COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 6, CHAPTER 7, POLICY 003

SUBSTANCE USE DISORDER DRUG MEDI-CAL CLINICAL DOCUMENTATION

POLICY NUMBER:	6-7-003
SYSTEM OF CARE:	SUBSTANCE USE
FINALIZED DATE:	12/22/2023
EFFECTIVE:	01/01/2024
SUPERSEDES # :	Supersedes Policy #'s: N/A

A. PURPOSE: To establish uniform guidelines, requirements, and timelines for Drug Medi-Cal Organized Delivery System (DMC-ODS) Clinical Documentation for Yolo County Health and Human Services Agency (HHSA) Substance Use Disorder (SUD) Outpatient and Residential Network Providers.

B. RELATED DOCUMENTS:

1. N/A

C. DEFINITIONS:

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

2. **Member**: Replaces the term, "beneficiary." For DMC-ODS services, member is defined as 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.

3. **Network Provider**: Any provider, group of providers, or entity that has a network provider agreement with Yolo County HHSA BH and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract (Title 42 Code of Federal Regulations [42 CFR] § 438.2)

4. **Problem List:** A list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

5. **Scope of Practice:** The extent and limits of the interventions that a provider may perform based on their credentials and/or classification. Refer to appropriate professional licensing boards for specific information about scope of practice; as well as any scope, supervision, or registration requirements set forth in the Business and Professions Code or associated regulations.

D. POLICY:

Substance Use Disorder Services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency. Documentation of outpatient and residential services shall include the following:

1. **Initial Paperwork**
    a. Providers shall provide beneficiaries with a copy of the Yolo County member handbook and provider directory when the members first access services and thereafter upon request.
2. **Assessment**
    a. A full ASAM criteria assessment or initial provisional referral tool for preliminary level of care recommendations prior to receiving DMC-ODS services is not required.
    b. Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, during the assessment, or prior to determination of whether DMC-ODS access criteria are met, even if the assessment ultimately indicates the member does not meet the access criteria for the delivery system in which they initially sought care.
    c. Providers shall use the American Society of Addiction Medicine (ASAM) criteria assessment that is designated by Yolo County, the free ASAM Criteria® Assessment Interview Guide, or ASAM Continuum software.
        i. Effective January 1, 2025, DMC and DMC-ODS providers shall use one of the following ASAM assessment tools: ASAM Criteria Assessment Interview Guide or ASAM Continuum software, or a validated tool subsequently approved by DHCS and added to the list of approved DMC and DMC-ODS ASAM Assessment tools.
    d. The assessment shall include the LPHA's recommendation for ASAM level of care (LOC) and medically necessary services, and additional provider referrals, as clinically appropriate.
        i. Both licensed and non-licensed providers, including those not qualified to diagnose an SUD, may contribute to the assessment consistent with their scopes of practice.
        ii. If the assessment of the member is completed by a registered or certified counselor, then a LPHA shall review that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

iii. The assessment shall include a typed or legibly printed name, signature of the service provider, provider title (or credentials), and date of signature.

e. Assessments shall be completed within the following timelines:
   i. Outpatient Treatment Services: To ensure that beneficiaries receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.
   ii. Residential Treatment Services: Each member shall receive a multidimensional LOC assessment within 72 hours of admission. Following the initial LOC assessment, a comprehensive assessment should be completed as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.
   iii. A resident receiving Withdrawal Management Services is exempt from the requirement to conduct a multidimensional assessment within 72 hours of admission.
f. Licensed or certified SUD recovery or treatment programs are required to conduct evidenced-based assessments of clients' needs for Medications for Addiction Treatment (MAT). Please refer to Yolo County's MAT policy for more information.
g. If it is determined, based on the assessment, that the member does not meet medical necessity criteria to receive DMC-ODS services, the client shall be provided a Notice of Adverse Benefit Determination (NOABD) and shall be referred to the appropriate provider based on their needs, as identified during the assessment process and in accordance with state and federal regulations.
h. The problem list and progress note requirements identified below shall support the medical necessity of each service provided. Assessments shall be updated as clinically appropriate when the member's condition changes. Please refer to Yolo County's SUD medical necessity policy and the Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) 21-075 (DMC-ODS) for more information.
   i. Yolo County shall monitor timely completion of assessments to ensure appropriate access to, and utilization of, services. Yolo County shall not enforce standards for timely initial assessments, or subsequent assessments, in a manner that fails to permit adequate time to complete assessments when such time is necessary due to a member's individual clinical needs
i. Crisis assessments completed during the provision of DMC or DMC-ODS Mobile Crisis Services encounter need not meet the comprehensive assessment requirements outlined this policy. However, crisis assessments are not a replacement for a comprehensive assessment. When a member who has received a crisis assessment subsequently receives other SMH, DMC, or DMC-ODS services, as assessment shall be completed in accordance with this policy.

3. **Diagnosis**
   a. The LPHA shall type or legibly print their name, and sign and date the diagnosis. The signature shall be adjacent to the typed or legibly printed name.
   b. Please refer to Yolo County's SUD Medical Necessity policy for more information.

4. **Problem Lists**

a. The provider(s) responsible for the member's care shall create and maintain a problem list.
b. The problem list and progress note requirements shall support the medical necessity of each service provided.
c. Problem lists shall include, but is not limited to, the following:
    i. Diagnoses identified by a provider acting with their scope of practice
        a. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable
    ii. Current International Classification of Diseases (ICD) Clinical Modification codes.
    iii. Problems identified by the provider acting with their scope of practice, if any
    iv. Problems identified by the member and/or significant support person, if any
    v. The name and title of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.
d. A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list
e. Providers shall update the problem list on an ongoing basis to reflect the current presentation of the member and within a reasonable time frame in accordance with generally accepted standards of practice
f. Providers shall add to, amend, or resolve problems from the problem list when there is a relevant change in the member's condition.

5. **Care Plans (formerly Treatment Plans)**
    a. Prospectively completed, standalone care plans are no longer required.
        i. There are some programs, services, and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities. In those situations, care plan requirements remain in effect (see Enclosure 1a: Care Planning Requirements that Remain in Effect). For DMC-ODS services, programs, or facilities for which care plan requirements remain in effect:
            a. Providers shall adhere to all relevant care planning requirements in state or federal law
            b. Providers shall document the required elements of the care plan within the member record. For example, required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within an Electronic Health Record
            c. To support delivery of coordinated care, the provider shall be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws
            d. Yolo County shall not enforce requirements for the location, format, or other specifications for documentation of the care plan that differ from those described within this policy and referenced in its Enclosures

b. Peer support services must be based on an approved plan of care. The plan of care shall be approved by any treating provider who can render reimbursable Medi-Cal services.

6. **Progress Notes:**
   a. Providers shall create progress notes for the provision of all services. Each progress note shall provide sufficient detail to support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described below, but the nature and extent of the information included may vary based on the service type and the member's clinical needs. Some notes may appropriately contain less descriptive detail than others. If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note
   b. The problem list and progress note requirements shall support the medical necessity of each service provided.
   c. Progress notes shall include:
      i. The type of service rendered
      ii. The date the service was provided to the member
      iii. The duration of direct patient care for the service
      iv. Location/ place of service
      v. A brief description of how the service addressed the member's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
      vi. Typed or legibly printed name, signature of the service provider, and date of signature
      vii. A brief summary of next steps. Next steps may include planned action steps by the provider or by the member, collaboration with the member, goals and actions to address health, social, educational, and other services needed by the member, referrals, and discharge and continuing care planning
      viii. Required coding
         a. For valid Medi-Cal claims, appropriate ICD-10 and Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes must appear in the clinical record, associated with each encounter and consistent with the description in the progress note timelines.
            i. These codes are not required in the narrative of each note.
   d. Timelines
      i. Progress notes shall be completed within the timelines outlined below. The day of service shall be considered day zero (0).
         a. Routine outpatient services
            i. Providers shall complete progress notes within 3 business days of providing a service.
         b. Crisis Services
            i. Providers shall complete crisis service progress notes within 1 calendar day of providing a service.
      ii. Daily Services
         a. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential. If a bundled service is delivered on the same day as a second service that is not included in

the bundled rate, there must also be a progress note to support the second, unbundled service.

e. Documentation of Group Services:
    i. When a group service is rendered, a list of participants shall be documented and maintained by the provider.
    ii. For groups facilitated by multiple practitioners, at least one progress note for each member, signed by one of the practitioners may be used to document the group service provided.
        a. The progress note shall clearly document the specific involvement and duration of direct patient care for each practitioner of the service.
        b. The progress note for the group service encounter shall also include a brief description of the member's response to the service that may include the effectiveness of an intervention, progress or problems noted, group dynamics, or other information relevant to the member's participation, comments or reactions during the treatment session.
    iii. Group service progress notes must meet all other progress note requirements as documented in this policy.

7. **Additional Documentation Requirements**
    a. Telehealth Consent
        i. Providers shall confirm consent for telehealth (synchronous audio and video) or telephone services, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Yolo County Medi-Cal member.
        ii. Member consent must include an explanation that:
            a. Beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit
            b. Use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the member without affecting their ability to access covered Medi-Cal services in the future
            c. Medi-Cal coverage for transportation services to in-person visits is available when other available resources have been reasonably exhausted
            d. There are potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risk are identified by the provider.
        iii. Providers shall document in the member record the provision of the above information and the member's verbal or written acknowledgment that the information was received.
    b. Records of Referrals
        i. Providers shall maintain records of referrals made to or from recovery residences, including, if available, information about where the client ultimately elected to go.

8. **Recoupment**

a. Recoupment shall be focused on fraud, waste, and abuse.

E. PROCEDURE:

1. Network providers shall develop internal policies and procedures which meet the requirements outlined in this policy and their executed contracts with Yolo County HHSA.

F. REFERENCES:

1. Intergovernmental Agreement
2. DHCS Information Notice 23-001: Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026
3. DHCS Information Notice 23-068: Updates to Documentation Requirements for all Specialty Mental Health (SMH), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

Approved by:

Julie Freitas _____ 12/22/2023

Julie Freitas, LMFT, Alcohol & Drug Administrator **Date**
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Karleen Jakowski, LMFT, Mental Health Director **Date**
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Enclosure 1a: Care Planning Requirements that Remain in Effect

Program, Service, or Facility Type	Authority/ Background
DMC-ODS Residential Treatment Services and Withdrawal Management Services provided in DHCS LOC designated AOD Treatment Facilities	BHIN 21-001 and attachments
Enhanced Care Management (ECM)[1]	ECM Policy Guide
Peer Support Services	CMS Directors' Letter 07-011; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan Section 3, Att. 3.1-B, Supps. 2, 3
Substance Abuse Block Grant (SABG) Programs/Services[2]	45 CFR § 96.136(d)(3)

[1] This service is covered through Medi-Cal Managed Care Plans (MCPs), not Medi-Cal behavioral health delivery systems. However, it is included here for ease of reference, given many specialty behavioral health clients are eligible to receive ECM and specialty behavioral health plans or network providers may contract with MCPs to provide this service.

[2]SABG treatment planning may be documented in the manner described in this policy. Federal regulations that apply to services funded with federal Substance Abuse Block Grants refer to treatment planning activities, but do not specify that treatment planning must be documented in any specific format or location.

Enclosure 1b: Other Data and Documentation Requirements that Remain in Effect

Requirement	Authority/ Background
Adolescent Substance Use Disorder Services • Generally speaking, these guidelines remain in effect. DHCS will not enforce the use of a care plan or specific care planning requirements for adolescent SUD services.	Adolescent Substance Use Disorder Best Practices Guide
American Society of Addiction Medicine (ASAM)	MHSUDS IN 18-046; BHIN 21-071; BHIN 23-001 (or subsequent guidance)
CalOMS Treatment (CalOMS)	Data Collection Guide; Data Compliance Standards; Data Dictionary
Certification of Alcohol and Other Drug Programs	HSC § 11832; See forthcoming BHIN and enclosure(s)
Drug and Alcohol Treatment Access Report (DATAR)	45 CFR § 96.126 DATAR Web User Manual
DHCS LOC Designations for AOD Treatment Facilities (applies to DMC/DMC-ODS Providers of Residential Treatment Services and Withdrawal Management Services)	BHIN 21-001 and attachments
Enhanced Care Management (ECM)[1] See Policy Guide for ECM-specific service delivery, documentation, and reporting standards. Standards for ECM care planning are addressed in Enclosure 1a.	ECM Policy Guide
Physical Exam Requirements (DMC & DMC-ODS)	22 CCR § 51341.1, subd. (h)(1)(A)(iv)(a-c)
Primary Prevention SUD Data Service (PPSDS)	Primary Prevention SUD Data Service Data Quality Standards
Perinatal Substance Use Disorder Services Generally speaking, these guidelines remain in effect. DHCS will not enforce the use of a care plan or specific care planning requirements for perinatal SUD services.	Perinatal Practice Guidelines

[1] This service is covered through Medi-Cal Managed Care Plans (MCPs), not Medi-Cal behavioral health delivery systems. However, it is included here for ease of reference, given many specialty behavioral health clients are eligible to receive ECM and specialty behavioral health plans or network providers may contract with MCPs to provide this service.