San Francisco Department of Public Health
Behavioral Health Services

Drug Medi-Cal Organized Delivery System (DMC-ODS)

CalAIM Chart Documentation Desk Reference 09.20.23

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CalAIM Overview and Changes in DMC-ODS

CalAIM Overview

- CalAIM stands for California Advancing and Innovating Medi-Cal and is a comprehensive initiative launched by the California Department of Health Care Services (DHCS) to transform the Medi-Cal program.
- Medi-Cal is California's Medicaid program, which provides health insurance coverage to low-income individuals and families.
- The goal of CalAIM is to improve the health outcomes and quality of care for Medi-Cal beneficiaries while also addressing health disparities and promoting health equity. CalAIM aims to achieve these objectives through a series of programmatic changes and enhancements.
- BHS will update this DMC-ODS Desk Reference tool as DHCS publishes guidance. Be sure to look for the version number to ensure you have the most up-to-date version published.

CalAIM Changes within the DMC-ODS

- Initial assessment and clinically appropriate DMC-ODS services (except Residential and NTP/OTP) are Medi-Cal reimbursable for up to 30 days in an adult program following the first visit with a licensed Practitioner of Healing Arts (LPHA) or registered/certified counselor, reimbursable up to 60 days if the beneficiary is in an adolescent program and if a provider documents that the adult client is experiencing homelessness. In addition, DMC-ODS county(ies) will not disallow reimbursement for clinically appropriate and overed DMC-ODS services provided during the assessment process if the assessment determines that the beneficiary does not meet the DMC-ODS Access Criteria for Beneficiaries After Assessment.
- CalAIM DMC-ODS MAT Policy
- DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanism to most clinically appropriate MAT services for beneficiaries with SUD diagnosis that are treatable with medications or biological products.
- Updated Chart Documentation Expectations:
    - As noted in BHIN 22-019, DMC-ODS system is responsible for creating and maintaining a Problem List. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of services encounters that reflect the current presentation of the beneficiary and should be updated on an ongoing basis. The current electronic health records (like Avatar and EPIC) are not able to separate MH and SUD, as required by CFR42 SUD privacy. As of the publication of this document, BHS has directed DMC-ODS providers to hold off on using Problem List until further notice, but a solution should be forthcoming.
    - Progress notes are expected to be completed within 3 business days of providing a service (except for crisis services which still need to be completed within 24 hours
    - Daily Progress note are required for services that are billed on a daily basis such as residential and day treatment services.

- There is no longer a requirement to complete the 6-month continuing services justification form.
- As noted in BHIN 22-019, health care service conducted by telehealth or telephone, the provider is required to confirm: (1) consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth; (2) an explanation that beneficiaries have the right to access services in-person/face-to-face; (3) an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time; (4) an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; (5) potential limitations or risks related to receiving services through telehealth (vs. in-person visit), to the extent any limitations or risks are identified by the provider. The provider must document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

Behavioral Health Services' Policies, Manuals, and CalAIM Implementation Resources

- 2019 SFDPH DMC-ODS Treatment Manual, which is being revised with CalAIM updates.
- CalAIM implementation can be found in Provider Billing & Documentation Library

Continuum of Care Substance Use Disorder Treatment Services

Below is a list of substance use treatment services offered in San Francisco County as part of DMC-ODS continuum of care:

- Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5) - forthcoming
- Outpatient Services (ASAM Level 1)
- Intensive Outpatient Services (ASAM Level 2.1)
- Residential Treatment and Inpatient Services (ASAM Levels 3.1 - 4.0)
  - ASAM Levels 3.1, 3.3, & 3.5 provided and subject to prior authorization by the County.
- Withdrawal Management (ASAM Levels 1-WM, , 3.2-WM, and 4-WM)
- Narcotic Treatment Program (NTP)
- Medication Assisted Treatment (MAT)
- Recovery services
- Contingency management
  - Contingency management is a pilot program that consists of a series of motivational incentives for meeting treatment goals. Only non-residential DMC-ODS providers can deliver contingency management services.

Service Frequency, Delivery Mode & Location

ASAM Level of Care	Service Frequency	Service Delivery Mode & Location
Outpatient Services	• Up to nine (9) hours of service per week for adults • Up to six (6) hours per week for adolescents.	• In person, by telephone, or by telehealth • Any appropriate setting in community
Intensive Outpatient Services	• A minimum of nine (9) hours with a maximum of nineteen (19) hours per week for adults • A minimum of six (6) hours with a maximum of nineteen (19) hours per week for adolescents	• In person, by telephone, or by telehealth • Any appropriate setting in community
Residential Services	• 24-hour care setting	• In a DHCS or Department of Social Services licensed residential facility for residential treatment services.

ASAM Level of Care	Service Frequency	Service Delivery Mode & Location
Opioid/Narcotic Treatment Program (OTP/NTP)	• Between 50 and 200 minutes of counseling per calendar month with a therapist or counselor and when medically necessary, additional counseling services • Daily or several times weekly opioid agonist medication and counseling for those with severe opioid disorder.	• In person at an OPT/NTP Clinic
Withdrawal Management Services	• Provide in conjunction with any of the levels of care mentioned above	• In-person at the facility associated with the level of care

Medical Necessity & Medically Necessary Services Requirements

"Medical Necessity" and "Medically Necessary 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 42 CFR438.210(a)(4) and Welfare and Institutions Code (W&I) Section 14059.5(a), and in the case of EPSDT, services that meet the criteria specified in Federal EPSDT Law – Title 42 USC 1396d(r)(5)).

For an individual to receive SUD treatment services, there must be documentation in the beneficiary record in the form of a narrative statement to show that she/he/they meet DMC-ODS Access Criteria after Assessment as noted in BHIN 23-001.

DMC-ODS Access Criteria for Beneficiaries after Assessment

1. Beneficiaries 21 and older: To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older must meet one of the following criteria:
    a. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) for a Substance-Related and Addictive Disorder with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorder, OR

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

2. Beneficiaries under the age of 21: To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and younger must meet following requirements pursuant to BHS CYF SUD CalAIM Updates At-A-Glance:
   a. Criteria 1: Has one covered diagnosis from the DSM for Substance Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders **OR** Is assessed to be at risk for developing a substance use disorder.
   b. Criteria 2: **AND** Beneficiary meets the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria

For youth under 21 years of age, services need not be curative or completely restorative to ameliorate a substance use condition, including substance misuse and substance use disorders (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services (BHS CYF SUD CalAIM Updates At-A-Glance).

Initial Assessment & Re-Assessment

Medi-Cal beneficiaries whose county of responsibility is San Francisco can receive covered and clinically appropriate DMC-ODS services consistent with the following assessment, access, and level of care determination criteria.

ASAM Criteria

DMC-ODS providers are required to use the ASAM Criteria® to determine placement into the appropriate level of care for all beneficiaries. San Francisco County Department of Public Health has created a comprehensive assessment based on ASAM Criteria® that is called *Substance Use Disorder Services Level of Care Recommendation form (SUD LOC)*. Beneficiary placement and level of care determinations ensure that beneficiaries can receive care in the least intensive level of care that is clinically appropriate to treat their condition. The ASAM Criteria® uses a multidimensional assessment to inform medical management needs, along with the structure, safety, security, and intensity of treatment services.

In San Francisco, the SUD LOC is used to determine the beneficiary's level of care. A full SUD LOC does not need to be repeated unless the beneficiary's condition changes or annually for youth in Adolescent Programs. Assessment and/or reassessment using the ASAM criteria must take place at the onset of each level of care and every transition to another level of care.

Six Dimensions of the ASAM Level of Care Multi-Dimensional Assessment

The ASAM Criteria uses six unique dimensions which represent different areas of a client's life to create a holistic, biopsychosocial assessment of an individual to support service planning and level of care placement decisions for the client.

ASAM Dimension		Description
Dimension 1	Substance Use, Acute Intoxication, Withdrawal Potential	Exploring an individual's past and current exposure to substance use and withdrawal
Dimension 2	Biomedical Condition and Complications	Exploring an individual's health history and current physical condition
Dimension 3	Emotional, Behavioral, or Cognitive Condition and Complications	Exploring an individual's thoughts, emotions, and mental health issues
Dimension 4	Readiness to Change	Exploring an individual's readiness and interest in changing
Dimension 5	Relapse, Continued Use, or Continued Problem Potential	Exploring an individual's unique relationship with relapse or continued use or problems
Dimension 6	Recovery/Living Environment	Exploring an individual's recovery or living situation and the surrounding people, places and things.

DPH Substance Use Disorder Services Level of Care Recommendation Form

In San Francisco County Department of Public Health (SFDPH), a full Substance Use Disorder Services Level of Care Recommendation form (SUD ASAM LOC form), based on ASAM criteria, is used as an assessment and re-assessment tool to determine beneficiary's level of care placement decisions. This form is available electronically in SFDPH's electronic record, Avatar, and will be available in the new electronic record, EPIC, in 2024.

The San Francisco SUD LOC Assessment contains the Eleven Elements of Client Assessment & Corresponding ASAM Dimensions.

Assessment Element	Maps to ASAM Dimension
1. Drug/Alcohol History	Dimension 1: Acute Intoxication and/or Withdrawal Potential
2. Medical History	Dimension 2: Biomedical Condition and Complications
3. Family History	Dimension 6: Recovery/Living Environment
4. Psychiatric/Psychological History	Dimension 3: Emotional, Behavioral, or Cognitive Condition and Complications
5. Social/Recreational History	Dimension 6: Recovery/Living Environment
6. Financial Status/History	Dimension 6: Recovery/Living Environment
7. Educational History	Dimension 6: Recovery/Living Environment
8. Employment History	Dimension 6: Recovery/Living Environment
9. Criminal History	Dimension 6: Recovery/Living Environment
10.Legal Status	Dimension 6: Recovery/Living Environment
11.Previous SUD Treatment History	Dimension 2: Biomedical Condition and Complications Dimension 5: Relapse/Continued Use/Continued Problem Potential

Sources: DHCS DMC-ODS Documentation Training, July 2018 and "The ASAM Criteria, Third Edition" found at www.asam.org

Client Multidimensional Risk Assessment

For each ASAM Dimension, a client is assessed for their individual severity and level of function, or in other words, "risk." The risk assessment integrates the client's history, current status, and changing situation:

1. Risk as it relates to the client's history;
2. Risk as expressed in the client's current status answering the question: "how acute, unstable, and active is the client's current clinical presentation"; and
3. The degree of change from baseline or premorbid functioning to present.

Clients are assigned a Dimension Severity Rating for each of the six ASAM Dimensions to inform level of care placements at admission and during transitions between ASAM Levels of Care. Table below outlines risk ratings and their definitions.

Severity and Risk Ratings

Risk Rating	4	This rating would indicate issues of **utmost severity**. The patient would present with critical impairments in coping and functioning, with signs and symptoms, indicating an **"imminent danger"** concern.	High
	3	This rating would indicate a **serious issue** or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near "imminent danger"	Moderate
	2	This rating would indicate **moderate difficulty** in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support system may be present.	
	1	This rating would indicate a **mildly difficult issue**, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.	Low
	0	This rating would indicate a **non-issue or very low risk issue**. The patient would present no current risk and any chronic issues would be mostly or entirely stable.	

Review and Signature Requirements

Physician/LPHA Review Requirements for Assessments Completed by Drug Counselors: Where a Drug counselor completes the intake assessment, there must be documentation in the client's record of the review of the personal, medical and substance use history by a physician or LPHA acting within their scope of professional practice, (Intergovernmental Agreement: Exhibit A, Attachment I A2, III.1.i.a.) including the signature, or electronic equivalent of the physician/LPHA, date, and printed name.

Due Dates for Assessments and Re-Assessments

Depending on the ASAM Leve of Care, there are different deadlines for completion of the SUD LOC, as noted in BHIN 23-001. Of particular note, reauthorization is required every 30 days for residential services, with a brief level of care justification based on ASAM criteria.

ASAM Level of Care*	Population	Initial Due Date from Admission	Update Due Date from Admission
Outpatient and Intensive, including Recovery Services	Adults	30 Days	As necessary
Out Outpatient and Intensive, including Recovery Services	Adults experiencing homelessness and therefore requiring additional time	60 Days	As necessary
Outpatient and Intensive, including Recovery Services	Adolescents	60 Days	As necessary, annually
Narcotic Treatment Programs	Adults	28 Days	As necessary, Every 3 months thereafter
Residential Services	Adults, Youth (when available)	Prior Authorization is required	Reauthorization is required every 30 days

*Sources:

- BHIN 23-001
- Adult SUD CalAIM Updates At-A-Glance
- CYF SUD CalAIM Updates At-A-Glance
- FAQ CalAIM Documentation Requirements
- Intergovernmental Agreement, Exhibit A, Attachment 1, A2, 9 CCR §10305, DPH SUD Residential Treatment Authorization Policy, v.11.18.18

Note: Staff performing assessments must complete the two e-learning ASAM modules: "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care."

Diagnosis

A beneficiary's diagnosis must be established by an LPHA, including a registered/waivered LPHA.

During Assessment (excludes Residential Treatment services):

Covered and clinically appropriate treatment services may be delivered following the first visit with an LPHA or registered/certified counselor and may be delivered before a final DSM diagnosis for Substance-Related and Addictive Disorders is established.

A provisional diagnosis must be used prior to the determination of a final diagnosis or in cases where a suspected SUD has not yet been diagnosed, per BHS FAQ CalAIM Documentation Requirements:

- An LPHA may document and categorize a suspected SUD under "Other Specified" and "Unspecified" disorder or "Factors influencing health status and contact with health services" (Z-codes).
- Diagnoses shall be updated by an LPHA when a beneficiary's condition changes to accurately reflect the beneficiary's condition.

These codes will meet ICD10 claiming requirements and allow for needed substance use services to be provided even while the LPHA or Medical Director is determining a diagnosis within the 30-day or 60-day window from opening a case (BHS FAQ CalAIM Documentation Requirements).

Diagnosis After Assessment Completion

A client in an adult program must have an SUD diagnosis within 30 calendar days of a client's first visit with LPHA or a counselor. For beneficiaries of an adolescent program and adults experiencing homelessness, an SUD diagnosis must be made within 60 calendar days of a client's first visit with LPHA or counselor. This diagnosis must include:

a. the basis for the diagnosis in a narrative summary format based on DSM 5 criteria, demonstrating that the Medical Director or LHPA evaluated each client's assessment and intake information, including their personal, medical, and substance use history; and
b. documentation of the Medical Director's or LHPA's typed/legibly printed names, signature (or electronic equivalent), and the date of the diagnosis determination. If utilizing AVATAR, please complete the SUD Diagnosis form instead of a progress note.

Problem List

Problem List was introduced in July 2022 as a replacement to client treatment/care plan, except for certain programs that still require a treatment/care plan. However, because of the way the county's Electronic Health Records system is unable to separate Mental Health and SUD records as required by 42 CFR Part 2 regulations, problem list is currently not available for AVATAR users. Until Problem List could be built on AVATAR/EPIC, agencies utilizing AVATAR will continue to only utilize the Treatment/Care Plans. For agencies with their own Electronic Health Record (EHR) system, problem list may be built as soon as feasible. Please consult with BHS regarding confidentiality and privacy parameters required from 42CFR, Part 2 (Adult SUD CalAIM Updates At-A-Glance).

The problem list is a comprehensive record of a beneficiary's substance use conditions, diagnoses, and related issues. It serves as an organized and centralized summary of the beneficiary's SUD needs, allowing treatment team providers to have a holistic understanding of the beneficiary's treatment needs. Providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client by staff working with the appropriate scope of practice. (BHIN 22-019)

However, due to strict 42 CFR, Part 2 regulations, viewing of Problem List by other providers should be restricted to only the description of the problem. The diagnosis should not be viewable by other entities who are not part of the agency's DMC-ODS program. 42 CFR will continue to require that *all* exchange of information, even with other external providers in the treatment team, be permitted only through a signed Release of Information (ROI) by the 12+ year old beneficiary with mental capacity to understand or a legal guardian. More clarification forthcoming (Adult SUD CalAIM Updates At-A-Glance).

At a minimum, the problem list shall include (BHIN 22-019):

1. Diagnoses identified by a provider within their scope of practice.
2. Problems identified by a provider, such as SDOH factors that may exacerbate substance use or impact the course of treatment.
3. Problems or illnesses identified by the beneficiary and/or significant support person.
4. Provider's name and title of the person who identified, added, or removed the problem.
5. The date the problem was identified, added, or removed.

Treatment Plan/Care Plans

Previously, all DMC-ODS services required treatment plans, now called Care Plans. As part of CalAIM documentation reform, a stand-alone Care Plan is no longer requirement for DMC-ODS, with the exception of NTP services and Peer Support Services, and programs that receive federal funding require a treatment/care plan. Agencies that receive funding from Substance Use Prevention, Treatment, and Recovery Services Block Grant (SABG) are no longer required to do a standalone treatment/care plan. For SABG agencies, to meet the federal requirements in 45 CFR 96.136, the treatment/care plan can be written in a progress note utilizing the AVATAR/EPIC progress note template for Care Plans. Please see below for due dates.

The medical director and supervising counselor must review the primary counselor's initial treatment plan and corresponding assessment before it can be finalized within the appropriate due date mentioned below.

Required Elements of Initial and Updated Client Care Plans:

For each client admitted to treatment services, a LPHA or counselor must prepare an *individualized* (tailored to a client's specific needs) written initial care plan based on the information gathered during the intake assessment including the client diagnosis and the ASAM Level of Care assessment.

NTP Initial Treatment/Care Plans

NTP Initial Client Treatment Plan Programs must develop an individualized treatment plan for each client (9 CCR § 10305). The primary counselor must enter in the client's record his or her name and the date the client was assigned to the counselor.

Within 28 calendar days after initiation of maintenance treatment, the primary counselor must develop the client's initial maintenance treatment plan which must include:

1. Goals to be achieved by the client based on the needs identified in paragraph (d) of this section and with estimated target dates for attainment in accordance with the following:
    a. Short-term goals are those which are estimated to require ninety (90) days or less for the client to achieve; and
    b. Long-term goals are those which are estimated to require a specified time exceeding ninety (90) days for the client to achieve.
2. Specific behavioral tasks the client must accomplish to complete each short-term and long-term goal.
3. A description of the type and frequency of counseling services to be provided to the client.
4. An effective date based on the day the primary counselor signed the initial treatment plan. The supervising counselor shall review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and shall countersign these documents to signify concurrence with the findings.

The medical director shall review the initial maintenance treatment plan, along with the corresponding needs assessment within fourteen (14) calendar days from the effective dates and must record the following in the client record:

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

NTP Updated Client Treatment Plan

The primary counselor must evaluate and update the client's maintenance treatment plan whenever necessary or at least once every three (3) months from the date of admission (9 CCR § 10305). This updated treatment plan must include:

1. A summary of the client's progress or lack of progress toward each goal identified on the previous treatment plan.
2. New goals and behavioral tasks for any newly identified needs, and related changes in the type and frequency of counseling services as required.
3. An effective date based on the day the primary counselor signed the updated treatment plan.

The supervising counselor must review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and must countersign these documents to signify concurrence with the findings.

The medical director must review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and must record the following:

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

Non-NTP Care Plans

All of the following Care Plan elements recommended to be documented in the client record

1. Problem Statements
2. ASAM Dimension
3. Goals
4. Action Steps
5. Target Dates
6. Description of Services, Type and Frequency
7. Assignment of Primary Counselor
8. Physical Examination Goals for NTPs
9. Evidence of Client Participation and Agreement
10. Name, Date, and Signature:

a. For All programs: Typed or legibly printed name of the LPHA or Counselor creating the treatment plan, legible signature (or electronic equivalent) and date the treatment plan was completed. The signature must be adjacent to the typed or legibly printed name.
b. For Outpatient and Residential programs: LPHA or Medical Director can approve the treatment plan with Typed or legibly printed name, legible signature (or electronic equivalent) and date the treatment plan was approved. The signature must be adjacent to the typed or legibly printed name.
c. For NTP programs: Medical Director can approve the treatment plan with Typed or legibly printed name, legible signature (or electronic equivalent) and date the treatment plan was approved. The signature must be adjacent to the typed or legibly printed name.

Treatment Plan Due Dates

ASAM Level of Care	Population	Initial Due Date from Admission	Update Due Date from Admission
Outpatient and Intensive, including Recovery Services	Adults	30 Days	As necessary
Outpatient and Intensive, including Recovery Services	Adults experiencing homelessness and therefore requiring additional time	60 Days	As necessary
Outpatient and Intensive, including Recovery Services	Adolescents	60 Days	As necessary, annually
NTP	Adults	28 Days	As necessary, Every 3 months thereafter

**Sources:*

- BHIN 23-001
- Adult SUD CalAIM Updates At-A-Glance
- CYF SUD CalAIM Updates At-A-Glance
- FAQ CalAIM Documentation Requirements
- Intergovernmental Agreement, Exhibit A, Attachment 1, A2, 9 CCR §10305, DPH SUD Residential Treatment Authorization Policy, v.11.18.18

Residential Authorizations

DMC-ODS counties are required to provide authorization for residential and inpatient services (excluding withdrawal management services) within 24 hours of the authorization request submission as noted in BHIN 23-001. In SFDPH, Residential treatment shall be reassessed and reauthorized every 30 days.

Initial Authorization for Adults:

At SFDPH, Initial Authorizations are approved in 30-day increments except for perinatal clients. Re-authorization is required any treatment after 30 days and is to be requested between 7-10 days before the expiration date of the current authorization. There is no limited number of episodes in 12 months period as long as client meets medical necessity as noted on BHIN 23-001.

Perinatal clients, who meet medical necessity, may receive longer substance use residential lengths of stay than non-perinatal adults. Perinatal clients can be considered under perinatal authorization for the duration of their pregnancy plus 60 days postpartum. Following the 60 days of authorized postpartum treatment, former perinatal clients who continue to meet medical necessity for treatment can be considered for a new non-perinatal substance residential and subsequent reauthorization under the non-perinatal guidelines.

Continuing and Extension Authorization:

Requests for continuing and extension authorizations are to be submitted to between 7-10 days before the expiration date of the current authorization. A copy of the re-assessment ASAM criteria must be included as part of the authorization. Continuation authorizations can be granted every 30 days for adults.

Continuing Services Justification Requirements for ASAM Level of Care	Medical Necessity Documentation Requirements
Narcotic Treatment Program	Per DHCS, the Medical Director, program physician or LPHA must document in the client record annually continued justification for maintenance treatment including: 1) his or her evaluation of client progress, or lack of progress in achieving treatment goals; and 2) a determination, in his or her clinical judgment, that the client's status indicates that treatment should be continued for a longer period of time because discontinuance from treatment would lead to a return to opiate addiction.

Residential Services	For Residential Services, if determined to be medically necessary, clients must receive reauthorization every 30 days. Reauthorization requests must be submitted to DPH 7-10 days before the current authorized period ends to ensure there is proper time for requests for clarification and transition planning.

Narcotic Treatment Program Specific Requirements

Medical Evaluation

Before admitting an individual to maintenance treatment, the medical director must either conduct a medical evaluation or document his or her review and concurrence of a medical evaluation conducted by a LPHA acting within his/her scope of professional practice. At a minimum, documentation of all the following must be in the client record:

1. A medical history which includes the client's history of illicit drug use;
2. Laboratory tests for determination of narcotic drug use, tuberculosis, and syphilis (unless the medical director has determined the individual's subcutaneous veins are severely damaged to the extent that a blood specimen cannot be obtained); and
3. A physical examination which includes:
    a. An evaluation of the client's organ systems for possibility of infectious diseases; pulmonary, liver, or cardiac abnormalities; and dermatologic sequelae of addiction;
    b. A record of the client's vital signs (temperature, pulse, blood pressure, and respiratory rate);
    c. An examination of the client's head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin, and general appearance;
    d. An assessment of the client's neurological system; and
    e. A record of an overall impression which identifies any medical condition or health problem for which treatment is warranted.

Before admitting a client to maintenance treatment, the medical director must:

1. Document the evidence, or review and concur with the LPHA's documentation of evidence, used from the medical evaluation to determine physical dependence and addiction to opiates; and
2. Document his or her final determination concerning physical dependence and addiction to opiates.

Progress Notes

Providers must create billable progress notes to claim for DMC-ODS Services. In addition to recording client's treatment journey, progress notes are important communication tools with client/family and other providers who have authorization to access that information.

Each progress note must provide sufficient detail to support the service/procedure/billing code selected. Each progress note should be understandable when read independent of other progress notes and provide an accurate picture of the beneficiary's conditions, treatment provided, and response to care at the time the service was provided.

Progress Notes Requirements per BHIN 23-001:

1. The type of service rendered.
2. A narrative description of the service (how it addressed client's needs including symptoms, condition/impairment, diagnoses, risk factors). Please ensure the narrative supports the CPT/HCPCS code selected.
3. The date the service was provided to the beneficiary.
4. The duration of the direct face-to-face service. Associated travel and documentation time will be entered separately in the same document.
5. The location of the service provision (office, field, phone, etc.)
6. An ICD-10 code.
7. A CPT/HCPCS code.
8. Next steps including but not limited to planned action steps for the provider or client, collaboration with the client and/or other providers, and any updates to the problem list.

While most of the above elements may be automatically populated by Avatar/EPIC when the systems are updated (such as CPT/HCPCS code or ICD-10 code), it is important to ensure that all elements of the progress note are accurate prior to finalizing.

Group Progress Notes Requirement per BHIN 23-001 and 2019 SFDPH DMC-ODS Treatment Manual:

1. A list of participants must be documented and maintained separately from AVATAR progress note.
2. A group must have a minimum of 2 participants and a maximum of 12 participants.
3. Each client needs a group progress note written for their specific participation.
4. If more than one provider provides a group service, then only one progress note may be completed for a group session and signed by one provider.
5. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time.

Progress Notes Due Dates per BHIN 23-001

- Outpatient progress notes should be finalized within 3 business days of the service date.
- Residential and Day Treatment progress notes shall be billed on a daily basis. Weekly summaries no longer required.
- Crisis progress notes should be finalized within 24 hours of the time the service was completed.

Discharge Planning & Discharge Summary

Discharge Planning

Discharge from treatment may occur on a voluntary or involuntary basis.

Voluntary Discharge

If voluntary discharge due client no longer meeting medical necessity, A LPHA or counselor is required to complete a discharge plan for each client, except for a client for whom a provider loses contact. When the Medical Director or LPHA determines that a client no longer meets medical necessity for treatment services, a discharge plan must be completed by a LPHA or counselor within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the client for outpatient, intensive outpatient, and residential services and no less than 15 days for NTP and Withdrawal programs. A discharge plan must include, but is not limited to, all of the following:

1. A list and description of each of the client's relapse triggers;
2. A plan to assist the client to avoid relapse when confronted with each trigger; and
3. A support plan.

During the LPHA's or counselor's last face-to-face treatment with the client, the LPHA or counselor and the client shall type or legibly print their names, sign (or electronic equivalent) and date the discharge plan. The signatures must be adjacent to the typed or legibly printed name. A copy of the discharge plan must be provided to the client and documented in the client record.

Involuntary Discharge

Where a client is being involuntarily discharged, the client must be given timely and adequate notice in writing (42 CFR §438.404) through a Notice of Adverse Benefit Determination (NOABD). However, if the medical director or program physician deems it clinically necessary to terminate a participation sooner, they can do so in accordance with agency policies. Such decisions must be documented in the client's record.

In accordance with the federal requirements, providers must use the Department of Health Care Services' (DHCS) uniform notice templates when providing beneficiaries with a written NOABD (SF Policy 3.11-04). The notice templates include both the NOABD and the NOABD Your Rights documents to notify beneficiaries of their rights in compliance with the federal regulations. DHCS-approved NOABD forms for San Francisco County providers can be found on our website.

The provider is required to mail the written notice of discharge from treatment services to the client at least 10 days before the date of the treatment discharge.

Discharge Summary per **2019 SFDPH DMC-ODS Treatment Manual**

SFDPH requires that a LPHA or counselor must prepare a discharge summary for all clients in the client record within 30 calendar days of the last face-to-face treatment contact with the client that includes all of the following:

1. The duration of the client's treatment as determined by the dates of admission to and discharge from treatment;
2. The reason for discharge;
3. A narrative summary of the treatment episode; **and**
4. The client's prognosis.

Reference Materials:

9 CCR §10305
42 CFR §438.404
45 CFR 96.136
Adult SUD CalAIM Updates At-A-Glance
BHIN 23-001
BHIN 22-019
BHS CYF SUD CalAIM Updates At-A-Glance
CalMHSA DMC-ODS Clinical Documentation Manual
FAQ CalAIM Documentation Requirements
Provider Billing & Documentation Library
San Francisco DMC-ODS Treatment Manual
SF Policy 3.11-04
SUD ASAM LOC Form
The ASAM Criteria