30555		84130	SALT LAKE CITY	UT	877-842-3210	1/1/2009	
1395	UNITED HEALTH CARE OPTIONS PPO	P O BOX 740800		30374	ATLANTA	GA	800-553-7360	1/1/2009	
3132	UNITED HEALTH CARE- OXFORD CLAIMS	P.O. BOX 29130		71903	Hot Springs National Park	AR	800-666-1353	7/11/2011	
3118	United Healthcare	P.O. Box 5220		12402	Kingston	NY	800-747-1446	7/1/2011	
2874	UNITED HEALTHCARE	P O BOX 740802		30374	ATLANTA	GA	877-842-3210	1/1/2009	
2804	UNITED HEALTHCARE OF TEXAS	PO BOX 659756	ROUTE #2625	78265	SAN ANTONIO	TX	800-705-1689	1/1/2009	
3151	UNITED HEALTHCARE STUDENT RESOURCES	PO BOX 809025		75380	Dallas	TX	800-767-0700	7/1/2011	
3195	UNIVERA SENIOR CHOICE	P O BOX 23000		14692	Rochester	NY	877-883-9577	7/1/2011	
2906	UNIVERSAL CARE	P O BOX 438		60068	Park Ridge	IL	562-424-6200	1/1/2009	
2958	UNIVERSAL CARE	P O BOX 794		60068	Park Ridge	IL	800-635-6668	1/1/2009	
3124	UNIVERSITY PHYSICIANS/MARICOPA CARE	P.O. Box 38549		85069	Phoenix	AZ	800-582-8686	7/1/2011	
3066	Unknown							7/1/2011	
3197	UPMC HEALTH PLAN	PO BOX 2995		15230	Pittsburgh	PA	888-876-2856	7/1/2011	
861	VA MEDICAL CENTER	FEE SRVCS SEC 136F	11201 BENTON ST	92357	Loma Linda	CA	909-825-7084	1/1/2009	
3167	Value Options	PO Box 1800		12110	West Latham	NY	877-796-7447	7/1/2011	
2558	VALUE OPTIONS	P O BOX 1008		60076	Skokie	IL	800-955-9409	1/1/2009	
2618	VALUE OPTIONS	P O BOX 1347		12110	Latham	NY	800-554-6701	1/1/2009	
2853	VALUE OPTIONS	P O BOX 1830		12110	Latham	NY	800-336-9117	1/1/2009	
2876	VALUE OPTIONS	P O BOX 1860		12110	Latham	NY	800-684-4293	1/1/2009	

Guarantors Address List
November, 20 2015

ID	Guarantor Name	Address 1	Address 2	ZIP	City	STATE	PHONE	Contract Effective Date	Contract Expiration Date
2894	VALUE OPTIONS	P O BOX 1290		12110	Latham	NY	866-277-5383	1/1/2009	
2386	VALUE OPTIONS OF CALIFORNIA	P O BOX 6065		90630	Cypress	CA	562-590-9004	1/1/2009	
2914	VANTAGE	2115 COMPTON AVE		92881	Corona	CA	800-406-6059	1/1/2009	
3121	WA DEPT OF LABOR & IND	P.O. BOX 44200		98504	Olympia	WA	800-848-0811	7/1/2011	
3076	WEB TPA	P O BOX 99906		76099	GRAPEVINE	TX	877-631-2432	1/1/2009	
2970	WELLCARE - PFFS	P O BOX 31619		33631	Tampa	FL	866-999-3945	1/1/2009	
1235	WESTERN GROWERS	PO BOX 7240		92658	NEWPORT BEACH	CA	800-777-7898	1/1/2009	
2954	WINDSTONE HEALTHCARE	3941 S. BRISTOL ST	#D503	92704	Santa Ana	CA	800-577-4701	1/1/2009	
1497	WORKER'S COMPENSATION CLAIMS			92513	RIVERSIDE	CA		1/1/2009	
3120	ZURICH NORTH AMERICA	P.O. BOX 968005		60196	Schaumburg	IL	818-227-1700	7/1/2011	

How To Read: Aid Code Master Chart

How to read the Aid Code Master Chart:

The chart columns identify Mental Health Services (MHS), Medicaid Eligibility Group (MEG), Drug Medi-Cal Program (DMC), Effective Dates and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The MHS and DMC column indicate a "yes" if the aid code is appropriate for use by MHS and/or DMC; and "no" if it is not. The SD/MC column indicates the effective date of the aid code for Medi Cal eligibility. The Inactive in MEDS column indicates the date for which FFP is no longer available for an aid code. The EPSDT column identifies aid codes that may include beneficiaries under age 21 who are eligible for expanded Medi-Cal benefits under the EPSDT program.

Department of Health Care Services – Short Doyle / Medi-Cal Aid Code Master Chart for MHS and DMC

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
8N	Restricted to emergency services only	No	133 Percent Program (OBRA). Child Undocumented / Nonimmigrant Alien (but otherwise eligible except for excess property) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 % of the federal poverty level.	Yes	MCHIP	No			No
8P	Full	No	133 Percent Program. Child – United States Citizen (with excess property), Permanent Resident Alien/PRUCOL Alien (FFP). Provides full-scope Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 % of the federal poverty level.	Yes	MCHIP	Yes			Yes

1. Identify that the "Benefits" are 'Full' or services rendered meet any identified 'Restrictions'. DMC does not fall under Emergency Services Category.

Benefit	Definition
Full	No restrictions
Restricted	Special Condition: e.g. Undocumented or non-satisfactory immigration status; Pregnancy; Emergency, etc.
Restricted Limited	A restriction based upon time (e.g. IP off the grounds of the prison for <24H)

2. Identify under the "DMC" column if 'No' or 'Yes'. (No = Aid Code not valid for DMC services) (Yes = Aid Code Valid for Reimbursement as long as the "Benefits" column is valid)

Link For Chart: http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx MedCCC Home Page

Checklist for Accessibility: Alcohol & Drug Programs

Funding provided by:
Department of Alcohol and Drug Programs
1700 K Street
Sacramento, CA 95813

Services provided by
California Association of Addiction Recovery Resources
Disability Access Project
2400 Marconi Ave., PO Box 214127
Sacramento, Ca 95821
916.338.9460 Voice – 916. 473. 0836 TTY
916.338.9468 Fax
bob@caarr.org – www.caarr.org

Support for this project is provided by the State of California, Health & Human Services Agency, Department of Alcohol & Drug Programs. Technical assistance and training services are provided at no cost to qualified agencies and programs.
Site reviews and architectural surveys of provided as a guide to assist programs to improve access to services for people with disabilities in accordance with:

- Americans with Disability Act (ADA);
- Section 504 of the Rehabilitation Act of 1973;
- 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance;
- Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance and;
- Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities.

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This publication is available upon request in accessible formats including Braille, large print, computer disk, or audiotape as a disability-related reasonable accommodation for people with disabilities.

Site Review - Checklist for Accessibility

Date of Application: Date of Review:

Program/Agency:

Contact Person: Job Title:

Address:

City: California ZIP: County:

Phone: Fax: Email:

Consultant**:**

1: Agency Classification **(Check all that apply)**

☐ **Funding/License/Certification from State DADP County ADP Administration** **(Check if yes)**

- ☐ Alcohol/Drug Prevention Program
- ☐ Alcohol/Drug Treatment Program
- ☐ Narcotic Treatment Program
- ☐ Sober Living Home
- ☐ County ADP Administration
- ☐ State ADP Administration
- ☐ Technical Assistance Program
- ☐ New License/Certification Applicant
- ☐ NPO
- ☐ For Profit
- ☐ Other

2: ☐ **Residential** ☐ **Non-residential**

If Residential: ☐ **Male** ☐ **Female** ☐ **Both**

If Residential: Total Bed Capacity

Male Bed Capacity:

Female Bed Capacity:

3: Disability Access Coordinator:

Programs with 15 or more employees are required to have a Disability Access Coordinator

☐ Yes ☐ No ☐ N/A

4: ADA/Access to Services Plan on File:

☐ Yes ☐ No ☐ In Process

5: Written Disability Admission and Referral Policy:

The referral policy shall include letters or memorandums of understanding with programs agreeing to accept disability related referrals.

☐ Yes ☐ No ☐ N/A ☐ In Process

Overall impression of accessibility for people with mobility impairments. (Non-Ambulatory, Wheelchair user)

☐ **YES** ☐ **NO** **Reviewer comments:**

Overall impression of accessibility for people with mobility impairments. (Ambulatory, Not wheelchair user, but may use canes, crutches, walkers, etc.)

☐ **YES** ☐ **NO** **Reviewer comments:**

Overall impression of accessibility for people with visual impairments.

☐ **YES** ☐ **NO** **Reviewer comments:**

Overall impression of accessibility for people who are deaf or hard of hearing.

☐ **YES** ☐ **NO** **Reviewer comments:**

Overall impression of accessibility for people with developmental disabilities.

☐ **YES** ☐ **NO** **Reviewer comments:**

Reviewer comments:

Checklist for Accessibility

This checklist will help you identify the accessibility problems in existing facilities in order to meet your obligations under the Americans with Disabilities Act and Title 24 of the California Access Compliance Code of Regulations.

The goal of this checklist is to help you plan how to make an existing facility more useable for people with disabilities. The United States Department of Justice recommends the development of an Implementation Plan, specifying what improvements you will make to remove barriers and a time table when each will be carried out. Such a plan could serve as evidence of good faith to comply with the ADA.

This checklist details some of the requirements found in the ADA Standards for Accessible Design (Standards). The ADA Accessibility Guidelines (ADAAG) are a part of the Department of Justice Title III Regulations, 28 CFR Part 36 *(Nondiscrimination on the basis of disability…Final Rules).*

The checklist is presented as a guide to help you determine what may be readily achievable barrier removal for existing facilities. The Standards should be followed for all barrier removal unless doing so is not readily achievable. If complying with the Standards is not readily achievable, you may undertake a modification that does not comply, as long as it does not pose a health or safety risk.

This checklist does not cover all of the requirements of the Standards, nor does it does not attempt to illustrate all possible barriers. Facilities undergoing new construction or alterations must comply with ADAAG.

Priorities for planning readily achievable barrier removal recommended by the ADA are:

- Priority 1: Accessible approaches and entrances.
- Priority 2: Access to goods and services.
- Priority 3: Access to restrooms.
- Priority 4: Any other measure necessary.

How to Use this Checklist

☑ **Get Organized:** Establish a timeframe for completing this survey. Determine how many copies of the checklist you will need to survey the whole facility. Decide who will conduct the survey. It is recommended that you invite two or three additional people including people with various disabilities and accessibility expertise to assist in identifying barriers, developing solutions for removing these barriers, and setting priorities for implementing improvements.

☑ **Obtain Floor Plans:** It is very helpful to have the building floor plans with you while you survey. If plans are not available, use graph paper to sketch the layout of all interior and exterior spaces. Make notes on the sketch or plan while you are surveying.

☑ **Conduct the Survey:** Bring copies of this checklist, a clipboard, a pencil or pen, and a flexible steel tape measure. Think about each space from the perspective of people with physical, hearing, visual, and cognitive disabilities noting areas that need improvement.

☑ **Summarize Barriers and Solutions:** List barriers found and ideas for their removal. Consider the solutions listed beside each question and add your own ideas. Consult with building contractors and equipment suppliers to estimate the cost for making the proposed modifications.

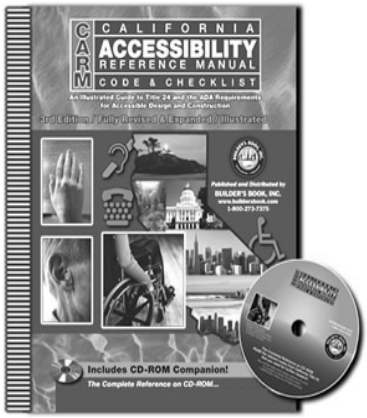
☑ **Make Decisions and Set Priorities:** Review the summary with decision makers and advisors. Decide which solutions will best eliminate barriers at a reasonable cost. Prioritize the items you decide upon and make a timeline for carrying them out. Where the removal of barriers is not readily achievable, you must consider whether there are alternative methods for providing access that are readily achievable.

- ☑ **Maintain Documentation:** Keep your survey notes, summary, record of work completed, and plans for alternative methods on file.
- ☑ **Make Changes:** Implement changes as planned. Always refer directly to ADAAG and California state and local codes for complete technical requirements before making any access improvements.
- ☑ **Follow Up:** Review your implementation plan each year to re-evaluate whether more improvements have become readily achievable.

The U .S. Department of Justice, Civil Rights Division, Disability Rights Section has a free ADA Technical Assistance CD-ROM available. This CD-ROM includes the ADA Regulations, Standards for Accessible Design, Technical Assistance Manuals and Technical Assistance Documents in PDF files, HTML files, Text files and WordPerfect files.

To order a copy of this CD-ROM contact the U.S. Department of Justice at 800.514.0301 (voice), 800.514.0383 (TTY), or on line at www.usdoj.gov/crt/ada

The California Accessibility Reference Manual Code and Checklist



Significant changes have made recently to California standards for accessible building and facility design. As a result, the new edition of California Accessibility Reference Manual has been completely updated with hundreds of new illustrations, tables and features.

The California Accessibility Reference Manual has been completely updated to reflect California's Title 24 and existing ADA regulations.

The California Accessibility Reference Manual Code and Checklist. Available from the Builders Book Store at 800.273.7375 for $71.95 or online at www.buildersbook.com

Sample Disability Admission and Referral Policy

It is the policy of **(insert name of program)** to support and comply with the requirements of the Americans with Disabilities Act-(ADA) Section 504 of the Rehabilitation Act of 1973; 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance; Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance and; Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities (PWD). to ensure that, to the maximum extent practicable, persons with disabilities are afforded equal access to our facilities, programs, and services**.**

Reasonable accommodations will be provided for individuals with a physical, sensory or cognitive disability, who meet our normal admission criteria, and consistent with the capabilities of our program design and staffing. Reasonable accommodations for individuals who identify as having a disability will be based an assessment of their functional limitations and discussion with the individual.

In the event **(insert name of program)** is unable to accommodate an individual because of a physical, sensory or cognitive disability he/she will given a referral to appropriate services and will be assisted in pursuing referrals.

We have cooperative agreements with the following programs to accept people with disabilities that we are unable to accommodate

(Insert name, address, phone number, and contact person of programs)

We may request the assistance of the County Alcohol and Drug Programs Administration and/or the California Disability Access Technical Assistance and Training Project.

County ADP Program
Administrator/Director
Address
City, State, ZIP
Phone Number
Fax number
E-mail address

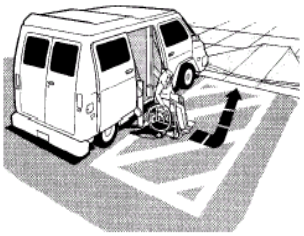
California Association of Addiction Recovery Resources (CAARR)
Disability Access Project
Bob Olson, Project Director
2400 Marconi Avenue
PO Box 214127
Sacramento, CA 95821
Phone: 916.338.9460 Voice
916.473.0836 TTY
916.338.9468 Fax
E-mail: bob@caarr.org

SECTION I: PARKING

1. Facility Parking

Does the facility have parking spaces designated for individuals with disabilities?

☐ **Yes** ☐ **No** ☐ **N/A**



Are accessible parking spaces designated with the International Symbol of Accessibility?

☐ **Yes** ☐ **No** ☐ **N/A**

---

2. Entrance to Parking Lot

Are the International Symbols of Accessibility used to designate the reserved parking spaces clearly visible at the entrance to the parking area?

☐ **Yes** ☐ **No** ☐ **N/A**

---

3. Number of Accessible Parking Spaces

Does the parking area have the minimum number of accessible spaces specified in the table below?

Total Parking Spaces	Designated Accessible Parking
1 to 25	Including 1 van accessible parking space
26 to 50	Including 2 van accessible parking spaces
51 to 75	Including 3 van accessible parking spaces

☐ **Yes** ☐ **No** ☐ **N/A**

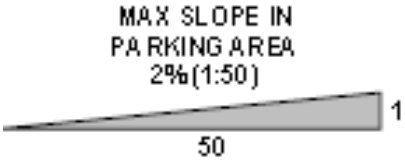
---

4. Space Location

Are the accessible parking spaces on the shortest possible accessible route to an accessible building entrance?

☐ **Yes** ☐ **No** ☐ **N/A**

Are the parking spaces located on level terrain with surface slopes that do not exceed 2% in all directions? (2% slope = 2 feet change in vertical elevation over a 100 foot horizontal distance)



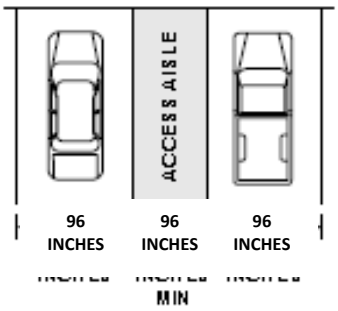
☐ **Yes** ☐ **No** ☐ **N/A**

---

5. Parking Identification and Dimensions of Spaces

Is there a sign showing the international symbol of accessibility located above grade and visible when a vehicle is parked in the designated space?

☐ **Yes** ☐ **No** ☐ **N/A**



Are parking spaces a minimum of 96 inches (8 feet) wide?

☐ **Yes** ☐ **No** ☐ **N/A**

Is there an access aisle adjacent to the parking space having a minimum width of 96 inches (8 feet)?

☐ **Yes** ☐ **No** ☐ **N/A**

Do accessible parking spaces not located adjacent to the accessible entrances have signage that indicates the direction to these entrances?

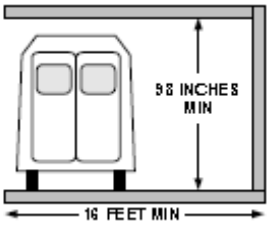
☐ **Yes** ☐ **No** ☐ **N/A**

---

6. Van Accessible Parking Space

Do accessible parking spaces for vans have adequate vertical and horizontal clearance? (Minimum 98 inches high and minimum 16 feet wide to accommodate both parking space and access aisle)

☐ **Yes** ☐ **No** ☐ **N/A**



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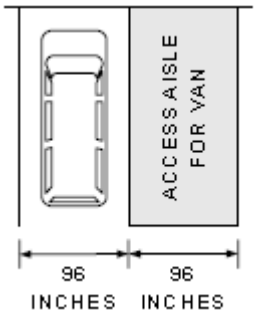
7. Van Accessibility

Is there at least one parking space designated “Van Accessible” with signage and does this space have a minimum 96 inch (8 foot) wide access aisle?

☐ **Yes** ☐ **No** ☐ **N/A**

Is there at least one van accessible space for every ten accessible parking spaces?

☐ **Yes** ☐ **No** ☐ **N/A**



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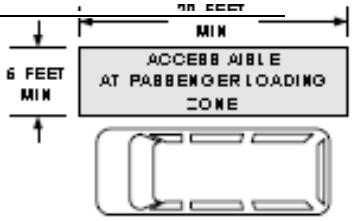
8. Passenger Loading Zone

Does the passenger loading zone have an unobstructed access aisle at least 60 inches (5 feet) wide and 20 feet long adjacent and parallel to the vehicle pull-up space?

☐ **Yes** ☐ **No** ☐ **N/A**



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9. Curb Ramp Placement

Are curb ramps provided wherever an accessible route crosses a curb?

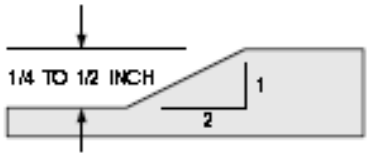
☐ **Yes** ☐ **No** ☐ **N/A**

SECTION II: WALKS, CURBS AND RAMPS

1. Ground and Floor Surfaces
Are ground, walk and floor surfaces along accessible routes stable, firm and relatively slip-resistant under all weather conditions?
☐ **Yes** ☐ **No** ☐ **N/A**

---

2. Changes in Surface Level
Are all ground and floor surfaces free of abrupt changes in surface level that do not exceed 1/4 inch in height?
☐ **Yes** ☐ **No** ☐ **N/A**

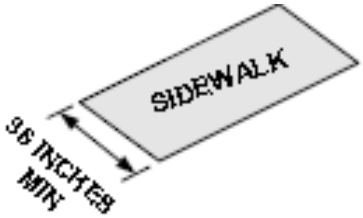


Where vertical elevation changes are between 1/4 and 1/2 inches in height, is the level change beveled with a slope no greater than 1:2?
☐ **Yes** ☐ **No** ☐ **N/A**

Are ramps provided for vertical elevation changes greater than ½ inch in height?
☐ **Yes** ☐ **No** ☐ **N/A**

---

3. Sidewalk Widths
Do sidewalks and ramps have a minimum clear width of 36 inches with an occasional space of 60 x 60 inches located at reasonable intervals not exceeding 200 feet which is used for turning and passing?
☐ **Yes** ☐ **No** ☐ **N/A**



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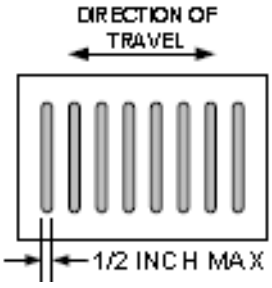
4. Gratings
Are gratings located on walking surfaces designed so that openings do not exceed 1/2 inch in one direction? Note: If gratings have elongated openings, the openings must be placed so that the long dimension is perpendicular to the direction of travel.
☐ **Yes** ☐ **No** ☐ **N/A**



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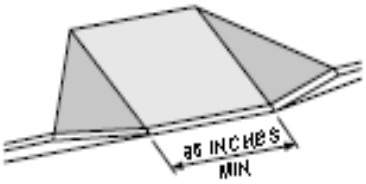
5. Width of Curb Ramps
Are curb ramps a minimum of 36 inches wide, exclusive of flared sides? Note: Curb ramps shall not extend into traffic lanes.
☐ **Yes** ☐ **No** ☐ **N/A**



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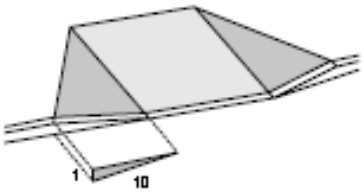
6. Sides of Curb Ramps

If curb ramps cross the walking path of pedestrians, do the curb ramps have flared sides with maximum slope of 1:10 (one inch vertical rise to every 10 inches of horizontal distance)?

☐ **Yes** ☐ **No** ☐ **N/A**



If curb ramps do not have flared sides, do the ramps have either a handrail or guardrail?

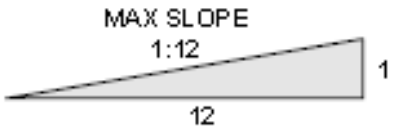
☐ **Yes** ☐ **No** ☐ **N/A**

---

7. Ramp Slope

Is the maximum slope of all ramps 1:12 (1 inch of vertical rise to every 12 inches of horizontal distance)? Note: Any part of an accessible route having a slope exceeding 1:20 is considered a ramp and must comply with the requirements stated in Part 7, 8, 9, 10 and 11 of this Section.

☐ **Yes** ☐ **No** ☐ **N/A**



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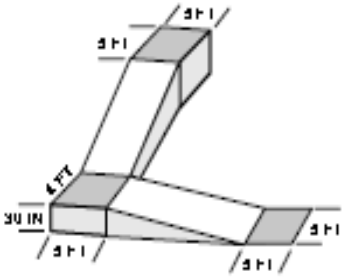
8. Landings

Do ramps and curb ramps have a 60 inch (5 feet) long level landing at the top and bottom?

☐ **Yes** ☐ **No** ☐ **N/A**

Do ramps have a 60 x 60 inch level landing at locations where ramps change direction (switchback) or at intervals of 30 inch vertical rise?

☐ **Yes** ☐ **No** ☐ **N/A**



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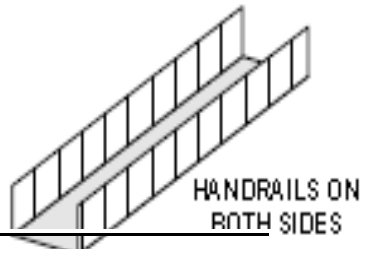
9. Sidewalk and Ramp Handrails

Do sidewalks and ramps with a vertical elevation change (rise) greater than 6 inches or horizontal run greater than 72 inches have handrails on both sides?

☐ **Yes** ☐ **No** ☐ **N/A**



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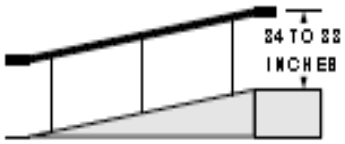
10. Handrail Location

Is the top surface of all handrails mounted between 34 inches and 38 inches above ramp surface?

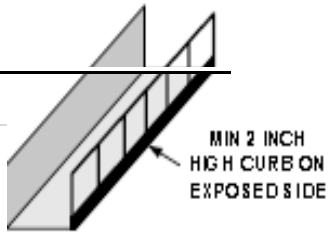
☐ **Yes** ☐ **No** ☐ **N/A**



If wall mounted, is the clear space between the handrail and the wall exactly 1-1/2 inches? (See figure in Section III, Part 14)

Is the diameter of the handrail 1-1/4 inches to 1-1/2 inches or does the shape provide an equivalent gripping surface?

☐ **Yes** ☐ **No** ☐ **N/A**



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11. Protective Edges on Ramps

Do ramps and landings with drop-offs have a curb which is a minimum of two inches high on all exposed sides of the ramp or landing?

☐ **Yes** ☐ **No** ☐ **N/A**

---

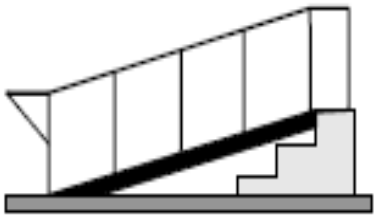
12. Temporary Ramps

Do temporary ramps meet standard ramp requirements? (See items 7, 8, 9, 10 and 11 in this Section of the Checklist)

☐ **Yes** ☐ **No** ☐ **N/A**

Are temporary ramps securely anchored?

☐ **Yes** ☐ **No** ☐ **N/A**



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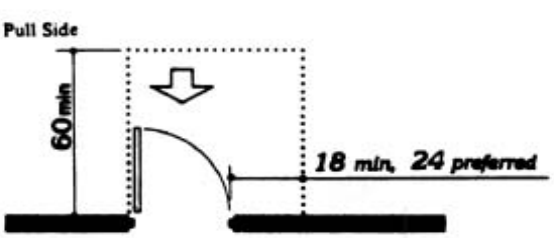
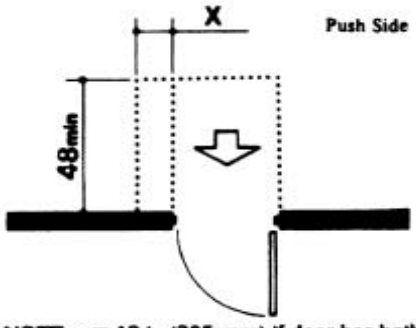
13. Ramps at Door Entrances

Do ramps at door entrances have adequate maneuvering clearances for a person using a wheelchair? (Refer to the diagrams on the following page)

☐ **Yes** ☐ **No** ☐ **N/A**

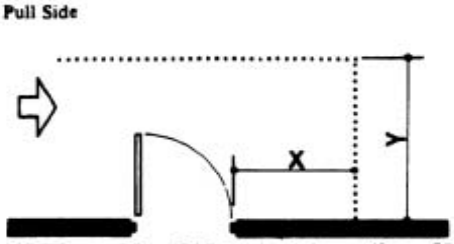
MANEUVERING CLEARANCES AT DOORS
(Taken from ADAAG 1991—Figure 25)



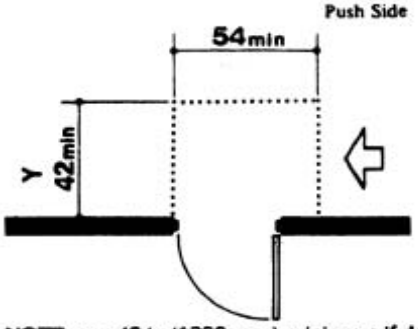


NOTE: x = 12 in (305 mm) if door has both a closer and latch.

(a)
Front Approaches — Swinging Doors

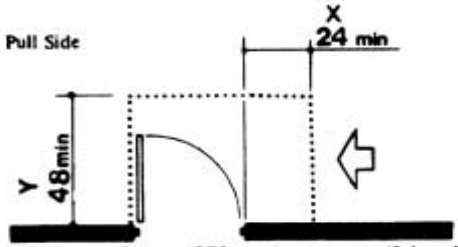


NOTE: x = 36 in (915 mm) minimum if y = 60 in (1525 mm); x = 42 in (1065 mm) minimum if y = 54 in (1370 mm).

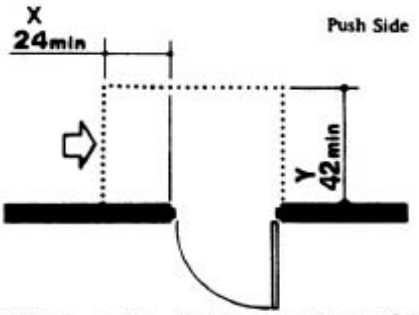


NOTE: y = 48 in (1220 mm) minimum if door has both a latch and closer.

(b)
Hinge Side Approaches — Swinging Doors



NOTE: y = 54 in (1370 mm) minimum if door has closer.



NOTE: y = 48 in (1220 mm) minimum if door has closer.

(c)
Latch Side Approaches — Swinging Doors

NOTE: All doors in alcoves shall comply with the clearances for front approaches.

SECTION III: ENTRANCES, CORRIDORS AND STAIRS

1. Marked Route

Is there at least one accessible route from the accessible parking areas or passenger loading zones to the accessible building entrance?

☐ **Yes** ☐ **No** ☐ **N/A**

If the accessible entrance is not visible from the parking or loading areas, are the accessible routes to the entrance clearly marked with appropriate signage?

☐ **Yes** ☐ **No** ☐ **N/A**

---

2. Signage at Entrances

Is the International Symbol of Accessibility displayed at all accessible entrances? ☐

☐ **Yes** ☐ **No** ☐ **N/A**

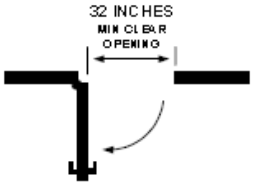
Are the primary entrances unlocked, or is provision made for a signaling device if that entrance must be locked during certain hours for security purposes?

☐ **Yes** ☐ **No** ☐ **N/A**

---

3. Doorway Width

Does the primary accessible entrance have a minimum clear opening (free of protrusions and obstructions) of 32 inches?



See diagrams referred to in Section II, Part 13

☐ **Yes** ☐ **No** ☐ **N/A**

Do the push and pull side of doors have minimum maneuvering clearances conforming with the figure referred to in Section II, Part13? (Exception: Automatic or power assisted doors)

☐ **Yes** ☐ **No** ☐ **N/A**

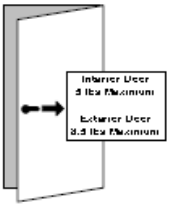
Is there a minimum of 60 x 60 inches of level space centered on the front of the accessible entrance?

☐ **Yes** ☐ **No** ☐ **N/A**

---

4. Door Opening Force

Can doors at accessible, exterior entrances be opened with 5 or less, pounds of force?



☐ **Yes** ☐ **No** ☐ **N/A**

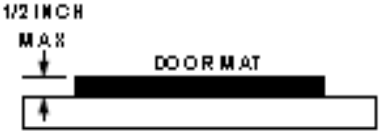
Can interior doors be opened with 5 or less, pounds of force? Note: Fire doors require a minimum of 15 pounds of force to open.

☐ **Yes** ☐ **No** ☐ **N/A**

---

5. Doormats

Are doormats stationary, flat, or recessed and less than 1/2 inch thick?

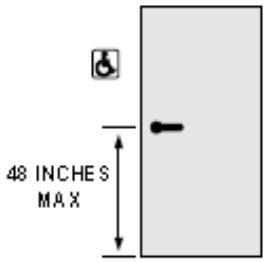


☐ **Yes** ☐ **No** ☐ **N/A**

6. Door Hardware

Are handles, pulls, latches, locks, and other operating devices on accessible doors easily grasped with one hand, and require no tight grasping, pinching, or twisting of the wrist to operate?

☐ **Yes** ☐ **No** ☐ **N/A**



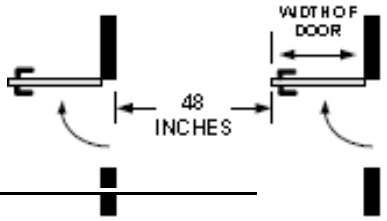
Is hardware required for accessible door passage mounted no higher than 48 inches from the finished floor surface?

☐ **Yes** ☐ **No** ☐ **N/A**

7. Doors in Series

Does approximately 48 inches, plus the width of in-swinging door(s), exist between two doors in a series to allow backing and turning space for a wheelchair or other mobility aid to clear the in-swinging door?

☐ **Yes** ☐ **No** ☐ **N/A**



8. Automatic and Power Assisted Doors

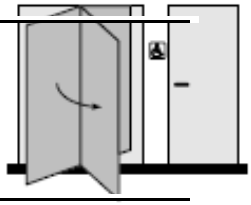
Do automatic and power assisted doors operate in a manner and direction which do not present a hazard?

☐ **Yes** ☐ **No** ☐ **N/A**

9. Revolving Doors and Turnstiles

Is there an accessible door adjacent to all revolving doors and turnstiles?

☐ **Yes** ☐ **No** ☐ **N/A**



10. Threshold

Are thresholds at exterior doors flush with the floor surface?

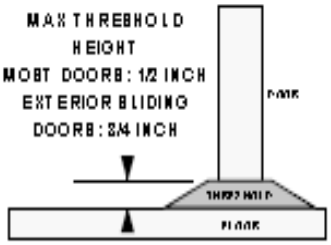
☐ **Yes** ☐ **No** ☐ **N/A**

If thresholds are higher than 1/2 inch, are they beveled on both sides to a slope of 1:2?

☐ **Yes** ☐ **No** ☐ **N/A**

If thresholds on exterior sliding doors exceed 3/4 inches in height, are they beveled on both sides at a slope of 1:2?

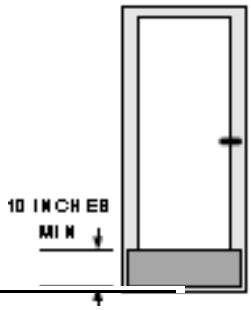
☐ **Yes** ☐ **No** ☐ **N/A**



11. Framed Glass Doors

If framed glass swinging doors are on accessible routes, is there a kick plate at least 10 inches high mounted on the bottom of the push side of the door? Note: This feature is not required by the existing ADA Accessibility Guidelines. This is a safety feature for people using wheelchairs to prevent their footrest from striking the glass.

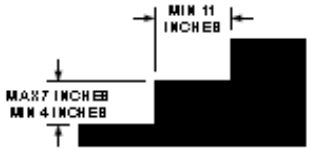
☐ **Yes** ☐ **No** ☐ **N/A**



12. Stair Risers, Treads and Nosing

For all stairs and steps: Are risers closed and have uniform height? Note: Riser height: maximum 7 inches, minimum 4 inches.

☐ **Yes** ☐ **No** ☐ **N/A**



Do treads have a uniform depth of 11 inches or more? Do nosings project no more than 1-1/2 inches and are the undersides free of abrupt, sharp angles?

☐ **Yes** ☐ **No** ☐ **N/A**

Do stair treads have non-slip surfaces?

☐ **Yes** ☐ **No** ☐ **N/A**

---

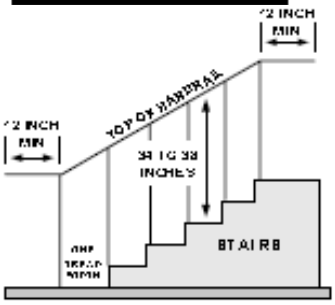
13. Location of Handrails

Do handrails on sides of all stairs extend at least 12 inches beyond the top riser and 12 inches plus the width of one tread beyond the bottom tread?

☐ **Yes** ☐ **No** ☐ **N/A**

Is the top of the handrail mounted 34 to 38 inches above the tread?

☐ **Yes** ☐ **No** ☐ **N/A**



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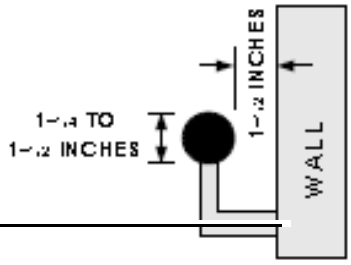
14. Handrail Dimensions

Are handrails 1-1/4 to 1-1/2 inches in diameter and easy to grasp? Is there a clear space of exactly 1-1/2 inches between the handrail and the wall?

☐ **Yes** ☐ **No** ☐ **N/A**



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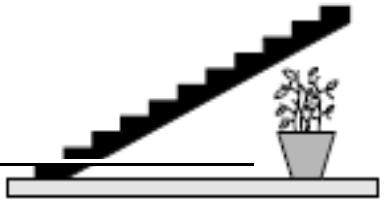
15. Suspended Stairs

Are all suspended stairs provided with sufficient warning devices, for example, railings, planters, etc., to alert people who are visually impaired?

☐ **Yes** ☐ **No** ☐ **N/A**



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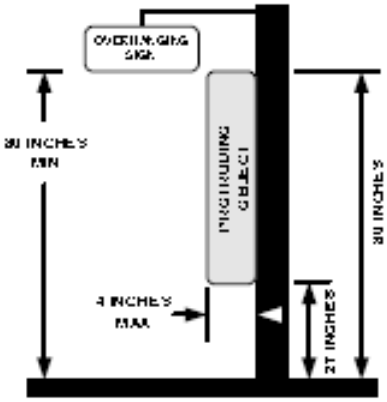
16. Protruding Objects

Do protruding and hanging objects (such as telephones, water fountains, signs, etc.) with their leading edge 27 inches to 80 inches above the floor, protrude no more than 4 inches into the path of travel?

☐ **Yes** ☐ **No** ☐ **N/A**

Do walks, halls, corridors, passageways, aisles or other circulation spaces have a minimum head clearance of 80 inches?

☐ **Yes** ☐ **No** ☐ **N/A**



SECTION IV: PUBLIC RESTROOMS

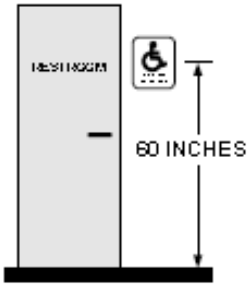
NOTE: Specifications for resident bathrooms are found in Section VIII, page 26

---

1. Restroom Identification

Is there an accessible restroom for each gender clearly marked with an International Symbol of Accessibility mounted on the latch side of the door at 60 inches above the finish floor to the centerline of the sign?

☐ **Yes** ☐ **No** ☐ **N/A**



Is the restroom identified with a sign having raised and Braille characters mounted on the latch side at 60 inches above the finish floor to the centerline of the sign?

☐ **Yes** ☐ **No** ☐ **N/A**

California Title 24 Bathroom signs are geometic door signs required by California law for restrooms to be identifiable by people with limited vision. These signs are to be mounted on the door in addition to the ADA wall sign required by the federal ADAAG

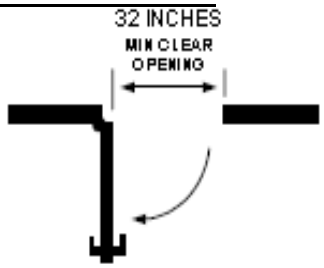
☐ **Yes** ☐ **No** ☐ **N/A**

---

2. Restroom Entrance

Do restroom entrances have a clear opening (free of protrusions and obstructions) of 32 inches and maneuvering clearance adjacent to the push and pull side of doors conforming to Section II, Part 13?

☐ **Yes** ☐ **No** ☐ **N/A**

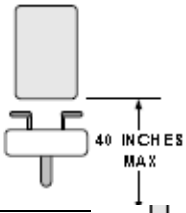


---

3. Restroom Mirror

Is the mirror mounted at a maximum height of 40 inches measured from the floor to the bottom edge of the reflective surface?

☐ **Yes** ☐ **No** ☐ **N/A**



---

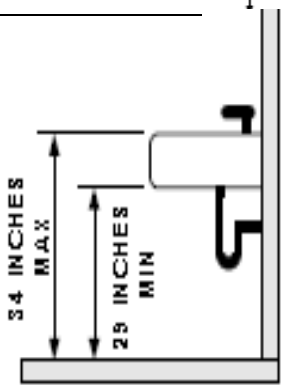
4. Lavatory Heights

Is the lavatory mounted so that the counter (rim) surface is no higher than 34 inches from the floor surface?

☐ **Yes** ☐ **No** ☐ **N/A**

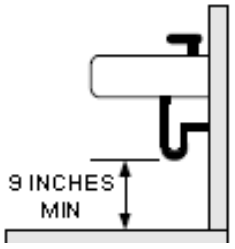
Is there a clearance space of at least 29 inches provided from the bottom of apron to the floor?

☐ **Yes** ☐ **No** ☐ **N/A**

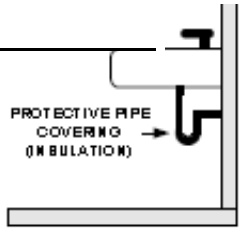


Is the drain pipe mounted so that there is at least 9 inches of clearance from the floor surface?

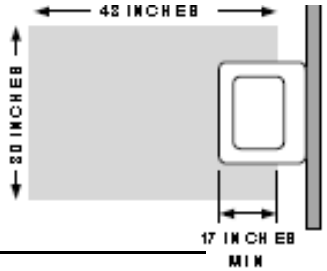
☐ **Yes** ☐ **No** ☐ **N/A**



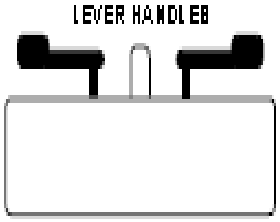
5. Protective Pipe Covering
Is insulation or other protective covering used on hot water and drain pipes under the lavatory to prevent contact?
☐ **Yes** ☐ **No** ☐ **N/A**



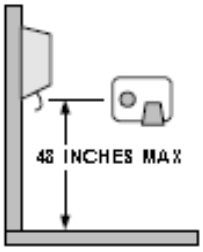
6. Lavatory Space
Is there clear floor space (30 x 48 inches) provided in front of the lavatory which includes a minimum extension of 17 inches under the lavatory to allow for forward approach?
☐ **Yes** ☐ **No** ☐ **N/A**



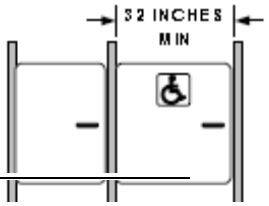
7. Faucet Controls Are faucets controlled by a hand lever, push button, or electronic control which is easily operated by one hand, not requiring tight grasping, pinching, or twisting and requiring a maximum of 5 pounds of force or less for operation? Note: Self-closing valves should stay open for a minimum of 10 seconds.
☐ **Yes** ☐ **No** ☐ **N/A**



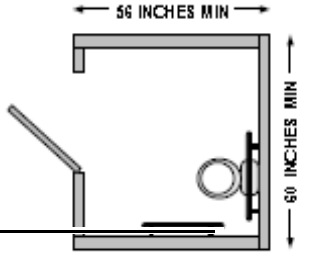
8. Dispensers in Restroom
Are restroom dispensers and accessories mounted so that there is no more than 48 inches to the highest control or operable part? Note: Dispensers which can be reached from a parallel (side) approach may be mounted so that there is no more than 54 inches to the highest operable control or part of the dispenser.
☐ **Yes** ☐ **No** ☐ **N/A**



9. Stall Door
Is at least one restroom stall available having a clear opening (free of protrusions and obstructions) of 32 inches? Does stall door swing outward?
☐ **Yes** ☐ **No** ☐ **N/A**



10. Standard Stall Size
Does the standard, accessible stall provide a minimum depth of 56 inches and a width of 60 inches for wall mounted water closets? Note: Add 3 inches to the depth if the water closet is floor mounted.
☐ **Yes** ☐ **No** ☐ **N/A**



11. Alternate Stall Size
Where a standard, accessible stall is technically infeasible, an alternate stall shall be provided. If the stall has a wall-mounted water closet, does it have a minimum depth of 66 inches? Note: Add three inches to the stall depth if the water closet is floor mounted.
☐ **Yes** ☐ **No** ☐ **N/A**

For alternate stalls allowing a forward approach to the water closet, is there a minimum width of 36 inches and grab bars mounted on both sides of the stall?
☐ **Yes** ☐ **No** ☐ **N/A**

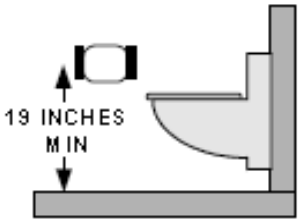
For alternate stalls allowing a side approach to the water closet, is there a minimum width of 48 inches and grab bars mounted to the side and rear of the water closet?
☐ **Yes** ☐ **No** ☐ **N/A**

Is the center of the water closet a minimum of 18 inches from both sides of the stall?
☐ **Yes** ☐ **No** ☐ **N/A**

If there are six or more stalls, is one additional stall provided which is 36 inches wide with out-swinging door, grab bars on both sides, and is the seat of the water closet 17 to 19 inches from the floor?
☐ **Yes** ☐ **No** ☐ **N/A**

---

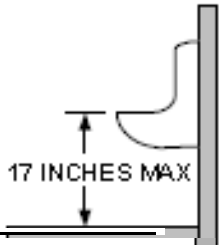
12. Dispensers in Commode Stall
Are toilet paper and seat cover dispensers located within easy reach of a person using the water closet?
☐ **Yes** ☐ **No** ☐ **N/A**



Do toilet paper dispensers permit delivery of a continuous flow of paper and are they mounted at a minimum height of 19 inches?
☐ **Yes** ☐ **No** ☐ **N/A**

---

13. Urinals
Does the men's restroom have at least one stall-type or wall-hung urinal with an elongated rim which is mounted at a maximum of 17 inches above the floor?
☐ **Yes** ☐ **No** ☐ **N/A**



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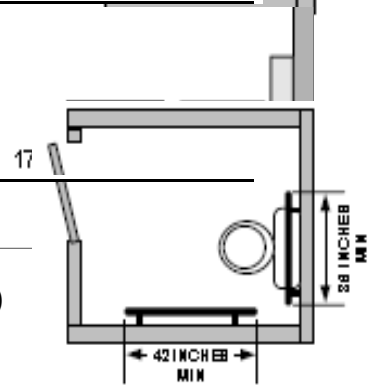
14. Water Closet Seat
Is the top of the water closet seat 17 to 19 inches from the floor surface?
☐ **Yes** ☐ **No** ☐ **N/A**



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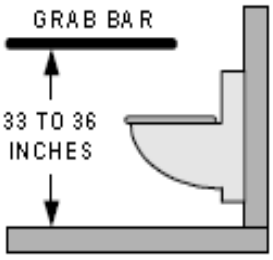
15. Grab Bars
When a side transfer in a stall is required, are two grab bars (a minimum 42 inch long bar to the side and a minimum 36 inch long bar to the back) mounted at 33 to 36 inches from the floor surface provided?
☐ **Yes** ☐ **No** ☐ **N/A**

For alternate stalls (see item 11 above) are there two grab bars 42 inches in length located on both sides of the stall and mounted 33 to 36 inches from floor surface?



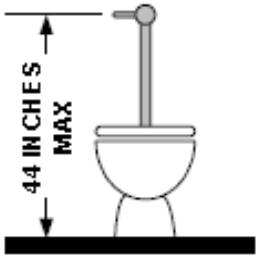
☐ **Yes** ☐ **No** ☐ **N/A**

Is the diameter of each grab bar 1-1/4 to 1-1/2 inches, is the space between the wall and each grab bar 1-1/2 inches, and will each grab bar support 250 lbs?

☐ **Yes** ☐ **No** ☐ **N/A**

---

16. Flush Controls



Are the flush controls mounted no higher than 44 inches above the floor surface?

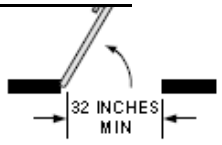
☐ **Yes** ☐ **No** ☐ **N/A**

Are flush controls operable with one hand, not requiring tight grasping, pinching, or twisting of the wrist or more than 5 pounds of force?

☐ **Yes** ☐ **No** ☐ **N/A**

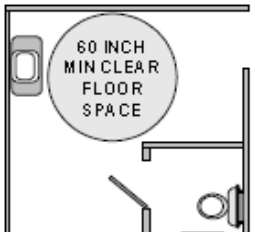
---

17. Clearance for Doors and Floor Space



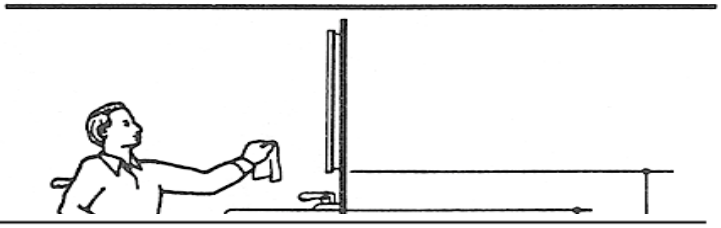
Do all stall doors swing outward and provide a minimum of 32 inches of clearance?

☐ **Yes** ☐ **No** ☐ **N/A**



Is there a clear floor space in the interior of multi-fixture restrooms having a minimum diameter of 60 inches to allow for turning in a wheelchair or other mobility aid?

☐ **Yes** ☐ **No** ☐ **N/A**



Where there is a privacy wall in a restroom, is there a minimum 60 inch diameter clear floor space for turning?

☐ **Yes** ☐ **No** ☐ **N/A**

4.19 Lavatories and Mirrors.

4.19.1 General. The requirements of 4.19 shall apply to lavatory fixtures, vanities, and built-in lavatories.

4.19.2 Height and Clearances. Lavatories shall be mounted with *the rim or counter surface no higher than 34 in (865 mm) above the finish floor.* Provide a clearance of at least 29 in (735 mm) above the finish floor to the bottom of the apron. Knee and toe clearance shall comply with Fig. 31.

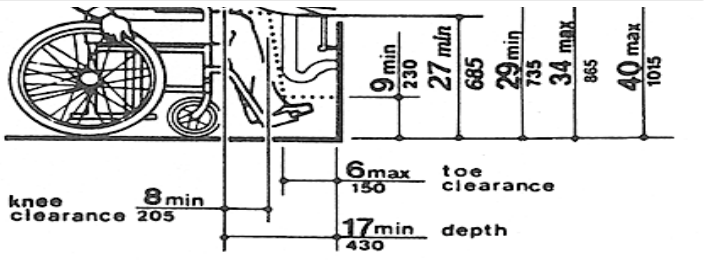


Fig. 31
Lavatory Clearances

4.19.3 Clear Floor Space. A clear floor space 30 in by 48 in (760 mm by 1220 mm) complying with 4.2.4 shall be provided in front of a lavatory

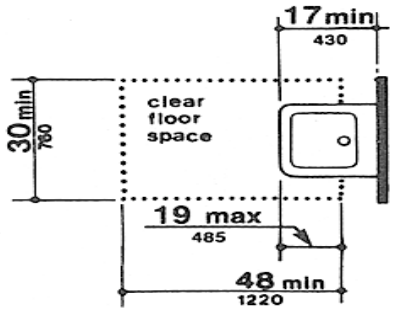


Fig. 32
Clear Floor Space at Lavatories

to allow forward approach. Such clear floor space shall adjoin or overlap an accessible route and shall extend a maximum of 19 in (485 mm) underneath the lavatory (see Fig. 32).

4.19.4 Exposed Pipes and Surfaces. Hot water and drain pipes under lavatories shall be insulated or otherwise *configured to protect against contact.* There shall be no sharp or abrasive surfaces under lavatories.

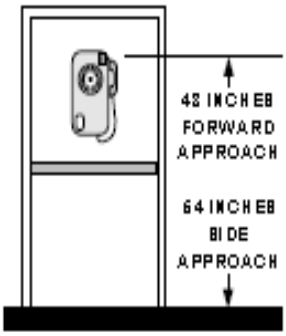
4.19.5 Faucets. Faucets shall comply with 4.27.4. Lever-operated, push-type, and electronically controlled mechanisms are examples of acceptable designs. *If* self-closing
valves are used the faucet shall remain open for at least 10 seconds.

4.19.6* Mirrors. Mirrors shall be mounted with the bottom edge *of the reflecting surface* no higher than 40 in (1015 mm) *above the finish* floor (see Fig. 31).

SECTION V: PUBLIC TELEPHONES AND WATER FOUNTAINS

1. Telephone Mounting If public telephones are provided, is at least one accessible with phone dial and coin receiver no higher than 48 inches (for forward approach) or 54 inches (for parallel approach)?

☐ **Yes** ☐ **No** ☐ **N/A**



Does it have a cord at least 29 inches long?

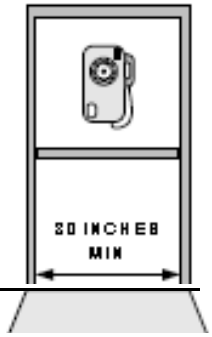
☐ **Yes** ☐ **No** ☐ **N/A**

---

2. Access

Do telephone enclosures have a minimum clear path width for forward approach of 30 inches?

☐ **Yes** ☐ **No** ☐ **N/A**



Is there a clear floor space of 30 x 48 inches provided at telephones?

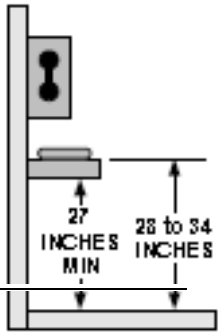
☐ **Yes** ☐ **No** ☐ **N/A**

---

3. Directory Access

Are phone directories usable at wheelchair level? (see dimensions in the figure)

☐ **Yes** ☐ **No** ☐ **N/A**



Are operation directions available in Braille and/or large print?

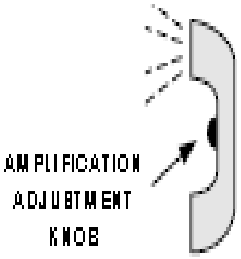
☐ **Yes** ☐ **No** ☐ **N/A**

---

4. Auditory Amplification

Are telephones equipped with an amplifier? Note: 25% of total phones but never less than one must have amplification.

☐ **Yes** ☐ **No** ☐ **N/A**



Are telephones hearing aid compatible? NOTE: Public pay telephones that are hearing aid compatible can be identified by a blue grommet at the where the handset connects to the cord.

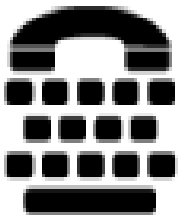
☐ **Yes** ☐ **No** ☐ **N/A**

---

5. Text Telephone

If there are four or more public telephones, is at least one a public text telephone (TT)? Note: Text Telephones are also known as Telecommunication Devices for the Deaf (TDD) or Tele-Type Writers (TTY).

☐ **Yes** ☐ **No** ☐ **N/A**



Are text telephones identified by the symbol shown at the right?

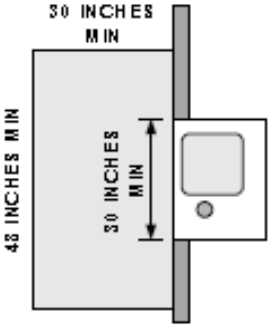
☐ **Yes** ☐ **No** ☐ **N/A**

---

6. Access to Water Fountain

If free-standing or built-in water fountains do not have a clear, open space under them, is there clear floor space of 30 x 48 inches for parallel approach plus space for maneuvering?

☐ **Yes** ☐ **No** ☐ **N/A**



Is the spout of the drinking fountain located in the front of the unit with a water flow trajectory that is parallel or nearly parallel to the front of the unit?

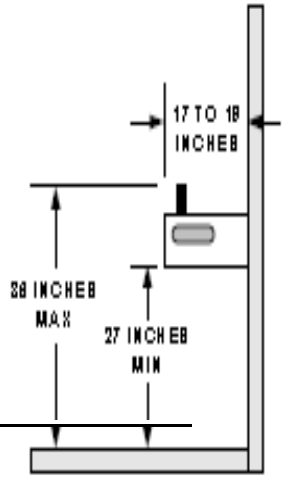
☐ **Yes** ☐ **No** ☐ **N/A**

---

7. Height

Is there a water fountain available that is mounted to provide a minimum clearance of 27 inches and depth of 17 to 19 inches so that it can be approached and used by a person in a wheelchair?

☐ **Yes** ☐ **No** ☐ **N/A**



Is the width of the water fountain at least 30 inches? (See figure in Item 6 above)

☐ **Yes** ☐ **No** ☐ **N/A**

Is the maximum height of the water spout 36 inches?

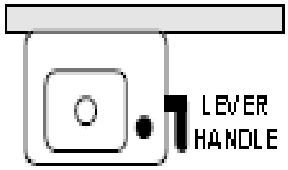
☐ **Yes** ☐ **No** ☐ **N/A**

---

8. Hand Controls

Are the controls on the water fountain located on the front or on the side near the front, can the controls be operated with one hand, not requiring tight grasping, pinching, or twisting, and can the controls be operated with 5 pounds of force or less?

☐ **Yes** ☐ **No** ☐ **N/A**



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9. Existing Water Fountain

Are drinking cups provided when water fountain exceeds recommended height?

☐ **Yes** ☐ **No** ☐ **N/A**

SECTION VI: MEETING ROOMS

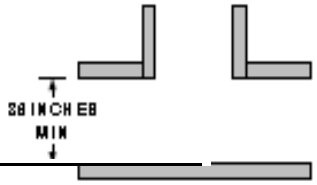
1. Accessible Rooms
Are accessible meeting rooms available?
☐ **Yes** ☐ **No** ☐ **N/A**

---

2. Location
Are the accessible meeting rooms centrally located in the facility to prevent unnecessary long travel for people with mobility impairments?
☐ **Yes** ☐ **No** ☐ **N/A**

---

3. Accessible Route
Do hallways and corridors have a clearance of 36 inches with an occasional space allowance for turning and passing at intervals not exceeding 200 feet?
☐ **Yes** ☐ **No** ☐ **N/A**



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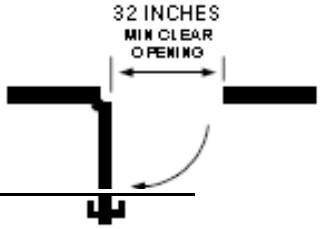
4. Door Width
Do the doors to meeting rooms have a minimum clear opening of 32 inches?
☐ **Yes** ☐ **No** ☐ **N/A**



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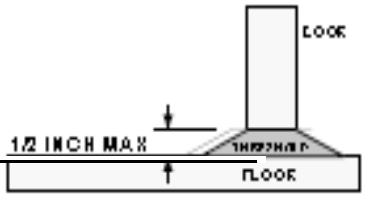
5. Thresholds
Do thresholds of interior doors have a maximum edge height of ½ inch? (See Section III, Part 10)
☐ **Yes** ☐ **No** ☐ **N/A**



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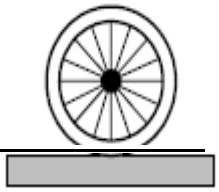
6. Amplifier and Sound System Equipment
Is there amplifier and sound system equipment available with individual or lavaliere microphones?
☐ **Yes** ☐ **No** ☐ **N/A**

---

7. Floor
Is the meeting room floor non-slip, level, and negotiable by persons in wheelchairs and other mobility aids?
☐ **Yes** ☐ **No** ☐ **N/A**



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8. Seating for People using Wheelchairs
Is there adequate space for seating at least two people using wheelchairs?
☐ **Yes** ☐ **No** ☐ **N/A**

Are the spaces for people using wheelchairs dispersed throughout the room within easy viewing of the stage?

☐ **Yes** ☐ **No** ☐ **N/A**

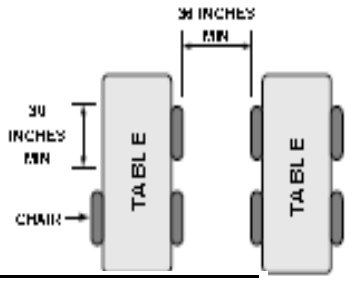
Are the spaces for people using wheelchairs or other mobility aids near accessible exits?

☐ **Yes** ☐ **No** ☐ **N/A**

\9. Table Placement

If tables are used in the meeting rooms, is there a minimum clearance of 36 inches in the aisles?

☐ **Yes** ☐ **No** ☐ **N/A**



Are the spaces for wheelchair access at the tables at least 30 inches wide?

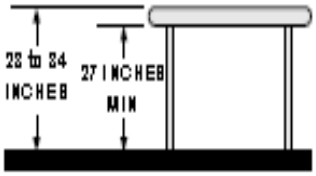
☐ **Yes** ☐ **No** ☐ **N/A**

---

10. Table Height

Do tables have a clear opening for knee space of at least 27 inches in height, 30 inches in width, and 19 inches in depth?

☐ **Yes** ☐ **No** ☐ **N/A**



Is the top surface of the table 28 to 34 inches from floor surface?

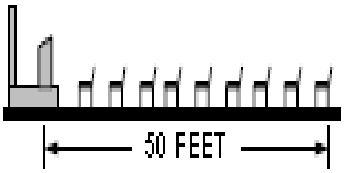
☐ **Yes** ☐ **No** ☐ **N/A**

---

11. Listening System

If requested, are participants provided with interpreter services or a listening system and are they seated within 50 feet of the stage for viewing?

☐ **Yes** ☐ **No** ☐ **N/A**



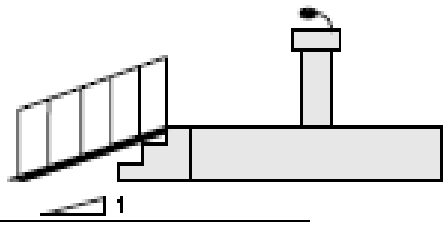
<u>Note: Assistive listening systems are available from the Disability Access Project at no cost loans.</u>

---

12. Temporary Ramp

Is a temporary ramp for the podium or head table available? Note: Maximum slope of ramp is 1 inch vertical rise in every 12 inches of horizontal distance.

☐ **Yes** ☐ **No** ☐ **N/A**



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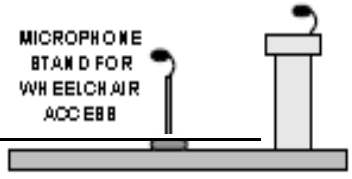
13. Microphones

Are the microphones accessible and flexible?

☐ **Yes** ☐ **No** ☐ **N/A**



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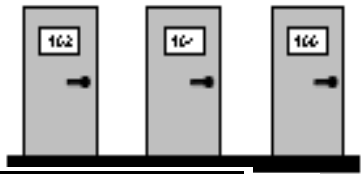
14. Lighting System
Is the lighting non-glare, non-reflecting, and non–blinking?
☐ **Yes** ☐ **No** ☐ **N/A**

SECTION VIII: GUEST ROOMS

1. Room Numbers

If numbered are guest rooms numbered in consecutive sequence (100, 102, 104, etc.) and are numbers raised for tactile identification?

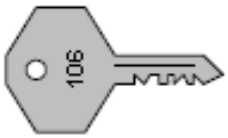
☐ **Yes** ☐ **No** ☐ **N/A**



2. Keys

Are room keys available with a large fixed handle for easy handling?

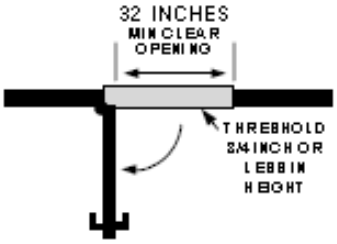
☐ **Yes** ☐ **No** ☐ **N/A**



3. Door

Do entry, bathroom, and closet doors have a minimum clear opening of 32 inches with maximum threshold height of 1/2 inch with beveled edges of 1:2 slope as necessary? (See Section III, Part 10)

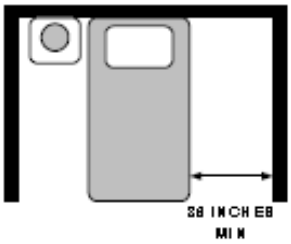
☐ **Yes** ☐ **No** ☐ **N/A**



4. Bed Spacing

Is there a minimum clear opening of 36 inch by at least one side of the bed or can furniture be moved to allow for a 36 inch space on at least one side of the bed?

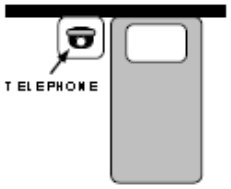
☐ **Yes** ☐ **No** ☐ **N/A**



5. Telephones

If provided, is there at least one telephone in the room which is accessible from the bed?

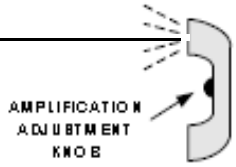
☐ **Yes** ☐ **No** ☐ **N/A**



6. Amplified Telephones

Are amplified telephones and text telephones available for residents?

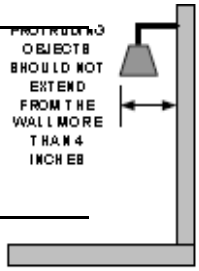
☐ **Yes** ☐ **No** ☐ **N/A**



7. Protruding Objects

Are rooms free of wall-mounted objects, such as televisions, shelves and lamps that protrude more than 4 inches?

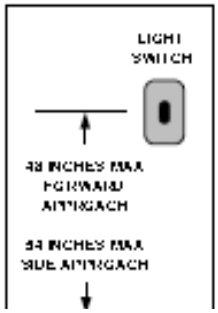
☐ **Yes** ☐ **No** ☐ **N/A**



8. Switch Access

Are light switches, controls for heating and cooling, and draperies, and other similar items accessible and placed so that they will allow access by forward or parallel approach in a wheelchair or other mobility aid?

☐ **Yes** ☐ **No** ☐ **N/A**



Are tactile instructions available on controls?

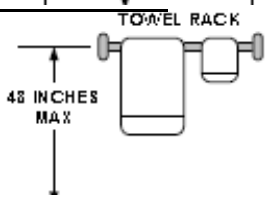
☐ **Yes** ☐ **No** ☐ **N/A**

---

9. Closet and Towel Racks

Are towel and closet racks mounted at a maximum height of 48 inches?

☐ **Yes** ☐ **No** ☐ **N/A**



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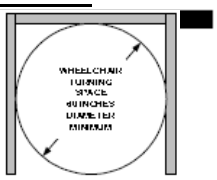
10. Space for Wheelchairs

Do guest rooms and bathrooms allow sufficient turning space for wheelchairs (60 inch diameter space is preferred)?

☐ **Yes** ☐ **No** ☐ **N/A**



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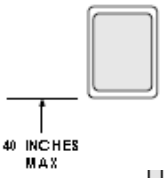
11. Mirrors

Is the mirror mounted at a maximum height of 40 inches measured from the floor to the bottom edge of the reflective surface?

☐ **Yes** ☐ **No** ☐ **N/A**



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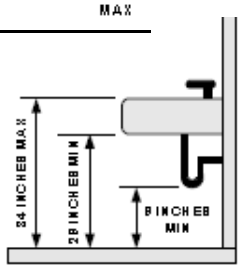
12. Lavatory Clearance

Is the lavatory mounted at least 29 inches from the floor to provide knee clearance, at a maximum height of 34 inches to the top surface of the lavatory, and with the bottom of the d rain pipe at least 9 inches from the floor surface? (See Section IV - Restrooms)

☐ **Yes** ☐ **No** ☐ **N/A**



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13. Exposed Hot Water and Drain Pipes

Is insulation or protective covering used on drain and hot water pipes under the lavatory to prevent contact?

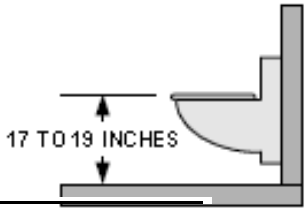
☐ **Yes** ☐ **No** ☐ **N/A**

---

14. Water Closet Seat

Is the top of the water closet seat between 17 to 19 inches from the floor surface?

☐ **Yes** ☐ **No** ☐ **N/A**



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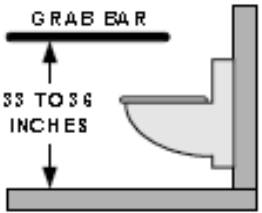
15. Grab Bars



Are grab bars of sufficient length and height (33 to 36 inches) mounted adjacent to the water closet and do these grab bars have a diameter of 1-1/4 to 1-1/2 inches, is there a 1-1/2 inch space between the grab bar and the wall, and are the grab bars able to support 250 pounds?

☐ **Yes** ☐ **No** ☐ **N/A**

---

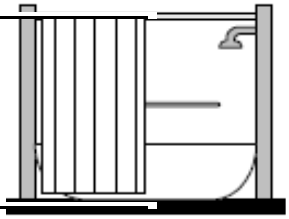
16. Faucet Controls

Are faucets controlled by a hand lever, push button, or electronic control that is easily operated by one hand, not requiring tight grasping, pinching, or twisting and operable with 5 pounds of force or less?

☐ **Yes** ☐ **No** ☐ **N/A**

---

17. Shower and Tub Combinations

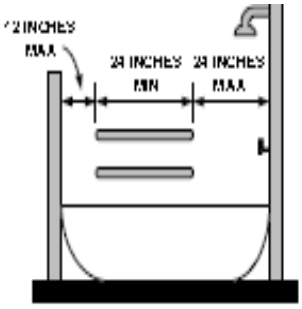


Do shower and tub combinations have curtains rather than glass doors?

☐ **Yes** ☐ **No** ☐ **N/A**

---

18. Grab Bars



Are grab bars of sufficient length, height and load capacity mounted in tub or shower?

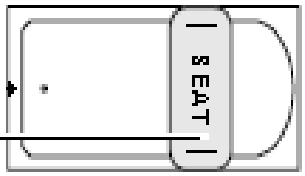
☐ **Yes** ☐ **No** ☐ **N/A**

Do these grab bars have a diameter of 1-1/4 to 1-1/2 inches, is there a 1-1/2 inch space between the grab bar and the wall, and are the grab bars able to support 250 pounds?

☐ **Yes** ☐ **No** ☐ **N/A**

---

19. Bath Tub Bench

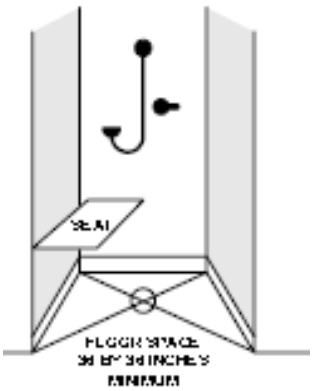


Is there a bench available for use in the tub?

☐ **Yes** ☐ **No** ☐ **N/A**

---

20. Shower Stall and Flexible Shower Hose



Is the floor space in the shower stall at least 36 x 36 inches? Note: Shower stalls that would fit into the space required for a bathtub (30 by 60 inches) are also allowed.

☐ **Yes** ☐ **No** ☐ **N/A**

Does the shower spray unit have a flexible hose of at least 60 inches long and can the shower head be used as both a hand-held and fixed unit?

☐ **Yes** ☐ **No** ☐ **N/A**

Is a seat provided in the shower stall?

☐ **Yes** ☐ **No** ☐ **N/A**

---

21. Number of Accessible Rooms

Does the number of accessible guest rooms or suites available comply with the table below?

1 to 25	1

26 to 50	2
51 to 75	3
76 to 100	4

☐ **Yes** ☐ **No** ☐ **N/A**

---

22. Sleeping Accommodations for Persons with Hearing Impairments

In addition to the number of accessible rooms or suites required above, do the number of rooms with Visual Alarm Notification Devices and Text Telephones comply with the following table?

1 to 25	1
26 to 50	2
51 to 75	3
76 to 100	4

☐ **Yes** ☐ **No** ☐ **N/A**

4.19 Lavatories and Mirrors.

4.19.1 General. The requirements of 4.19 shall apply to lavatory fixtures, vanities, and built-in lavatories.

4.19.2 Height and Clearances. Lavatories shall be mounted with *the rim or counter surface no higher than 34 in (865 mm) above the finish floor.* Provide a clearance of at least 29 in (735 mm) above the finish floor to the bottom of the apron. Knee and toe clearance shall comply with Fig. 31.

4.19.3 Clear Floor Space. A clear floor space 30 in by 48 in (760 mm by 1220 mm) complying with 4.2.4 shall be provided in front of a lavatory to allow forward approach. Such clear floor space shall adjoin or overlap an accessible route and shall extend a maximum of 19 in (485 mm) underneath the lavatory (see Fig. 32).

4.19.4 Exposed Pipes and Surfaces. Hot water and drain pipes under lavatories shall be insulated or otherwise *configured to protect against contact.* There shall be no sharp or abrasive surfaces under lavatories.

4.19.5 Faucets. Faucets shall comply with 4.27.4. Lever-operated, push-type, and electronically controlled mechanisms are examples of acceptable designs. *If* self-closing valves are used the faucet shall remain open for at least 10 seconds.

4.19.6 Mirrors. Mirrors shall be mounted with the bottom edge *of the reflecting surface* no higher than 40 in (1015 mm) *above the finish* floor (see Fig. 31).

4.20 Bathtubs.

4.20.1 General. Accessible bathtubs shall comply with 4.20.

4.20.2 Floor Space. Clear floor space in front of bathtubs shall be as shown in Fig. 33.

4.20.3 Seat. An in-tub seat or a seat at the head end of the tub shall be provided as shown in Fig. 33 and 34. The structural strength of seats and their attachments shall comply with 4.26.3. Seats shall be mounted securely and shall not slip during use.

4.20.4 Grab Bars. Grab bars complying with 4.26 shall be provided as shown in Fig. 33 and 34.

4.20.5 Controls. Faucets and other controls complying with 4.27.4 shall be located as shown in Fig. 34.

4.20.6 Shower Unit. A shower spray unit with a hose at least 60 in (1525 mm) long that can be used both as a fixed shower head and as a hand-held shower shall be provided.

4.20.7 Bathtub Enclosures. If provided, enclosures for bathtubs shall not obstruct controls or transfer from wheelchairs onto bathtub seats or into tubs. Enclosures on bathtubs shall not have tracks mounted on their rims.

4.21 Shower Stalls.

4.21.1* General. Accessible shower stalls shall comply with 4.21.

4.21.2 Size and Clearances. Except as specified in 9.1.2, shower stall size and clear floor space shall comply with Fig. 35(a) or (b). The shower stall in Fig. 35(a) shall be 36 in by 36 in (915 mm by 915 mm). Shower stalls required by 9.1.2 shall comply with Fig. 57(a) or (b). The shower stall in Fig. 35(b) will fit into the space required for a bathtub.

4.21.3 Seat. A seat shall be provided in shower stalls 36 in by 36 in (915 mm by 915 mm) and shall be as shown in Fig. 36. The seat shall be mounted 17 in to 19 in (430 mm to 485 mm) from the bathroom floor and shall extend the full depth of the stall. In a 36 in by 36 in (915 mm by 915 mm) shower stall, the seat shall be on the wall opposite the controls. *Where a fixed seat is provided in a 30 in by 60 in minimum (760 mm by 1525 mm) shower stall, it shall be a folding type and shall be mounted on the wall adjacent to the controls as shown in Fig. 57.* The structural strength of seats and their attachments shall comply with 4.26.3.

4.21.4 Grab Bars. Grab bars complying with 4.26 shall be provided as shown in Fig. 37.

4.21.5 Controls. Faucets and other controls complying with 4.27.4 shall be located as shown in Fig. 37. In shower stalls 36 in by 36 in (915 mm by 915 mm), all controls, faucets, and the shower unit shall be mounted on the side wall opposite the seat.

4.21.6 Shower Unit. A shower spray unit with a hose at least 60 in (1525 mm) long that can be used both as a fixed shower head and as a hand-held shower shall be provided. *EXCEPTION: In unmonitored facilities where vandalism is a consideration, a fixed shower*

head mounted at 48 in (1220 mm) above the shower floor may be used in lieu of a hand-held shower head.

4.21.7 Curbs. If provided, curbs in shower stalls 36 in by 36 in (915 mm by 915 mm) shall be no higher than 1/2 in (13 mm). Shower stalls that are 30 in by 60 in (760 mm by 1525 mm) minimum shall not have curbs.

4.21.8 Shower Enclosures. If provided, enclosures for shower stalls shall not obstruct controls or obstruct transfer from wheelchairs onto shower seats.

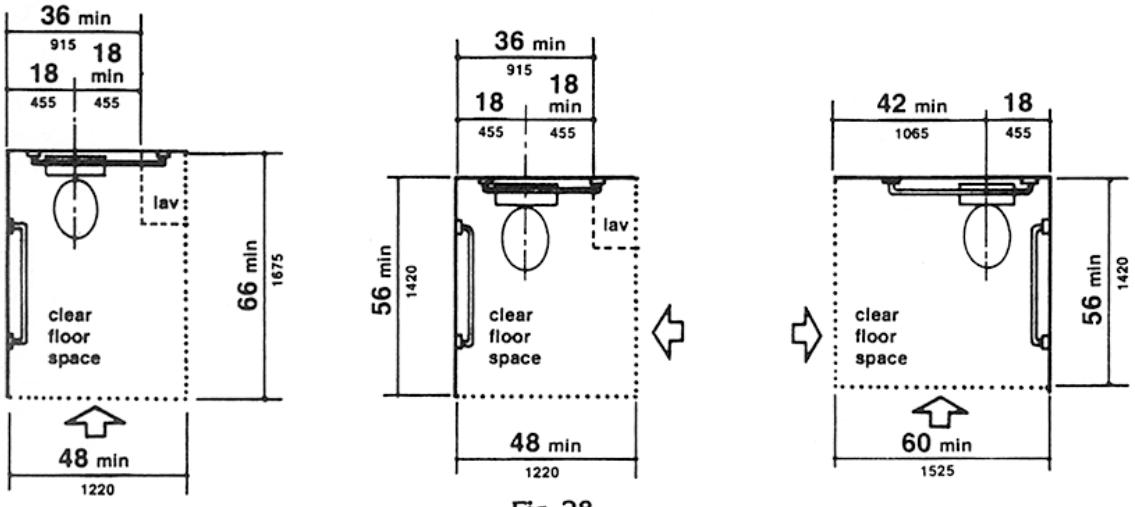


Fig. 28
Clear Floor Space at Water Closets

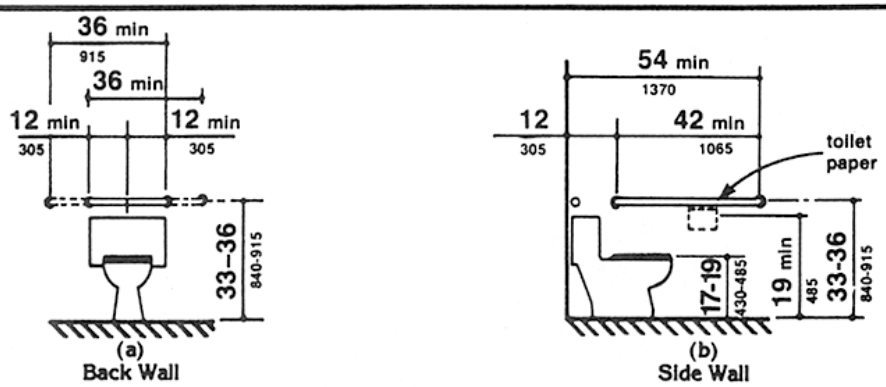
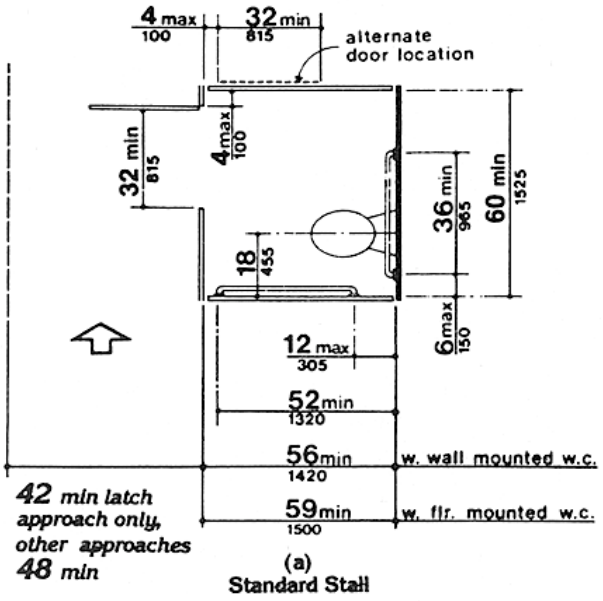
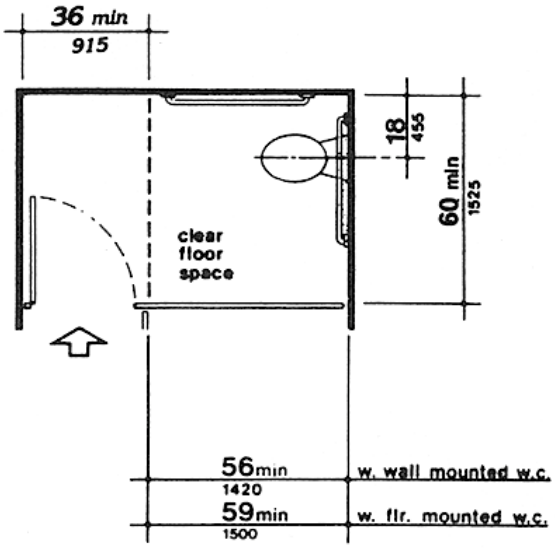


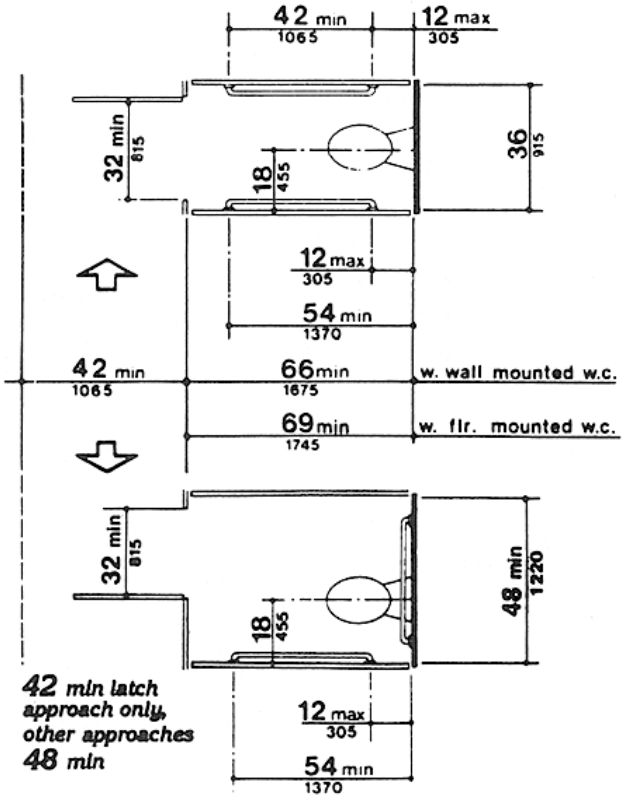
Fig. 29
Grab Bars at Water Closets



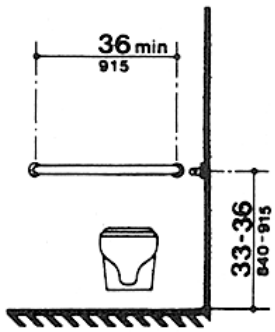
(a)
Standard Stall



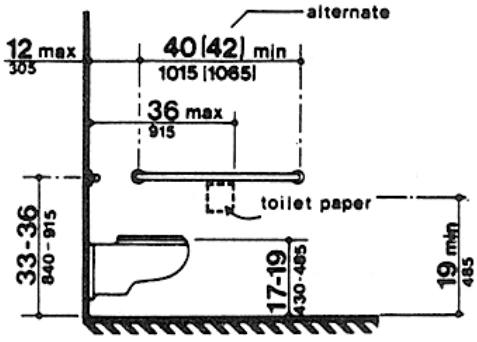
(a-1)
Standard Stall (end of row)



(b)
Alternate Stalls



(c)
Rear Wall of Standard Stall



(d)
Side Walls

Fig. 30
Toilet Stalls

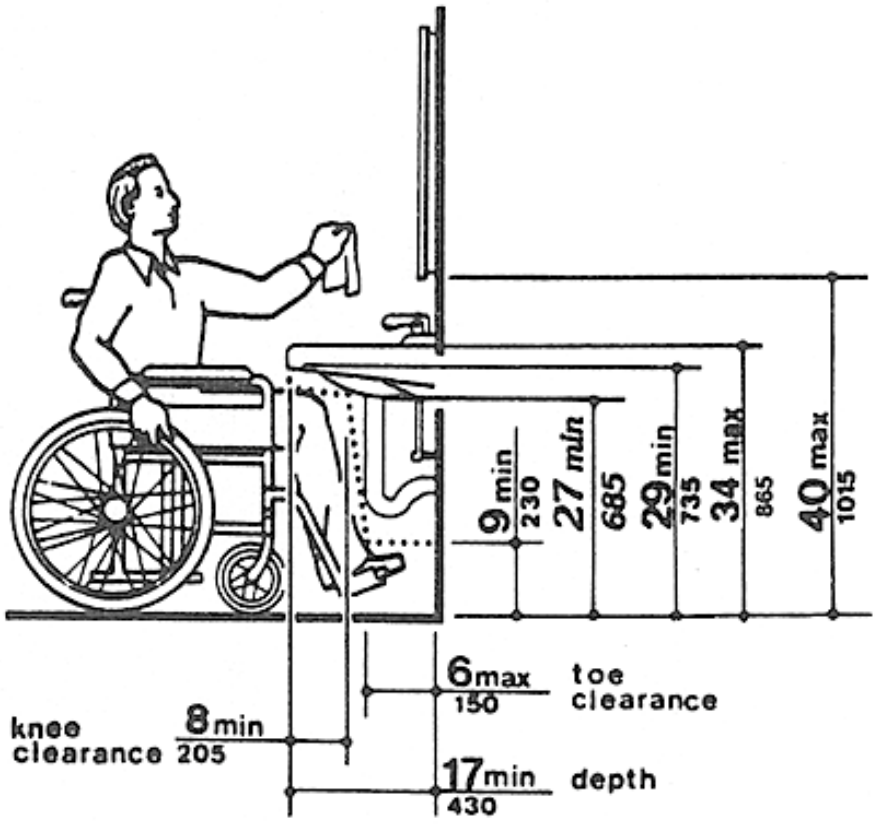


Fig. 31
Lavatory Clearances

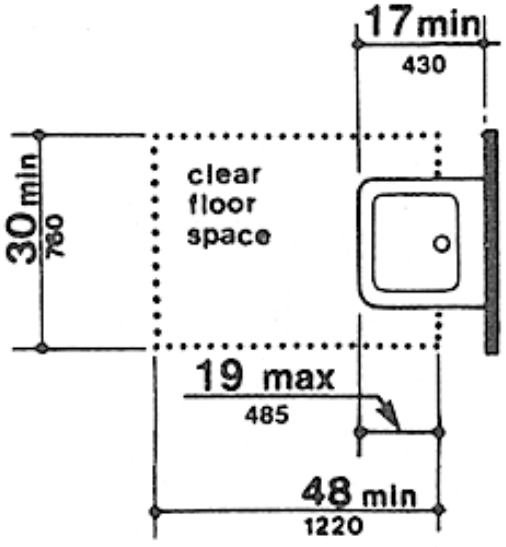


Fig. 32
Clear Floor Space at Lavatories

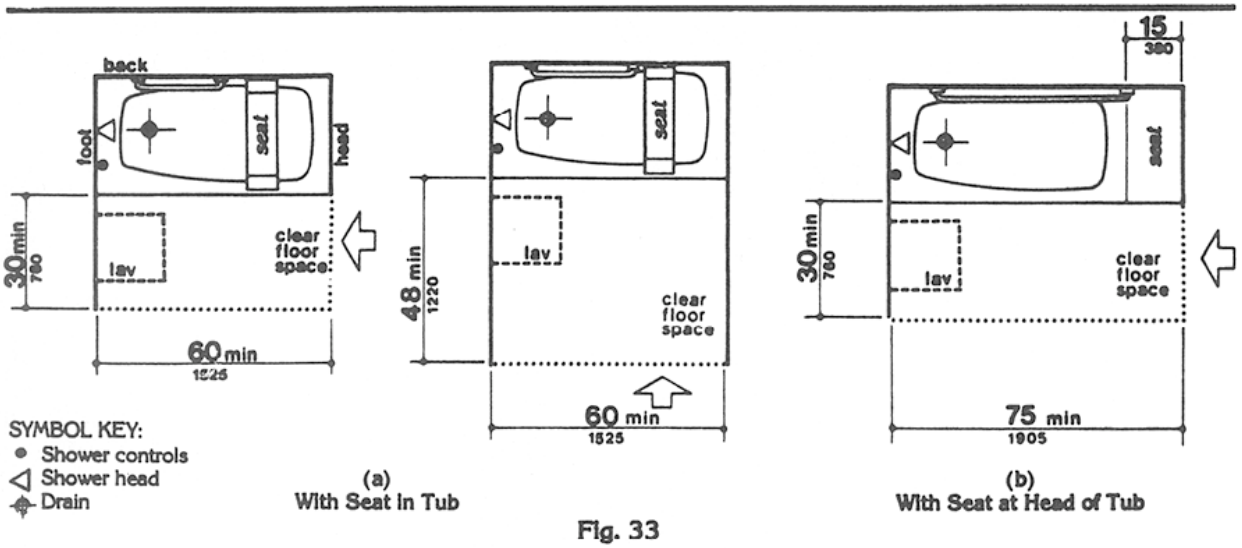


Fig. 33
Clear Floor Space at Bathtubs

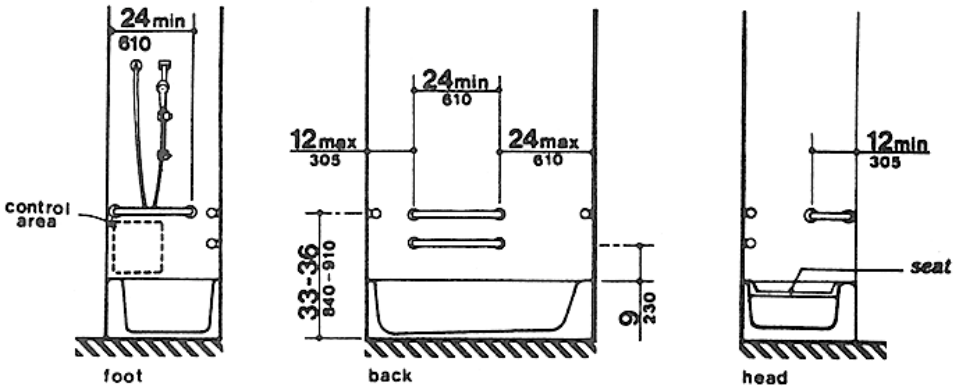
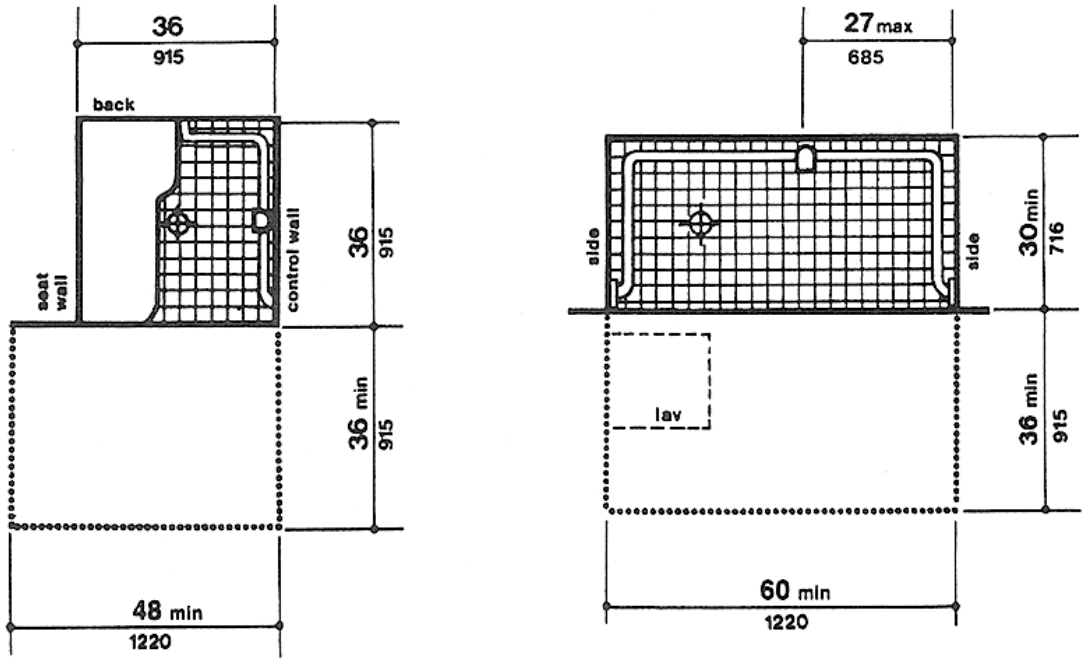


Fig. 34
Grab Bars at Bathtubs



(a)
36-in by 36-in
(915-mm by 915-mm) Stall

(b)
30-in by 60-in
(760-mm by 1525-mm) Stall

Fig. 35
Shower Size and Clearances

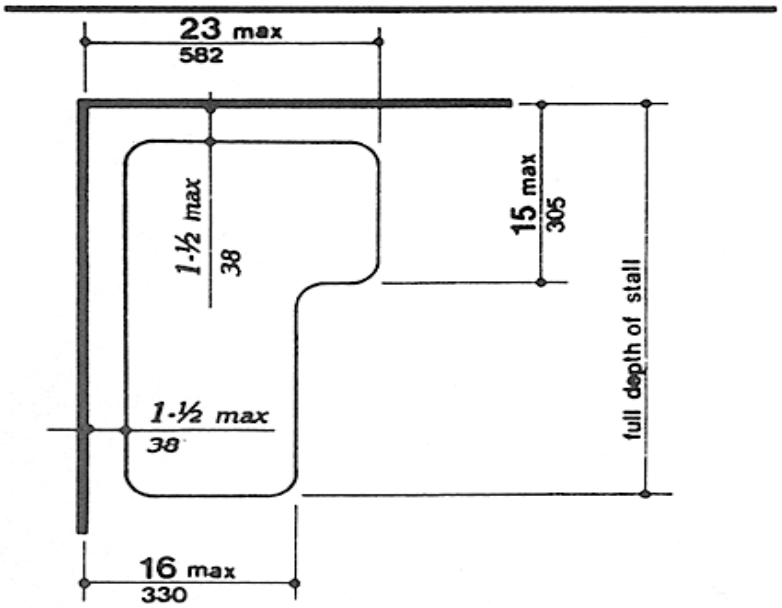
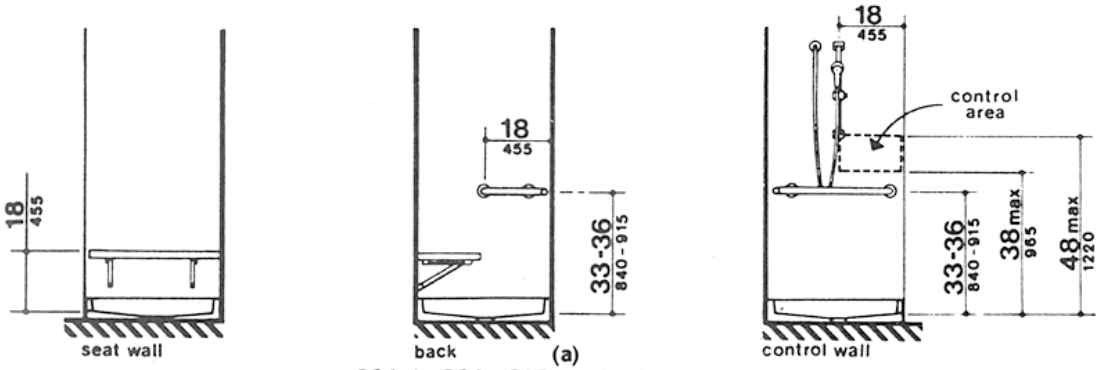
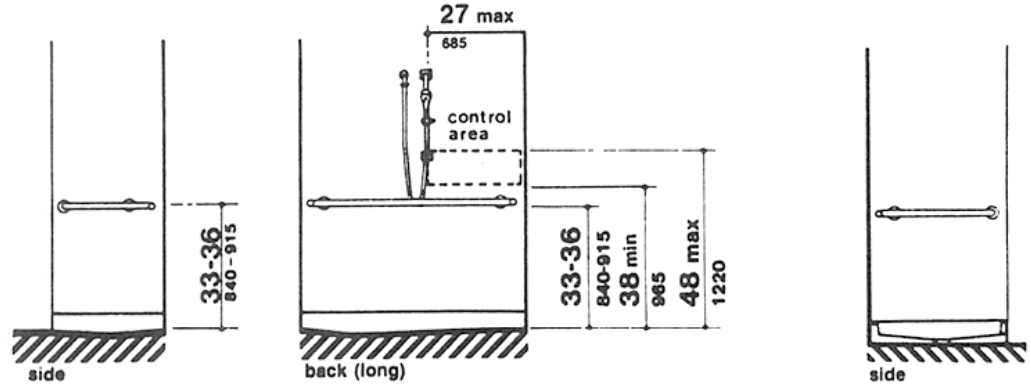


Fig. 36
Shower Seat Design



36-in by 36-in (915-mm by 915-mm) Stall



NOTE: Shower head and control area may be on back (long) wall (as shown) or on either side wall.

(b)
30-in by 60-in (760-mm by 1525-mm) Stall

Fig. 37
Grab Bars at Shower Stalls

4.25 Storage.

4.25.1 General. Fixed storage facilities such as cabinets, shelves, closets, and drawers required to be accessible by 4.1 shall comply with 4.25.

4.25.2 Clear Floor Space. A clear floor space at least 30 in by 48 in (760 mm by 1220 mm) complying with 4.2.4 that allows either a forward or parallel approach by a person using a wheelchair shall be provided at accessible storage facilities.

4.25.3 Height. Accessible storage spaces shall be within at least one of the reach ranges specified in 4.2.5 and 4.2.6. Clothes rods or shelves shall be a maximum of 54 in (1370 mm) above the finish floor for a side approach. Where the distance from the wheelchair to the clothes rod or shelf exceeds 10 in (255 mm) (as in closets without accessible doors) the height and depth to the rod or shelf shall comply with Fig. 38(a) and Fig. 38(b).

4.25.4 Hardware. Hardware for accessible storage facilities shall comply with 4.27.4. Touch latches and U-shaped pulls are acceptable.

4.13.9* Door Hardware. Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.

Lever-operated mechanisms, push-type mechanisms, and U-shaped handles are acceptable designs. When sliding doors are fully open, operating hardware shall be exposed and usable from both sides. Hardware required for accessible door passage shall be mounted no higher than 48 in (1220 mm) above finished floor

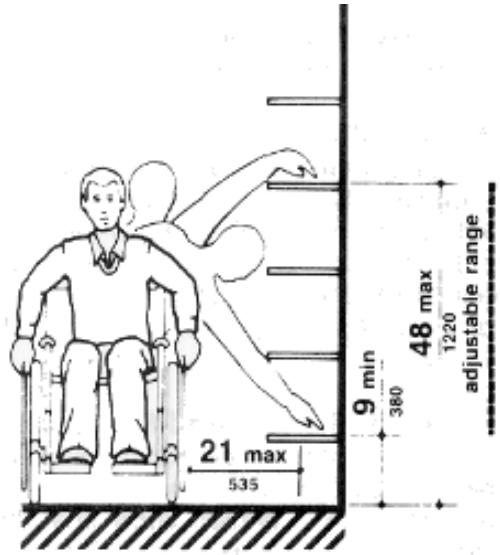


Fig.38(a)
Closets

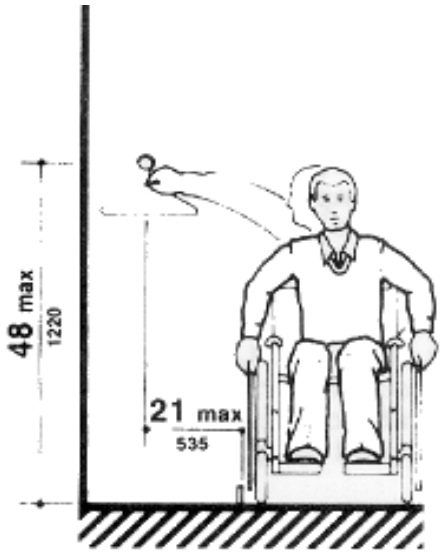


Fig.38(b)
Shelves

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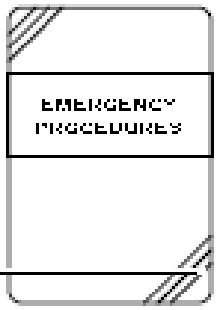
1. Staff Awareness

Has the staff received special instructions about the needs of persons with disabilities, particularly emergency procedures?

☐ **Yes** ☐ **No** ☐ **N/A**



Has staff received disability awareness and sensitivity training?

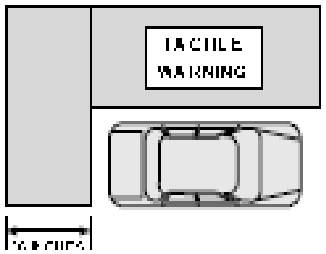
☐ **Yes** ☐ **No** ☐ **N/A**

---

2. Hazardous Vehicular Area

Is the boundary between the pedestrian and vehicle area marked with some type of tactile warning if not separated by curbs, rails or similar element? Note: Truncated domes having a diameter of 0.9 inches, a height of 0.2 inches, a center-to-center spacing of 2.35 inches, and of a color that contrasts with the walk surface may be used as a tactile warning.

☐ **Yes** ☐ **No** ☐ **N/A**



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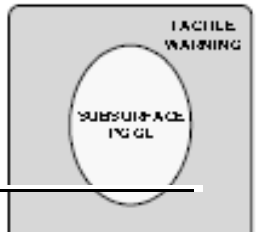
3. Standard Warnings at Subsurface Pools

Are standardized textured surfaces for tactile warnings (i.e. rails, walls, curbs, or truncated domes) present at subsurface pools?

☐ **Yes** ☐ **No** ☐ **N/A**



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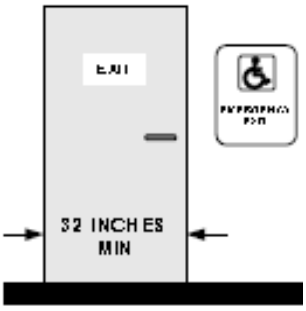
4. Emergency Exits

Are all emergency exit doors clearly marked, and do they have a minimum opening of 32 inches?

☐ **Yes** ☐ **No** ☐ **N/A**

Are exit doors equipped with tactile symbols to designate their location?

☐ **Yes** ☐ **No** ☐ **N/A**



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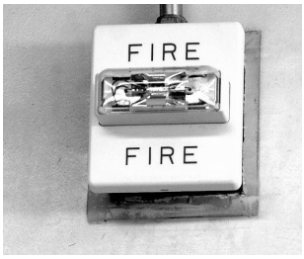
5. Audible and Visual Alarm Signals

Are all audible alarms accompanied by visual alarms?

☐ **Yes** ☐ **No** ☐ **N/A**



Do audible alarms produce a noise which exceeds the ambient noise level by at least 15 decibels?

☐ **Yes** ☐ **No** ☐ **N/A**

Are visual alarms xenon strobe type (or equivalent) with intensity of 75 candela and a flash rate of 1 per second minimum and 3 per second maximum?

☐ **Yes** ☐ **No** ☐ **N/A**

Are visual alarms not more than 50 feet apart and mounted 80 inches above highest floor level or 6 inches below the ceiling, whichever is lower?

☐ **Yes** ☐ **No** ☐ **N/A**

Note: Residential programs with central alarm systems that do not have visual alarm signals should not be coded accessible for people who are deaf or hard of hearing. CA Title 24 Architectural Code requires visual alarm signals although many fire marshals have approved fire clearance without visual alarm signals.

28.3* Visual Alarms. Visual alarm signal appliances shall be integrated into the building or facility alarm system. If single station audible alarms are provided then single station visual alarm signals shall be provided. Visual alarm signals shall have the following minimum photometric and location features:

(1) The lamp shall be a xenon strobe type or equivalent.

(2) The color shall be clear or nominal white (i.e., unfiltered or clear filtered white light).

(3) The maximum pulse duration shall be two-tenths of one second (0.2 sec) with a maximum duty cycle of 40 percent. The pulse duration is defined as the time interval between initial and final points of 10 percent of maximum signal.

(4) The intensity shall be a minimum of 75 candela.

(5) The flash rate shall be a minimum of 1 Hz and a maximum of 3 Hz.

(6) The appliance shall be placed 80 in (2030 mm) above the highest floor level within the space or 6 in (152 mm) below the ceiling, whichever is lower.

(7) In general, no place in any room or space required to have a visual signal appliance shall be more than 50 ft (15 m) from the signal (in the horizontal plane). In large rooms and spaces exceeding 100 ft (30 m) across, without obstructions 6 ft (2 m) above the finish floor, such as auditoriums, devices may be placed around the perimeter, spaced a maximum 100 ft (30 m) apart, in lieu of suspending appliances from the ceiling.

(8) No place in common corridors or hallways in which visual alarm signaling appliances are required shall be more than 50 ft (15 m) from the signal.

4.28.4* Auxiliary Alarms. Units and sleeping accommodations shall have a visual alarm connected to the building emergency alarm system or shall have a standard 110-volt electrical receptacle into which such an alarm can be connected and a means by which a signal from the building emergency alarm system can trigger such an auxiliary alarm. When visual alarms are in place the signal shall be visible in all areas of the unit or room. Instructions for use of the auxiliary alarm or receptacle shall be provided.

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6. Area of Rescue Assistance

Except in fully sprinkled buildings, is there an area of rescue assistance that meets one of the following seven requirements specified in ADA Accessibility Guidelines and is it identified by a sign?

(1) Portion of a stairway landing within a smoke-proof enclosure.
(2) Portion of an exterior exit balcony located adjacent to an exit stairway.
(3) Portion of a one-hour fire restrictive corridor located adjacent to an exit enclosure.
(4) Fire-resistive vestibule located adjacent to an exit enclosure.
(5) Portion of a stairway landing within an exit enclosure which is vented and separated from the interior of the building with fire resistive doors (not less than one hour).
(6) An area or room separated from portions of the building by a smoke barrier.
(7) An elevator lobby with shafts that are pressurized once activated by smoke detectors.

☐ **Yes** ☐ **No** ☐ **N/A**

Areas of Rescue Assistance

4.3.11.1 Location and Construction. An area of rescue assistance shall be one of the following:

(1) A portion of a stairway landing within a smoke proof enclosure (complying with local requirements).

(2) A portion of an exterior exit balcony located immediately adjacent to an exit stairway when the balcony complies with local requirements for exterior exit balconies. Openings to the interior of the building located within 20 feet (6 m) of the area of rescue assistance shall be protected with fire assemblies having a three-fourths hour fire protection rating.

(3) A portion of a one-hour fire-resistive corridor (complying with local requirements for fire-resistive construction and for openings) located immediately adjacent to an exit enclosure.

(4) A vestibule located immediately adjacent to an exit enclosure and constructed to the same fire-resistive standards as required for corridors and openings.

(5) A portion of a stairway landing within an exit enclosure which is vented to the exterior and is separated from the interior of the building with not less than one-hour fire-resistive doors.

(6) When approved by the appropriate local authority, an area or a room which is separated from other portions of the building by a smoke barrier. Smoke barriers shall have a fire-resistive rating of not less than one hour and shall completely enclose the area or room. Doors in the smoke barrier shall be tight-fitting smoke- and draft-control assemblies having a fire-protection rating of not less than 20 minutes and shall be self-closing or automatic closing. The area or room shall be provided with an exit directly to an exit enclosure. Where the room or area exits into an exit enclosure which is required to be of more than one-hour fire-resistive construction, the room or area shall have the same fire-resistive construction, including the same opening protection, as required for the adjacent exit enclosure.

(7) An elevator lobby when elevator shafts and adjacent lobbies are pressurized as required for smoke proof enclosures by local regulations and when complying with requirements herein for size, communication, and signage. Such pressurization system shall be activated by smoke detectors on each floor located in a manner approved by the appropriate local authority. Pressurization equipment and its duct work within the building shall be separated from other portions of the building by a minimum two-hour fire-resistive construction.

4.3.11.2 Size. Each area of rescue assistance shall provide at least two accessible areas each being not less than 30 inches by 48 inches (760 mm by 1220 mm). The area of rescue assistance shall not encroach on any required exit width. The total number of such 30-inch by 48-inch (760 mm by 1220 mm) areas per story shall be not less than one for every 200 persons of calculated occupant load served by the area of rescue assistance.

EXCEPTION: The appropriate local authority may reduce the minimum number of 30-inch by 48-inch (760 mm by 1220 mm) areas to one for each area of rescue assistance on floors where the occupant load is less than 200.

4.3.11.3* Stairway Width. Each stairway adjacent to an area of rescue assistance shall have a minimum clear width of 48 inches between handrails.

4.3.11.4* Two-way Communication. A method of two-way communication, with both visible and audible signals, shall be provided between each area of rescue assistance and the primary entry. The fire department or appropriate local authority may approve a location other than the primary entry.

4.3.11.5 Identification. Each area of rescue assistance shall be identified by a sign which states "AREA OF RESCUE ASSISTANCE" and displays the international symbol of accessibility. The sign shall be illuminated when exit sign illumination is required. Signage shall also be installed at all inaccessible exits and where otherwise necessary to clearly indicate the direction to areas of rescue assistance. In each area of rescue assistance, instructions on the use of the area under emergency conditions shall be posted adjoining the two-way communication system.

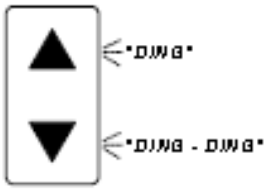
SECTION X: ELEVATORS

1. Elevators
Does the facility have a passenger elevator?
☐ **Yes** ☐ **No** ☐ **N/A**

Does the elevator provide access to all levels of the facility?
☐ **Yes** ☐ **No** ☐ **N/A**

---

2. Signal Identification
Are there both visual and audible signals used to identify direction of elevator travel (for example, for audible alarms, one sound for UP and two sounds for DOWN)?
☐ **Yes** ☐ **No** ☐ **N/A**



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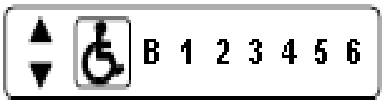
3. Accessible Routes
Are the accessible elevators on a normally used accessible route?
☐ **Yes** ☐ **No** ☐ **N/A**



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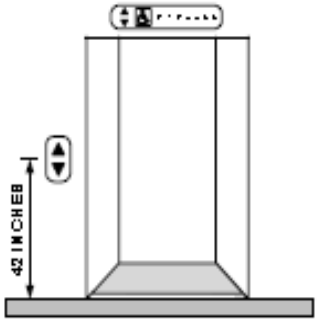
4. Call Buttons/Floor Buttons
Are call buttons in lobbies and halls mounted at 42 inches (on center) above the floor with no access obstructions?
☐ **Yes** ☐ **No** ☐ **N/A**

Are there raised and Braille floor destinations on both sides of elevator jambs 60 inches above the floor surface?
☐ **Yes** ☐ **No** ☐ **N/A**



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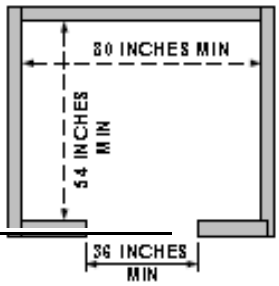
5. Elevator Car Dimensions
Does the elevator have minimum inside dimensions of 54 x 80 inches and a minimum clear door opening of 36 inches? Note: If the elevator door is not on center of the elevator entrance, the interior dimensions should be 54 x 68 inches.
☐ **Yes** ☐ **No** ☐ **N/A**



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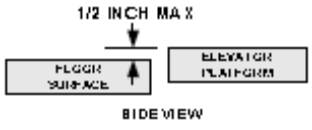
6. Leveling
Does the elevator stop within 1/2 inch above or below the outside floor surface on each level?
☐ **Yes** ☐ **No** ☐ **N/A**



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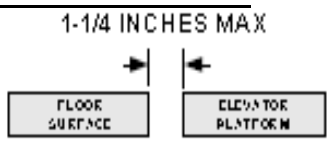
7. Space Between Elevator and Floor
Is the open space between the outside floor surface and the elevator platform no greater than 1-1/4 inches?
☐ **Yes** ☐ **No** ☐ **N/A**



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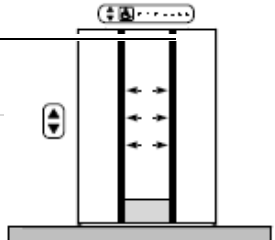
8. Floor Protective Re-Opening Device



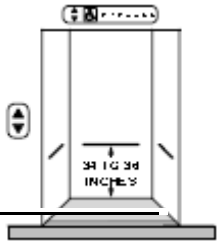
Are the elevators equipped with a safety system that automatically opens the door when it becomes obstructed by an object or person?

☐ **Yes** ☐ **No** ☐ **N/A**

---

9. Elevator Handrails

Does the elevator interior have handrails mounted 34 to 36 inches above the floor and with a clear space of 1-1/2 inches between the rail and the wall?



☐ **Yes** ☐ **No** ☐ **N/A**

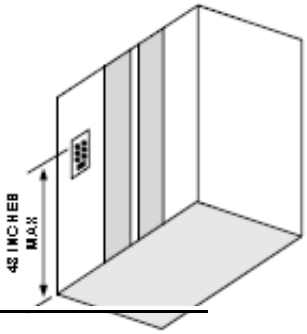
---

10. Controls, Call Buttons and Alarms

Are controls, call buttons, and alarm buttons at least 3/4 inch in diameter with Braille and raised lettering located to the left of each control or button?

☐ **Yes** ☐ **No** ☐ **N/A**

Are all controls or buttons on the elevator control panel mounted no higher than 48 inches above the floor?



☐ **Yes** ☐ **No** ☐ **N/A**

SIGNAGE

1. Mounting Location and Height

Is adequate signage placed in standardized, appropriate locations throughout the building or facility? (Signs can be used to designate permanent rooms and spaces, or provide direction and information)

☐ **Yes** ☐ **No** ☐ **N/A**

International Symbol of Accessibility

Does the signage use raised letters and numerals which are also accompanied by Braille characters?

☐ **Yes** ☐ **No** ☐ **N/A**

---

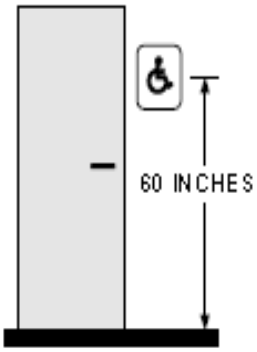
2. Interior Signage Adjacent to Doors

Is interior signage located on the walls adjacent to the latch side of the doors?

☐ **Yes** ☐ **No** ☐ **N/A**

Is signage mounted 60 inches above the floor surface to the centerline of the sign?

☐ **Yes** ☐ **No** ☐ **N/A**



NOTE: California Title 24 Architectural Code also requires the use of additional door mounted signs for male, female, and unisex restrooms. See section IV (1), page 14

---

3. Exterior Signage

Is exterior signage available at non-accessible entrances and along walks that provides directions to the accessible routes and entrances?

☐ **Yes** ☐ **No** ☐ **N/A**

4.30 Signage.

4.30.1* General. Signage required to be accessible by 4.1 shall comply with the applicable provisions of 4.30.

4.30.2* Character Proportion. Letters and numbers on signs shall have a width-to-height ratio between 3:5 and 1:1 and a stroke-width-to-height ratio between 1:5 and 1:10.

4.30.3 Character Height. Characters and numbers on signs shall be sized according to the viewing distance from which they are to be read. The minimum height is measured using an upper case X. Lower case characters are permitted.

4.30.4* Raised and Brailled Characters and Pictorial Symbol Signs (Pictograms). Letters and numerals shall be raised 1/32 in, upper case, sans serif or simple serif type and shall be accompanied with Grade 2 Braille. Raised characters shall be at least 5/8 in (16 mm) high, but no higher than 2 in (50 mm). Pictograms shall be accompanied by the equivalent verbal description placed directly below the pictogram. The border dimension of the pictogram shall be 6 in (152 mm) minimum in height.

4.30.5* Finish and Contrast. The characters and background of signs shall be eggshell, matte, or other non-glare finish. Characters and symbols shall contrast with their background --either light characters on a dark background or dark characters on a light background.

4.30.6 Mounting Location and Height. Where permanent identification is provided for rooms and spaces, signs shall be installed on the wall adjacent to the latch side of the door. Where there is no wall space to the latch side of the door, including at double leaf doors, signs shall be placed on the nearest adjacent wall. Mounting height shall be 60 in (1525 mm) above the finish floor to the centerline of the sign. Mounting location for such signage shall be so that a person may approach within 3 in (76 mm) of signage without encountering protruding objects or standing within the swing of a door.

4.30.7* Symbols of Accessibility. (1) Facilities and elements required to be identified as accessible by 4.1 shall use the international symbol of accessibility. The symbol shall be displayed as shown in Fig. 43(a) and (b)

Fig.43(a)
Proportions
International Symbol of Accessibility

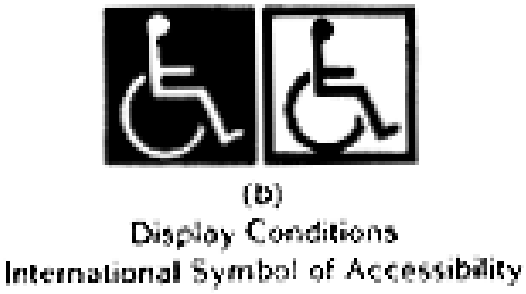


Fig. 43(b)
Display Conditions
International Symbol of Accessibility

Tax Incentives for Improving Accessibility

Two tax incentives are available to businesses to help cover the cost of making access improvements. The first is a tax credit that can be used for architectural adaptations, equipment acquisitions, and services such as sign language interpreters. The second is a tax deduction that can be used for architectural or transportation adaptations. (NOTE: A tax credit is subtracted from your tax liability after you calculate your taxes, while a tax deduction is subtracted from your total income before taxes, to establish your taxable income.)

Tax Credit
The tax credit, established under Section 44 of the Internal Revenue Code, was created in 1990 specifically to help small businesses cover ADA-related eligible access expenditures. A business that for the previous tax year had either revenues of $1,000,000 or less or 30 or fewer full-time workers may take advantage of this credit. The credit can be used to cover a variety of expenditures, including:

- provision of readers for customers or employees with visual disabilities
- provision of sign language interpreters
- purchase of adaptive equipment
- production of accessible formats of printed materials (i.e., Braille, large print, audio tape, computer diskette)
- removal of architectural barriers in facilities or vehicles (alterations must comply with applicable accessibility standards)
- fees for consulting services (under certain circumstances)

Note that the credit cannot be used for the costs of new construction. It can be used only for adaptations to existing facilities that are required to comply with the ADA.

The amount of the tax credit is equal to 50% of the eligible access expenditures in a year, up to a maximum expenditure of $10,250. There is no credit for the first $250 of expenditures. The maximum tax credit, therefore, is $5,000.

Tax Deduction
The tax deduction, established under Section 190 of the Internal Revenue Code, is now a maximum of $15,000 per year a reduction from the $35,000 that was available through December 31, 1990. A business (including active ownership of an apartment building) of any size may use this deduction for the removal of architectural or transportation barriers. The renovations under Section 190 must comply with applicable accessibility standards.

Small businesses can use these incentives in combination if the expenditures incurred qualify under both Section 44 and Section 190. For example, a small business that spends $20,000 for access adaptations may take a tax credit of $5000 (based on $10,250 of expenditures), and a deduction of $15,000. The deduction is equal to the difference between the total expenditures and the amount of the credit claimed.

Example: A small business' use of both tax credit and tax deduction
$20,000 cost of access improvements (rest room, ramp, 3 doors widened)
- $5,000 maximum credit
$15,000 remaining for deduction

Annual Incentives

The tax credit and deduction can be used annually. You may not carry over expenses from one year to the next and claim a credit or deduction for the portion that exceeded the expenditure limit the previous year. However, if the amount of credit you are entitled to exceeds the amount of taxes you owe, you may carry forward the unused portion of the credit to the following year.
For further details and information, review these incentives with an accountant or contact your local IRS office or the national address below.

For More Information...
Request IRS Publications 535 and 334 for further information on tax incentives, or Form 8826 to claim your tax credit.
IRS Publications and Forms
(800) 829-3676 Voice, (800) 829-4059 TTY

(Sample ADA Plan) XYZ Recovery Services: Access to Services Plan: FY 7/1/2005-6/30/2006						
Barrier	**Solution**	**Priority**	**Projected Cost**	**Funding Source**	**Projected Completion Date**	**Responsible Person**
Physical Access: In-accessible entrance to building	Install ramp to main entrance	A: This Year	$5,000	Building maintenance	June 30, 2006	Program Manager
Physical Access Water fountain spout too high	Install paper cup dispenser	A: Now	$10.00	Unrestricted funds	July 15, 2005	Program Manager
Physical Access: Narrow door to counseling office	Widen doorway	B: Next FY	$500	Building maintenance	March 1, 2007	Program Manager
Program Access: No pet policy	Modify policy to allow for service animals for people with disabilities	A: Now	None	N/A	July 15, 2005	Executive Director
Communication Access: No TTY	Obtain TTY or train staff to use CRS	A: This Year	$350	Office equipment funds	December 30, 2005	Office Manager
Communication Access: Assistive Listening Systems	Purchase or borrow assistive listening system: Insert into policy	C: As needed	None	Available from Disability Access Project Technology Loan Program	N/A	Program Manager

Practitioner Enrollment - Request Form

Contracting Provider Name: _____ Number: _____

Practitioner First Name _____ Practitioner Last Name _____

Date of Birth: _____ Date of Hire: mm/yyyy _____

Discipline: Substance Abuse

Practitioner Categories for Coverage
(Choose ONE)

- ☐ Behavioral Health Specialist I
- ☐ Behavioral Health Specialist II
- ☐ Behavioral Health Specialist III
- ☐ Behavioral Health Specialist IV
- ☐ Supervising Behavioral Health Specialist
- ☐ Drug and Alochol Counselor
- ☐ Licensed Vocation Nurse (LVN I)
- ☐ Licensed Vocation Nurse (LVN II)
- ☐ Nurse (RN)
- ☐ Registered Nurse Practitioner (RNP)
- ☐ Other: _____

Practitioner Category: **AOD**

Location

Street # and Name: _____

Zip Code: _____ Telephone: _____

List all Program ID (RU): (for mapping) _____

NPI: _____ **Taxonomy:** _____

SA Admin Instructions: Submit request to MRU support for entry and practitioner number assignment. Make sure that the Contracting Provider Name and Number (3-digit) is the same as the one used when entering the service authorization. Review that all RU for the contractor are listed. Ensure that the appropriate taxonomy code is used for type of practitioner category.

***CONTRACTOR**: Send request via email to Sarah Stewart

New Provider Information Form
Riverside University Health System - Behavioral Health

Please Complete and Send to:
Riverside University Health System - Behavioral Health
4095 County Circle Drive, Riverside, CA 92503
Attn: Email:
Phone: Fax:

Corporate Office

Date Completed:

Official DBA Name		
Business Office Mailing Address		
City, State, Zip		
Remit To Address - If different from above		
City, State, Zip		
Phone & Fax Numbers		
Website Address		
CEO/Admin Contact		
Phone Number		
Email		
Program/Clinical Contact		
Phone Number		
Email		
Fiscal/Admin Contact		
Phone Number		
Email		

Name & Title of Authorized Signer(s)	Documents Authorized to Sign

Medi-Cal Certified Locations

Facility Name:	
Address	
City, State, Zip	
Facility Contact:	
Phone #	
Facility NPI #	
Drug Medi-Cal #	
CalOMS #	
Special Service Contract # (If applicable)	

Facility Name:	
Address	
City, State, Zip	
Facility Contact:	
Phone #	
Facility NPI #	
Drug Medi-Cal #	
CalOMS #	
Special Service Contract # (If applicable)	

Facility Name:	
Address	
City, State, Zip	
Facility Contact:	
Phone #	
Facility NPI #	
Drug Medi-Cal #	
CalOMS #	
Special Service Contract # (If applicable)	

Facility Name:	
Address	
City, State, Zip	
Facility Contact:	
Phone #	
Facility NPI #	
Drug Medi-Cal #	
CalOMS #	
Special Service Contract # (If applicable)	

Staff NPI Required Information

Provider Name:

First Name	Last Name	Staff NPI #	Date of Birth	Date of Hire	Title	Taxonomy Code	Registration, Certification or License # (as applicable)	Registration, Certification or License Expiration Date (as applicable)

RIVERSIDE COUNTY INFORMATION TECHNOLOGY

VPN Account Request Form – Vendor

VERSION 1.0 | DATE OF REVISION 2015-11-03

This application is used for establishing a VPN account for authorized third parties. A supervisor or manager must complete this application and submit it along with the signed VPN Access Agreement. Follow the instructions below.

1. A supervisor or manager completes the information below. All fields must be completed.
2. The account request form and agreement are provided to user for review of agreement and user signature.
3. The form and agreement are submitted to RCIT-Help Desk via email. Incomplete forms will not be processed.
4. Once processing is complete and account created, user and supervisor are emailed documentation. User will be required to call the RCIT-Help Desk for initial account password reset. The Requesting Supervisor / Manager will be identified as the person the user will contact for support of the departmental systems.

SUPERVISOR / MANAGER FROM SPONSORING COUNTY AGENCY / DEPARTMENT

SUPERVISOR / MANAGER NAME Rhyan Miller	
TITLE Substance Abuse Prevention and Treatment Program Administrator	
COUNTY AGENCY / DEPARTMENT Riverside University Health System-Behavioral Health	
EMAIL RHMiller@rcmhd.org	PHONE (951)955-2310

USER REQUESTING ACCESS

FIRST NAME Type First Name		MIDDLE INITIAL Middle
LAST NAME Type Last Name		
JOB TITLE Type Job Title		
VENDOR NAME Type Vendor Name		
OFFICE STREET ADDRESS Type Office Street Address		
CITY Type City	STATE State	ZIP CODE Zip
OFFICE PHONE Type Office Phone		
EMAIL ADDRESS Type Email Address		

ACCOUNT DETAILS

DEPARTMENT BILLING STRING Type Department Billing String
VPN GROUP NAME Type VPN Group Name
ASSIGN SAME RIGHTS AS STAFF MEMBER Click here to enter text
DESCRIPTION / PURPOSE OF ACCESS REQUIRED Click here to enter text

Riverside University HEALTH SYSTEM
Behavioral Health

SFTP Account Application

Contract Providers will be issued one username and password enabling them to send and receive documents via the SFTP server. Please fill out the information below to obtain a Username and Password:

Company: _____

Main Contact: _____

Phone Number: _____

Email: _____

How many users need access? _____

Note that password has to be changed every 90 days, which is a security policy enforced by RCIT.

Please complete and send a copy of this form to ELMRSupport@rcmhd.org. If you have any questions or concerns please call ELMR support at 951.955.7360.

Signature_____ Date_____

RIVERSIDE COUNTY INFORMATION TECHNOLOGY

VPN Access Agreement – Vendor

VERSION 1.0 | DATE OF REVISION 2015-08-18

USER REQUESTING ACCESS

USER NAME	Type User Name
USER TITLE	Type User Title
VENDOR NAME	Type Vendor Name

I, the individual named above understand that I am being granted access to a County of Riverside network for the sole purpose of accomplishing the tasks that I have been contracted with County of Riverside to complete. I understand that this access is a privilege and that it may be revoked at any time if I fail to comply with the provisions set forth herein.

Riverside County creates and maintains demographic and health information relating to its patients (defined as "Confidential Information"). This Confidential Information is located in computer information systems as well as paper charts and files. Confidential Information is protected from unauthorized or inappropriate access by Riverside County policies, as well as state and federal law.

Riverside County provides access to a network segment for pre-authorized 3rd parties. Remote Access Users may not gain access to, use, copy, make notes of, remove, divulge or disclose Confidential Information, except as necessary for contracted business purposes. County of Riverside provides access to a network segment for pre-authorized 3rd parties. This access is intended solely for business purposes and is filtered, monitored, and managed accordingly.

Due to the wide variety of hardware and software configurations that may be present on 3rd party devices, the County of Riverside and its employees cannot accept responsibility/liability for:

- Loss, corruption or virus infection of customer data and/or applications.
- Hardware or software damage resulting from the use of equipment or software while on the County of Riverside network.
- Hardware or software damage resulting from service by County of Riverside employee.

This includes, but is not limited to:

- Damage to portable electronic storage, communication, or media devices.
- Damage to a laptop's software configuration due to service by County of Riverside staff.
- Loss of data on an electronic storage, communication, or media device; or loss of data from an email server.

Authorized Vendors are required to:

- Use County of Riverside's network only for authorized business purposes.
- Ensure anti-malware, and encryption applications are actively employed on their equipment and that corresponding signatures and patches are maintained in a current manner.

USER AGREEMENT

1. Access to Confidential Information through Riverside County Information Systems. Riverside County agrees to provide Remote Access User with access to the County of Riverside Information Systems, which may contain Confidential Information, including Protected Health Information ("PHI"), subject to the conditions outlined in this Agreement. Remote Access User may access only the minimum amount of Confidential Information necessary to perform contracted services on behalf of Riverside County.

2. Protection of Confidentiality and Security of Confidential Information. Remote Access User agrees to protect the confidentiality and security of any Confidential Information accessed from Riverside County. Remote Access User will comply with Health Insurance Portability and Accountability Act ("HIPAA") and the rules implementing HIPAA.

   The Remote Access User agrees to never access Confidential Information for "curiosity viewing." The Remote Access User understands that this includes viewing their own personal Confidential Information as well as that of their children, family members, friends, or coworkers, and all others unless access is necessary to provide contracted services.

3. User Name and Passwords. Remote Access User agrees not to share his/ her user name, password or access device with any other person or allow anyone else to access Riverside County Information Systems under his/her user name, password or device. Remote Access User agrees to notify the Riverside County Information Security Office at (951) 955-8282 immediately if he/she becomes aware or suspects that another person used his/her user name, password or device to gain access to Riverside County Information Systems.

4. Printing Confidential Information. If Remote Access User prints Confidential Information, User will protect the printed Confidential Information from any access or use not authorized by this Agreement, and thereafter shred such copies when they are no longer required for the purposes authorized herein. If printed Confidential Information is stolen or lost the Remote Access User agrees to notify the Riverside County Information Security Office within 12 hours.

5. Auditing Compliance. Remote Access User agrees that his/her compliance with this Agreement may be reviewed/audited by Riverside County and will return any software or equipment and/or un-install/delete any software programs upon request by Riverside County.

6. Risks and Warranties. The parties recognize that remote access introduces unique risks that may exist on the remote access device that compromises the integrity and security of data and remote access, including but not limited to spyware, hacker access, viruses, worms, and other harmful software (collectively referred to as "Remote Access Risks"). Riverside County will not be responsible or liable for any losses or damages related to Remote Access Risks.

   Remote Access User agrees that Riverside County will not be liable for any direct, indirect, incidental, special or other damages incurred by Remote Access User. Riverside County does not guarantee or warrant the availability of remote access of Riverside County Information Systems.

   Riverside County reserves the right to impose additional information security safeguards, including (without limitation) software and hardware requirements.

7. Breach Notification. Remote Access User must report to the Riverside County Information Security Office within 12 hours, any access, use, or disclosure of Confidential Information for purposes other than those permitted by this Policy or this Agreement.

8. Vendor Responsibilities. The Responsibilities of the contracted Remote Access User's employer are set forth below. This agreement must be signed by an authorized representative of Remote Access User's employer. This Agreement will not become

effective, and Riverside County will not grant remote access, unless this agreement is signed by such authorized representative of Remote Access User's employer.

9. Confidentiality Concerns. Riverside County, in its sole judgment and discretion, may take any or all of the following actions, when a suspicion of or actual security incident occurs involving a Remote Access User who has obtained unauthorized access to Confidential Information, has disclosed Confidential Information in violation of federal or state laws or regulations, has violated any Riverside County policies or procedures regarding confidentiality or the use of Confidential Information, or has violated any provisions of this Agreement:
    a. Suspend or terminate Remote Access User's access to Riverside County Information Systems.
    b. Bring legal action to enforce this Agreement.
    c. Notify the appropriate authorities if necessary.

VENDOR RESPONSIBILITIES FOR REMOTE ACCESS USER ACCOUNTS

1. Vendor will require each employee who which has been granted remote access to Riverside County Information Systems to sign a separate Remote Access User Agreement with Riverside County and obtain a distinct user name and password. Vendor will not permit employees to share user names and passwords.
2. Vendor agrees to train employees on the requirements of this Agreement and is responsible for its employee's compliance with all provisions of this Agreement.
3. Vendor must notify the sponsoring department listed on this form or the Riverside County Help Desk at (951) 955-9900 within 12 hours of an employee's termination. Riverside County will terminate such user's remote access upon notification.
4. This Agreement cannot be transferred or otherwise assigned to other employees.
5. Vendor shall be financially responsible for all costs (including, but not limited to, the required notification and the maintenance of customer relation phone lines, civil penalties, and damages) Riverside County incurs as the result of an unauthorized use or disclosure caused by its employees or agents.

VPN Access Agreement – Vendor

Notwithstanding the above, Riverside County may terminate this Agreement and any user's remote access at any time for any reason. County of Riverside appreciates your support and understanding in this matter. By signing this agreement, you acknowledge your understanding of, and agreement with, the terms of County of Riverside network use.

USER REQUESTING ACCESS

USER NAME	Type User Name
USER TITLE	Type User Title
VENDOR NAME	Type Vendor Name

REQUESTING USER SIGNATURE

DATE

AUTHORIZED AGENT OF VENDOR

AGENT NAME	Type Agent Name
AGENT TITLE	Type Agent Title
VENDOR NAME	Type Vendor Name

VENDOR AUTHORIZED AGENT SIGNATURE

DATE

SUPERVISOR / MANAGER FROM SPONSORING COUNTY AGENCY / DEPARTMENT

SUPERVISOR / MANAGER NAME	Type Supervisor / Manager Name
SUPERVISOR / MANAGER TITLE	Type Supervisor / Manager Title
COUNTY AGENCY / DEPARTMENT	Type County Agency / Department

SUPERVISOR / MANAGER SIGNATURE

DATE

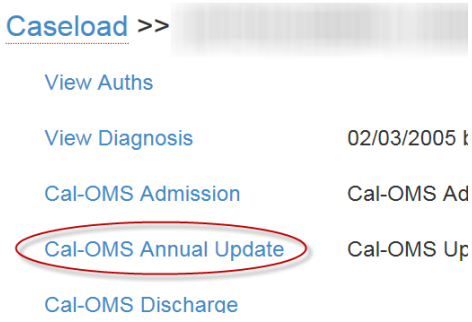
Annual Updates after Initial Update

-

Format: ELMR Data Entry
Access: Provider ELMR Login, Provider Caseload
Frequency: Annually

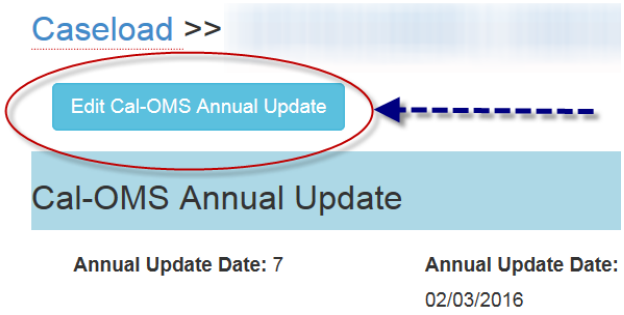
Purpose: Annual Updates must be completed on all clients that are to remain in treatment over 1 year, then annually every year thereafter. Updates can be completed up to 60 days prior to anniversary date. Instructions for Annual Updates completed for the first time (first update) are found in the Contract Provider Data Entry and Billing Manual. Subsequent updates are completed slightly different as described below.

1. From consumer view, select Annual update:

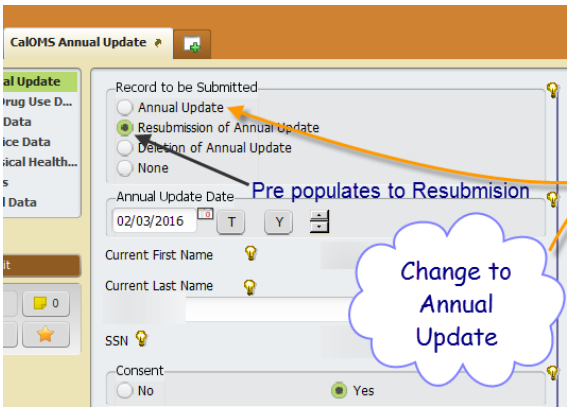


2. The most recent update record will show, select the date underlined in blue to view current record:

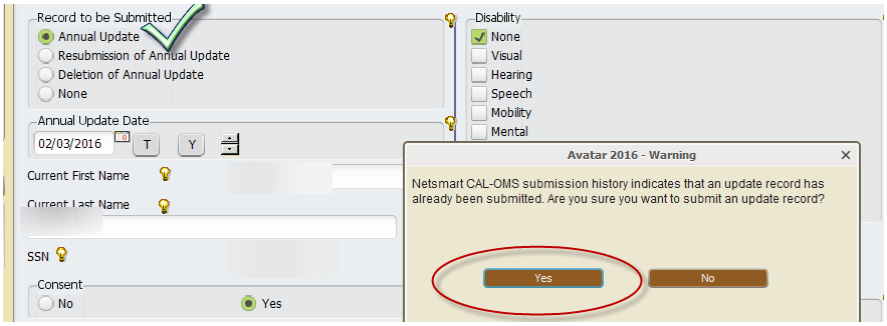
3. Select Edit CalOMS Annual Update:



4. Resubmission for Annual Update will pre-populate. Change the "Record to be Submitted" field to Annual Update:

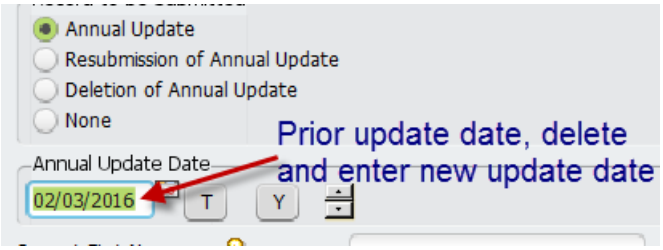


5. Once Annual Update is selected, a warning will appear, select YES if completing a new yearly update:

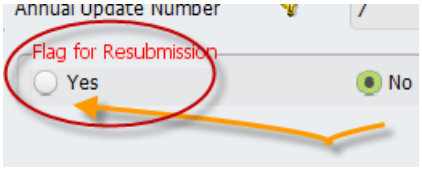


-

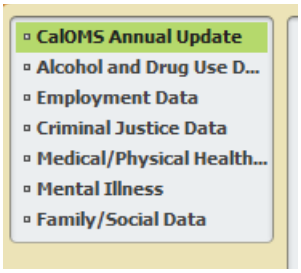
6. The last update date will pre-populate, CHANGE to new update date:



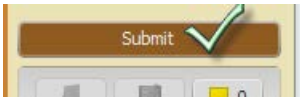
7. CHANGE Flag for Resubmission to Yes:



8. Review remainder of forms to complete update data entry.



Once reviewed and/or updated, select submit:



Substance Use – DAS ASAM Data

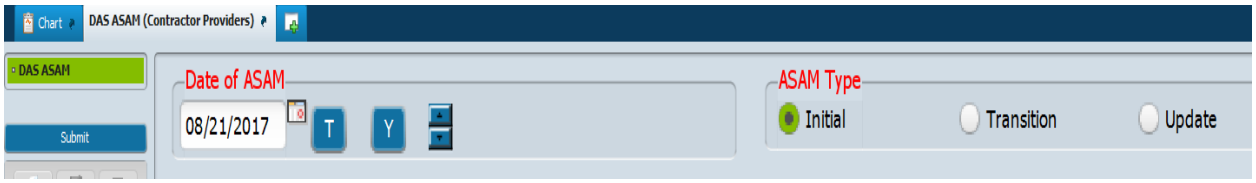
The DAS ASAM data collection form is for contract providers to collect needed information.

Access the DAS ASAM via contract provider portal.

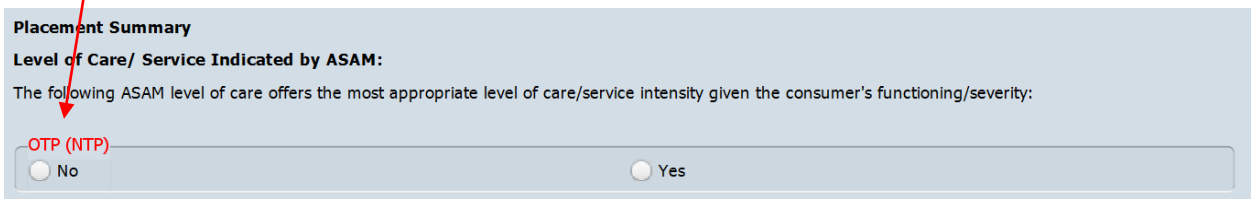
Remember: Any field in **RED** is required and must be completed in order to submit the form.

1. Enter the Date of ASAM and ASAM Type.

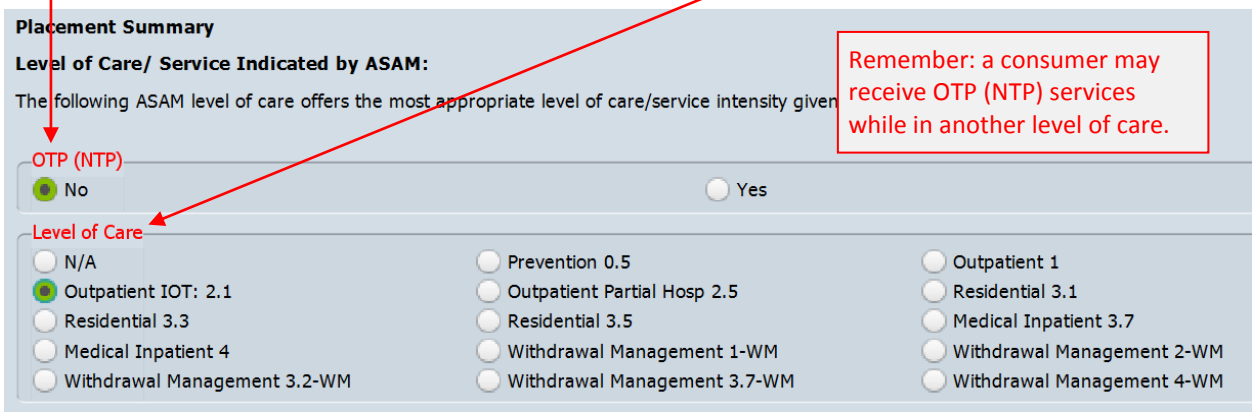
   Note: ASAM Type has three potential selections: Initial, Update, or Transition.
   - **Initial –** when it is the consumer's first contact, passed the ASAM review deadline and/or consumer is not longer active in any SAPT treatment episode.
   - **Update –** at a minimum of every 30 days for Inpatient modalities, or at a minimum 90 days for outpatient modalities.
   - **Transition –** when completing an ASAM to move consumer from one level of care to another or for discharge (at minimum 14 days from date of discharge).



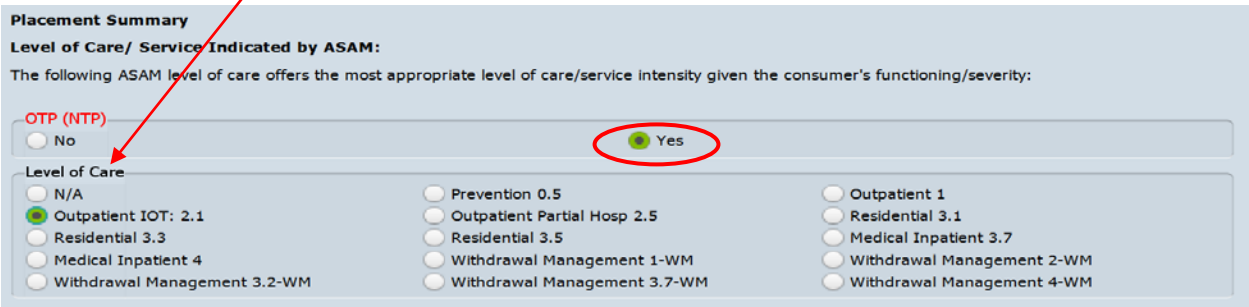
2. **Level of Care/ Service Indicated by ASAM**
   OTP (NTP): Select Yes or No indicating if the ASAM indicated the consumer meets criteria for OTP (NTP) placement.



   If "No" is selected under OTP (NTP), the Level of Care is required for an appropriate level of care selection or N/A for Recovery Service referral. Select the Level of Care indicated by the ASAM as applicable.

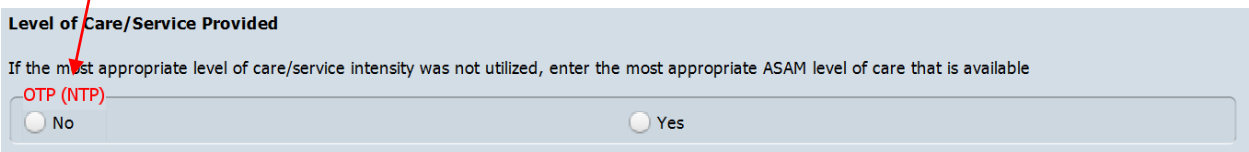


If "Yes" is selected under OTP (NTP) and a consumer will be receiving OTP (NTP) services while in another level of care, **IT IS STILL NECESSARY TO COMPLETE THE LEVEL OF CARE ACCORDINGLY**. Also, if "Yes" is selected, the Level of Care field is not required but optional, because an additional level of care can be selected for simultaneous treatment with the OTP/NTP service. Select the Level of Care indicated by the ASAM.

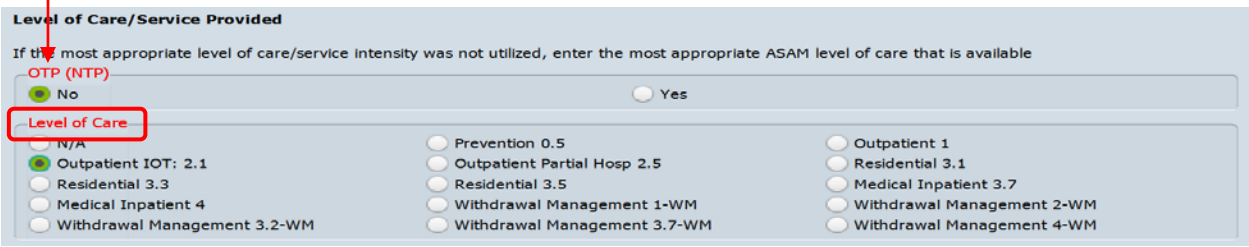


3. **Level of Care / Service Provided**

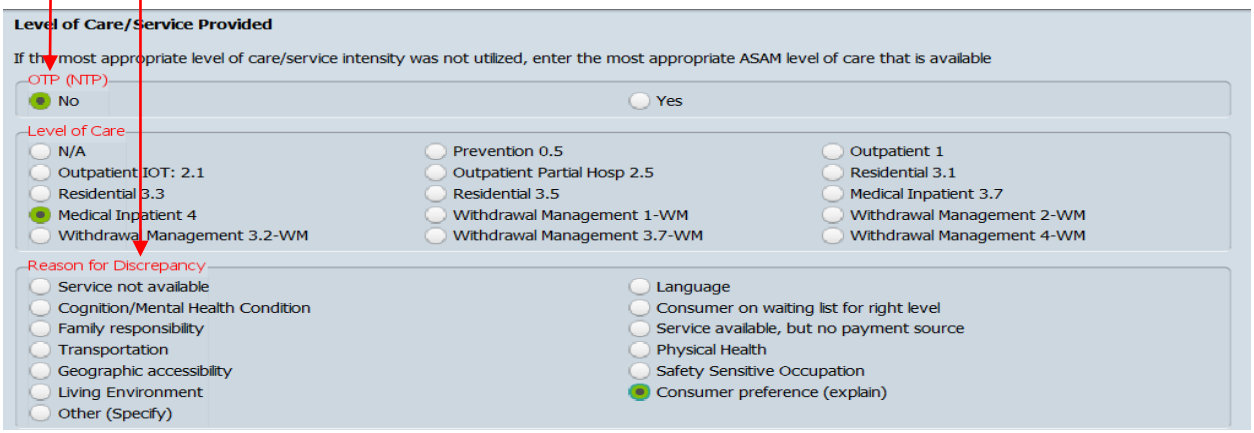
OTP (NTP): Select Yes or No if the consumer will be placed in OTP (NTP) Level of Care.



If "No" is selected under OTP (NTP), the Level of Care becomes required (red). Select the Level of Care provided to the consumer.

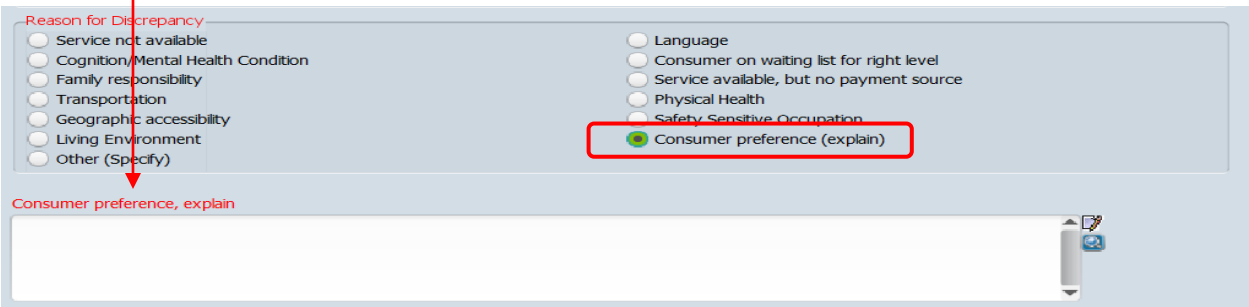


If "No" is selected under OTP (NTP) and the Level of Care provided is different from the **Level of Care indicated by the ASAM**, the Reason for Discrepancy becomes required (red). Complete the Reason for Discrepancy.

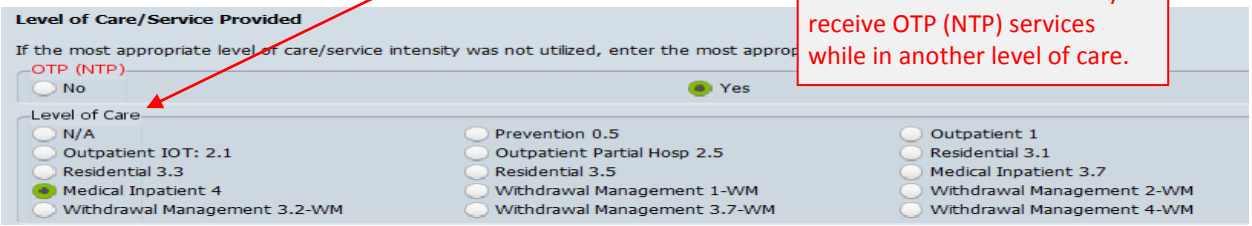


Substance Use – DAS ASAM Data

If the Consumer preference (explain) is selected in the Reason for Discrepancy field, the Consumer preference, explain text box becomes required (red). Complete any comments.



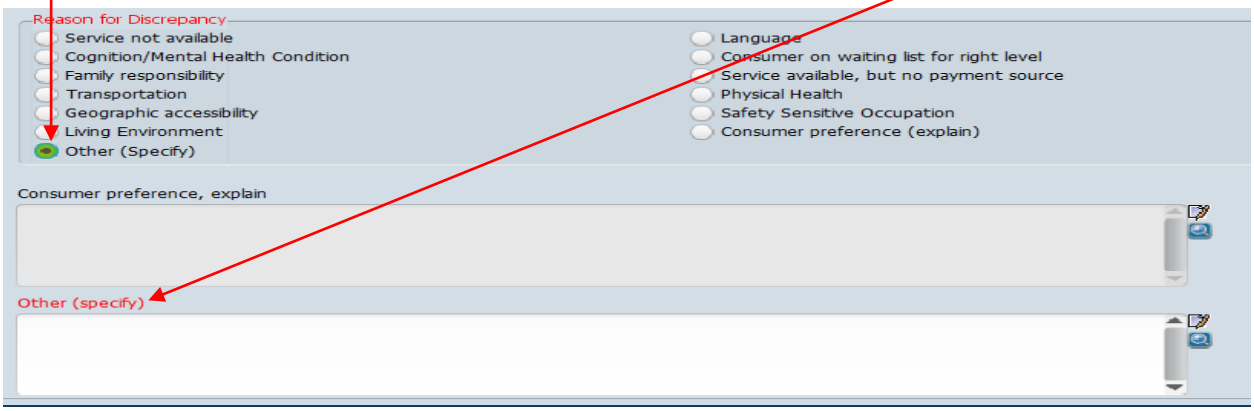
If "Yes" is selected under OTP (NTP), the Level of Care doesn't turn red, but it **is still necessary to complete**. Select the Level of Care provided.



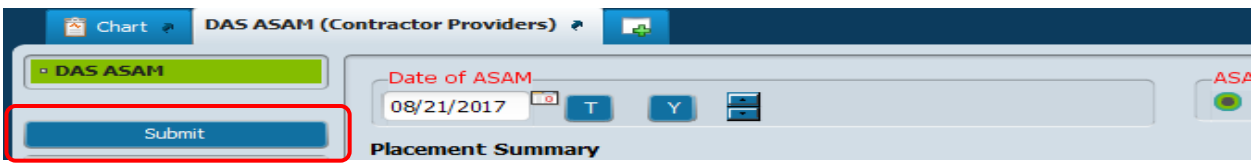
Remember: a consumer may receive OTP (NTP) services while in another level of care.

If the Level of Care provided is different from the **Level of Care indicated by the ASAM**, the Reason for Discrepancy becomes required (red). Select the correct Reason for Discrepancy.

If the Other (specify) is selected in the Reason for Discrepancy area, the Other (specify) text box becomes required (red). Complete the Other (specify) text box.



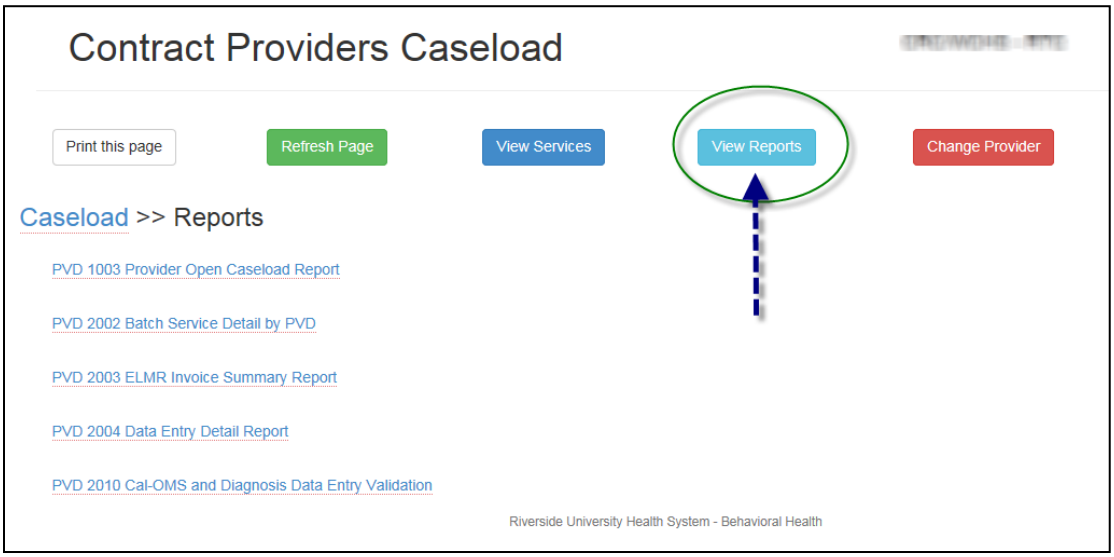
4. Submit the form.



Contract Provider Report Access

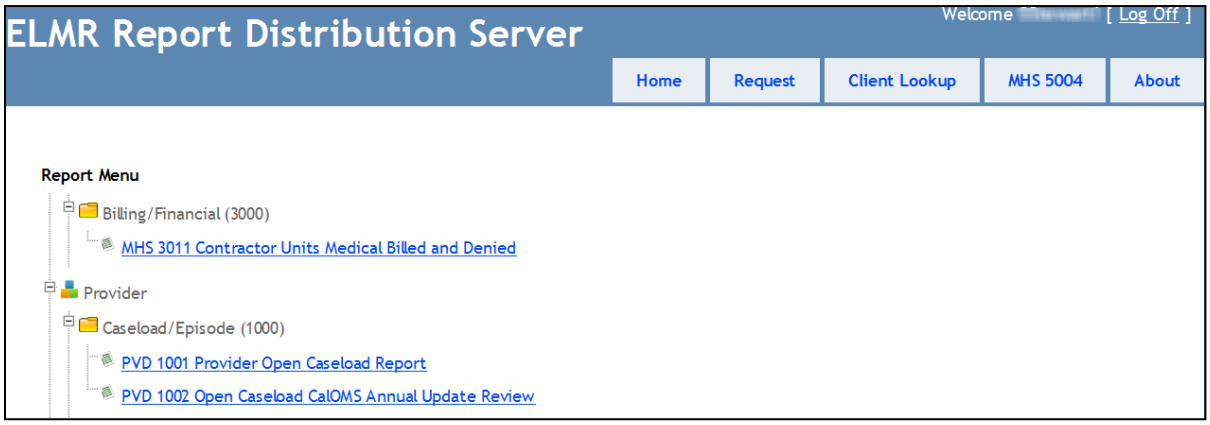
Contact Providers have access to the following reports in ELMR via the Home Page:

PVD 1003 Provider Open Caseload Report: All open clients assigned to specific provider, sorted by Program RU.
PVD 2002 Batch Service Detail by PVD: Finalized batch detail, based on date range.
PVD 2003 ELMR Invoice Summary Report: Due with monthly Provider Integrity Form (PIF), accounts for all services within date range, in final status, with assigned batch numbers.
PVD 2004 Data Entry Detail Report: Draft and Finalized batch detail, based on date range.
PVD 2010 CalOMS and Diagnosis Data Entry Validation: Report generates list of any consumers assigned to caseload that are missing CalOMS Admission form and/or Diagnosis entry.



Contact Providers have access to the following reports in ELMR Reports Distribution Server:

MHS 3011 Contractor Units Medical Billed and Denied: Shows all approved services provided by Contractor. This report further details Medi-cal services regarding what has not been billed, what has been billed then denied, and those that were rebilled. Services that do not show a claim number have not yet been billed to the State. All approved units will be used during the cost report settlement process.
PVD 1001 Provider Open Caseload Report: All open clients assigned to specific provider by Program RU.
PVD 1002 Open Caseload CalOMS Annual Update Review: Identifies open consumers and if due or past due for Annual Update.



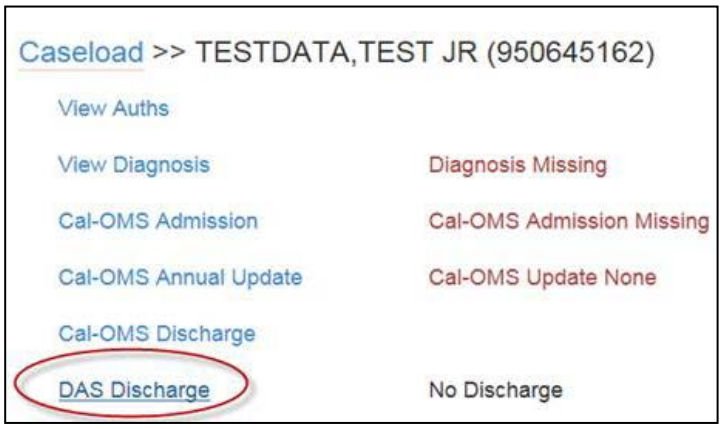
Format: ELMR Data Entry
Access: Provider ELMR Login, Provider Caseload

Purpose: Discharges for all consumers are completed by Contract Provider via Provider's ELMR access. Discharges are completed in two steps: DAS Discharge and CalOMS Discharge.

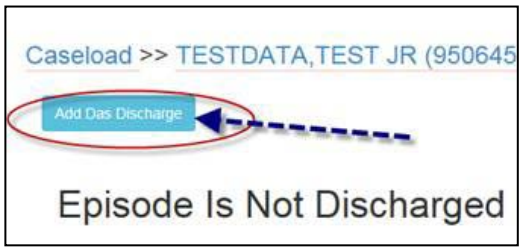
Step #1 DAS Discharge:

1. Select the consumer number:

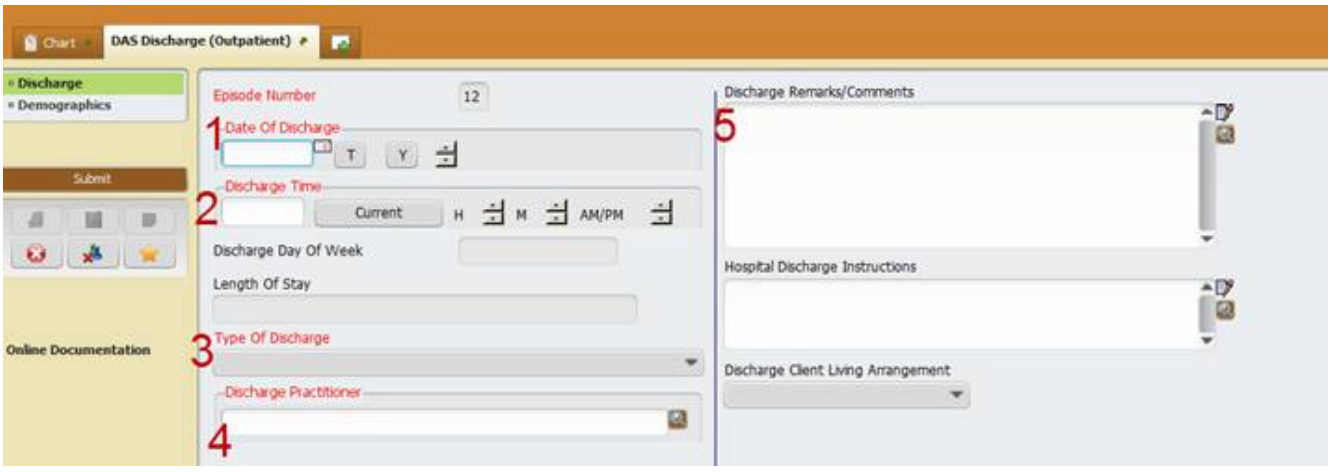
2. Access the DAS Discharge form:



3. Select Add DAS Discharge



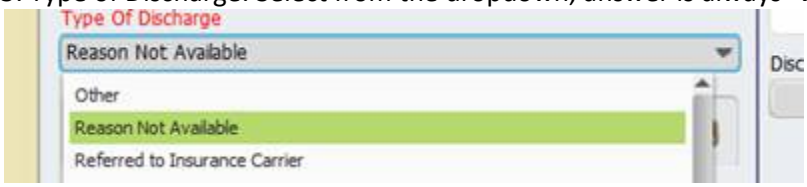
4. DAS Discharge form will load:



Complete items 1-5:
1: Date of Discharge

2: Discharge Time

3: Type of Discharge: Select from the dropdown, answer is always **"Reason Not Available"**



4: Discharge Practitioner

5: Discharge Remarks/Comments

Once completed, select the Submit button:

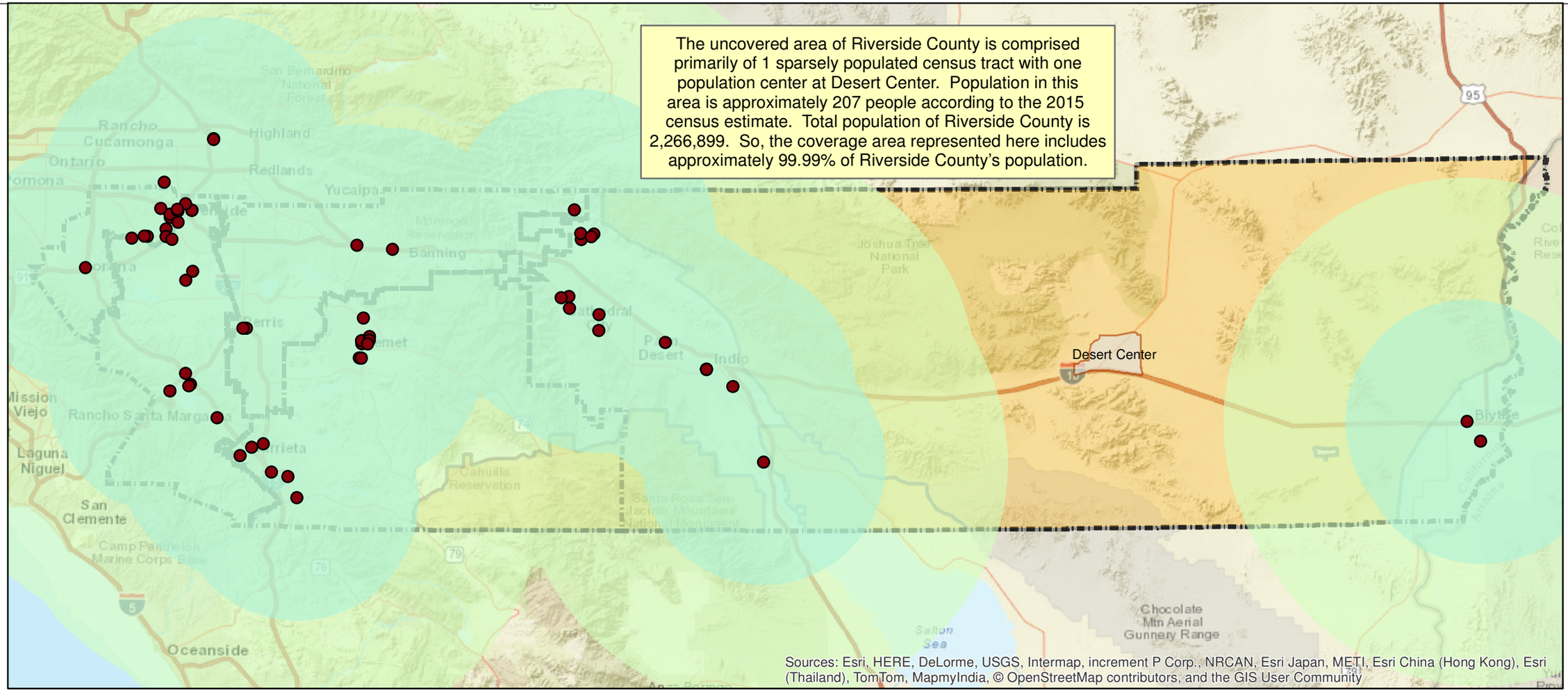
Consumer will show as discharged on caseload view:

Proceed to Step #2- CalOMS discharge form.
Instructions provided in SAPT Contract Provider User Manual.

*Note- once the DAS Discharge form is completed, there is no access to edit the date of discharge. If the date of discharge is entered incorrect, Contractors is to submit a request for deletion via email notification to SAPT Administration.

Riverside University Health System - Behavioral Health

Riverside County Substance Abuse Prevention and Treatment Network Coverage Area (15- and 30-Mile radius)



Network Coverage Legend

- Substance Abuse Programs
- Substance Abuse Buffer 30Mi
- Substance Abuse Buffer 15Mi
- Uncovered Census Tracts
- SUPERVISORIAL DISTRICTS

Sources include County of Riverside RCIT DMH Facility data, and ESRI ArcGIS Online basemaps.
MHD041a Produced by Research & Technology on May 15, 2017.

Substance Abuse Prevention and Treatment Administration
Friday Night Live (FNL)
3525 Presley Avenue, Riverside, CA 92507
(951) 782-2400 Phone (951) 683-4904 FAX

Substance Use Community Access, Referral, Evaluation, and Support Line (SU CARES) 1 - 800 - 499 - 3008

Behavioral Health SU CARES Hotline: Guidance and assistance is just a phone call away! We provide substance abuse prevention and treatment service information for individuals and families, screening and placement services, and direct referrals for consumers of Riverside County communities seeking help with substance use difficulties or questions. Pregnant or know someone who is and wants treatment and a chance at recovery? Immediate access to treatment for pregnant and parenting women. Call today and ask about our peri-natal programs.

Services Available at all below RUHS Behavioral Health Clinics

- Personal and private screening, assessment, and placement services
- Individual and family prevention services
- Substance abuse treatment, individual and family counseling, and group counseling
- Individual and family guidance for individuals desiring help and a life of recovery
- Information for individuals and families regarding help and assistance

Clinic Locations and Hours

BLYTHE
1297 W. Hobsonway
Blythe, CA 92225
(760) 921-5000
M-F, 8am to 5:30pm

CORONA
623 N. Main Street, Suite D11
Corona, CA 92880
(951) 737-2962
M-F, 8am to 5pm

CATHEDRAL CITY
68615 Perez Road, Suite 6A
Cathedral City, CA 92234
(760) 770-2286
M-Th, 8AM to 5pm
Fri., 8am to 4:30pm

LAKE ELSINORE
31764 Casino Drive, Suite 200
Lake Elsinore, CA 92530
(951) 471-4649
M-Th, 8am to 5pm
Fri., 8am to 4:30pm

DESERT HOT SPRINGS
14320 Palm Drive
Desert Hot Springs, CA 92240
(760) 770-2264
M-F, 8am to 5pm

INDIO
83-912 Avenue 45, Suite 9
Indio, CA 92201
(760) 347-0754
M-F, 8am to 5pm

SAN JACINTO
1370 S. State St., Suite A
San Jacinto, CA 92583
(951) 791-3350
M-Th, 8am to 5pm
Fri., 8am to 4:30pm

TEMECULA
40925 County Center Drive, Suite 200
Temecula, CA 92591
(951) 600-6360 M-Th, 8am to 5pm
Fri., 8am to 4:30pm

RIVERSIDE
2085 Rustin Avenue, #3
Riverside, CA 92507
(951) 955-2105
M-Th, 8am to 5pm
Fri. 8am to 4:30pm

DRINKING DRIVER PROGRAMS (DDP) LOCATIONS AND HOURS

INDIO
83-912 Avenue 45, Suite 9
Indio, CA 92201
(760) 863-8471
M-F, 8am to 5pm

RIVERSIDE
2085 Rustin Avenue, #3
Riverside, CA 92507
(951) 955-7350
M-F, 8am to 5pm

Riverside County
SAPT Commonly Used Acronyms

State/Federal:	
CFR-	Code of Federal Regulations
AOD –	Alcohol and Other Drugs
CalOMS –	California Outcome Measurement System: California's outcomes reporting mechanism/system
CALWORKS-	California Work Opportunity and Responsibility to Kids
CARF-	Commission on Accreditation of Rehabilitation Facilities
DAS-	Drug and Alcohol Screening
DATAR	Drug and Alcohol Treatment Access Report
DHCS-	Department of Health Care Services
DMC-	Drug Medi-Cal aka Medicaid
DMC-ODS-	Drug Medi-Cal Organized Delivery System
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
HIPAA	Health Insurance Portability and Accountability Act
MAT-	Medically Assisted Treatment
NPI-	National Provider Identifier (required for all facilities and practitioners)
OHC-	Other Health Care
SAMSHA-	Substance Abuse and Mental Health Services Administration
SAPT–	Substance Abuse Prevention and Treatment (Federal Block Grant Fund)
SOC-	Share of Cost (referenced under DMC eligibility)
STC-	Special Terms and Conditions
STOP-	CDCR eligible funding for criminal justice population
SUD-	Substance Use Disorder
Title 22-	Regulations for Drug Medi-Cal
Title 9-	Regulations for Rehabilitative and Developmental Services
YTF-	Youth Treatment Funding

County:	
CARF-	Computer Account Request Form
CMT-	Contract Monitoring Team
ELMR-	(Electronic Medical Record-county's system nickname for EHR System AVATAR)
RU-	Reporting Unit
RUHS-BH-	Riverside University Health System - Behavioral Health

Clinical:	
ASAM	American Society of Addiction Medicine
ASI-	Addiction Severity Index
BHS-	Behavioral Health Specialist
CBT-	Cognitive Behavioral Therapy
CCT-	Care Coordination Team (Case Managers)
COD-	Co-occurring Disorders
CT-	Clinical Therapist
DDX-	Detox
IMS-	Incidental Medical Services
IOT-	Intensive outpatient treatment (formerly DCR-Day Care Rehabilitative and DCH-Day Care Habilitative
LGBTQ-	Lesbian, Gay, Bisexual, Transvestite and Questioning
LPHA-	Licensed Practitioner of the Healing Arts
MI-	Motivational Interviewing

Riverside County

SAPT Commonly Used Acronyms

NPI-	National Provider Identifier
NTP-	Narcotic Prevention Treatment aka Opioid Treatment Prevention (OTP)
ODF-	Outpatient Drug Free
PERI-	Perinatal
RES-	Residential
RS-	Recovery Services
SAPT-	Substance Abuse Prevention and Treatment Program
SLE-	Sober Living Environment or Recovery Residence
START-	Substance Treatment and Recovery Team
SU CARES-	Substance Use Community Access, Referral, Evaluation and Support (Placement Team)