EL DORADO COUNTY
HEALTH AND HUMAN SERVICES AGENCY

COUNTY OF EL DORADO
Substance Use Disorder Services
Practice Guidelines

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INTRODUCTION

The El Dorado County Drug Medi-Cal Organized Delivery System (DMC-ODS) is a managed care plan organized under 42 Code Federal Regulations Section 438.2 as a Prepaid Inpatient Health Plan. The plan is authorized by the California Department of Health Care Services (DHCS) in coordination with the Center for Medicare & Medicaid Services of the U.S. Department of Health and Human Services.

The El Dorado County Health and Human Services Agency (HHSA is authorized by the El Dorado County Board of Supervisors to administer the plan under an intergovernmental agreement with DHCS. The plan is administered by HHSA's Behavioral Health Division. The Drug Medi-Cal Organized Delivery System (DMC-ODS) was implemented to create a more organized and comprehensive approach to providing substance use disorder (SUD) treatment services to Medi-Cal eligible youth and adults.

TREATMENT PRACTICE GUIDELINES

The El Dorado County Practice Guidelines represent a combination of local, State and Federal regulations, standards and guidelines, as well as best practices for effectively treating substance use disorders. Contracted and County-operated providers are expected to adhere to all applicable regulations, standards, guidelines, policies and practices. These guidelines are to be disseminated to all providers and, upon request, to beneficiaries and potential beneficiaries. These guidelines are available through the online provider portal, and will be made available during training, technical assistance and via email.

OVERVIEW OF REGULATIONS

Substance Use Services administered in El Dorado County are held to varying, and at times overlapping, regulations depending on, but not limited to, the service modality, activities being performed and funding source. The El Dorado County (EDC) DMC-ODS will operate according to the regulations set forth by the Federal Government, the State of California, as well as its own provisions outlined in specific provider contracts. It is common for providers in El Dorado County to offer a variety of services each of which with their own set or multiple sets of regulations to follow. No one set of regulations addresses all components of the provision of Substance Use Services and at times differences in regulatory language may create multiple interpretations on how regulations may apply. Whenever questions regarding regulation interpretation arise, the more stringent regulation applicable shall apply as this is how El Dorado County QA/UR and the Department of Health Care Services will evaluate providers. The following links will direct providers on where to access specific requirements to their programs.

42 CFR Part 438 – Managed Care

As a participant in Drug Medi-Cal Organized Delivery System (DMC-ODS), the administrative entity, El Dorado County, becomes a specialty managed care plan responsible for overseeing the specialty SUD system. As a component of becoming a managed care entity, El Dorado County and its SUD network must abide by the 42 Code of Federal Regulations (CFR) Part 438 managed care requirements.

In general, one of the primary aims of 42 CFR Part 438 is to achieve delivery system and payment reforms by focusing on the following priorities:

- Network adequacy and access to care standards (e.g., timeliness of services, distance standards. For more information see (Network Adequacy Section)
- Patient/beneficiary protections
- Quality of care

42 CFR PART 2

All SUD treatment programs must operate in accordance with legal and ethical standards. Federal and state laws and regulations protect the confidentiality of patient records maintained by all contracted providers. Maintaining appropriate confidentiality is of paramount importance. All providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records.

42 CFR Part 2 – Confidentiality of Alcohol and Drug Patient Records Covers all records relating to the identity, diagnosis, and/or treatment of any patient in a SUD program that is conducted, regulated, and/or assisted in any way by any federal agency.

For a summary of 42 CFR Part 2, please see:
42 CFR Part 2 -- Confidentiality of Substance Use Disorder Patient Records

- Subpart A includes an introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc.).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, and minor members, etc.).
- Subpart C covers disclosures allowed with the beneficiaries' consent (e.g., prohibition on re-disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs, etc.).
- Subpart D covers disclosures that do not require patient consent (e.g., medical emergencies, research, evaluation and audit activities).
- Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc.).

HIPAA – Health Insurance Portability and Accountability Act

HIPAA Provides data privacy and security provisions for safeguarding medical information. A summary of the HIPAA privacy rule can be found here:

HIPAA Home | HHS.gov

For more general information on HIPAA, please see:

http://www.hhs.gov/ocr/privacy/index.html.

For more specific information concerning covered entities, beneficiary information and health information technology, please see:

HIPAA and Part 2 | HHS.gov

Note: These laws and regulations should not be used as barriers to providing coordinated and integrated care. Provided that the appropriate patient releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of care (including mental and physical health). Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the SUD system must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

REQUIRED STANDARDS AND GUIDELINES

Providers in El Dorado County's DMC-ODS are required to obtain and maintain the following, as applicable:

- Drug Medi-Cal Certification
- SUD Licensing (NTP, Residential)
- DHCS ASAM Designation

Drug/Medi-Cal Certification Standards

Substance use treatment programs participating in the Drug/Medi-Cal programs are required to comply with the applicable Drug/Medi-Cal Certification Standards. For more information see:

https://www.dhcs.ca.gov/services/adp/Pages/Drug_MediCal.aspx

Re-Certification Events:

Contractor shall notify DHCS and the County Alcohol and Drug Administrator within the timeframes noted in the Provider Contract, in addition to applicable federal, state and local regulations and policies of any triggering re-certification events, such as change in ownership, change in scope of services, remodeling of facility, or change in location.

Facility Licensing Standards

The Department of Health Care Services (DHCS) has sole authority to license facilities providing 24-hour residential nonmedical services to eligible adults who are recovering from problems related to alcohol or other drug (AOD) misuse or abuse. Licensure is required when one or more of the following services are provided: detoxification, individual sessions, group sessions, educational sessions, or alcoholism or drug abuse recovery or problem list/treatment planning, incidental medical services. Additionally, facilities may be subject to other types of permits, clearances, business taxes or local fees that may be required by the cities or counties in which the facilities are located. You may also want to check with your county alcohol and drug program office to ensure compliance with any requirements they might have.

Beginning January 1, 2025 all DMC-ODS SUDS providers shall be certified by DHCS in accordance with HSC, Chapter 7.1 (commencing with Section 11832). In addition, all providers shall ensure that their program meets the minimum requirements of DHCS Alcohol and Other Drug Program Certifications, which can be found here. For more information please review BHIN 23-058.

In addition, DHCS provides Drug Medi-Cal Certification to SUD treatment providers that meet requirements found under Title 22 of the California Code of Regulations (CCR): 1) Section 51431.1 – Program Administration; 2) Section

51490.1 – Claim Submissions Requirements; and 3) Section 51561.1 – Reimbursement Rates and Requirements. Title 22 refers and ties to Title 9 of the CCR which governs requirements for Narcotic Treatment Programs. Providers are encouraged to learn more about state licensing and certification requirements by visiting the DHCS website.

ASAM Level of Care Designation

All El Dorado Providers, In accordance with HSC Sections 11834.015, must obtain either a DHCS LOC Designation and ASAM LOC Certification. In 2021, DHCS adopted the ASAM criteria as the minimum standard of care for licensed SUD/AOD facilities. All Licensed SUD/AOD facilities shall obtain at least one DHCS LOC Designation and/or at least on residential ASAM LOC Certification consistent with all of its program services. If and AOD facility opts to obtain and ASAM LOC Certification, then that facility will not be required to obtain a DHCS LOC Designation. However, nothing precludes a facility from obtaining both a DHCS LOC Designation and ASAM LOC Certification. For additional information please refer to DHCS BHIN 21-001.

Minimum Quality Drug Treatment Standards for DMC

Compliance with the following Minimum Quality Treatment Standards is required in addition to CCR Title 9 and 22 regulations for all SUD treatment programs either partially or fully funded through DMC. If conflict between regulations and standards occurs, the most restrictive shall apply. See link below for more information: MQDTS

Minimum Quality Drug Treatment Standards for SABG

All substance use treatment providers either partially or fully funded through SABG funding are required to comply with the Minimum Quality Treatment Standards.

California Code of Regulations (CCR) Title 9 Counselor Certification

CCR Title 9, section titled Counselor Certification provides minimum requirements on the level of credentials counseling staff secure prior to conducting services. The minimum standards are designed to ensure a baseline quality of treatment services and effectiveness.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The national Culturally and Linguistically Appropriate Services (CLAS) Standards which are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. It is intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate

health services to ensure access to quality care by diverse populations, each service provider receiving funds from the State-County Contract shall adopt CLAS national standards.

Contractors are responsible to provide culturally competent services. Contractors must 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. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.

Perinatal Guidelines

Perinatal programs shall comply with the most updated version of Perinatal Practice Guidelines found on DHCS Perinatal Services Website.

Adolescent Guidelines

All Youth providers shall follow the updated DHCS Adolescent Substance Use Disorder Best Practices Guidelines in developing and implementing adolescent treatment programs.

DMC-ODS Requirements 2022-2026.

Previously, DMC-ODS requirements were governed by the 1115 Special Terms and Conditions (STC's). Beginning in 2022, the Centers for Medicare and Medicaid Services (CMS) approved a set of updates that now govern DMC-ODS services. These updates and communicated through a set of BHINs and an Updated Intergovernmental Agreements between County and State. This BHIN aligns the DMC-ODS program requirements with the CalAIM behavioral health initiatives that are effective July 2022, including the policies outlined in BHIN 22-005, BHIN 22-011, BHIN 22-013, BHIN 22-019, and BHIN 22-026 and the new policy updates in BHIN 24-001 that replaces the STCs that were used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I Code section 14184.102(d).

Addressing Barriers to Services

DMC-ODS SUDS providers in accordance with state and federal statutes and regulations, assure that in planning for the provision of services, the following barriers to services are considered and addressed:

- Lack of educational materials or other resources for the provision of

- services.
- Geographic isolation and transportation needs of persons seeking
- services or remoteness of services.
- Institutional, cultural, and ethnicity barriers.
- Language differences.
- Lack of service advocates.
- Failure to survey or otherwise identify the barriers to service accessibility.
- Needs of persons with a disability.

INTERPRETATION SERVICES

DMC-ODS SUDS providers must make interpretation services and Text Telephone Relay or Telecommunications Relay Service (TTY/TRS) available for members including those with disabilities, as required by BHIN 24-007 & BHIN 24-001. These services shall include:

- Oral Interpretation – services offered for spoken language processed in real time, whether in-person, via video call, phone, or other medium.
- Written Translation – services offered for written language content, often processed separately from the time of the request for assistive language services.
- ASL – services offered for a spoken language processed in real time, whether in-person or via video call

BENEFICIARY ELIGIBILITY AND ENROLMENT

It is the responsibility of each DMC-ODS SUDS provider to conduct a verification/determination of each beneficiary's Medi-Cal eligibility and county of residence as part of program acceptance. Providers shall verify the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for Drug/Medi-Cal services to that beneficiary for that month. Medi-Cal eligibility verification must be performed prior to rendering service, in accordance with and as described in the DHCS's DMC Provider Billing Manual. For additional information, please refer to the DHCS DMC Billing Manual.

DMC-ODS Program Criteria for Services

Medi-Cal beneficiaries of all ages whose county of responsibility is El Dorado County are able to receive DMC-ODS services consistent with the following access criteria, assessment, and level of care determination criteria.

EPSDT

In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905(r) of the Social Security Act, all Counties, irrespective of their participation in the DMC-ODS program, shall ensure that all beneficiaries under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act. Nothing in the DMC- ODS limits or modifies the scope of the EPSDT mandate. DMC-ODS counties are responsible for the provision of SUD services pursuant to the EPSDT mandate. Counties should refer to BHIN 22-003 regarding Medi-Cal SUD treatment services for beneficiaries under age 21 for further compliance with EPSDT requirements. Please note that the access criteria for beneficiaries under 21 is different and more flexible than the access criteria for adults accessing DMC-ODS services, to meet the EPSDT mandate and the intent for prevention and early intervention of SUD conditions.

Telehealth Consent

Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. It is a tool for the benefit of the beneficiary not the practitioner. Providers that offer telehealth services to Medi-Cal beneficiaries must meet all applicable Medi-Cal licensure and program enrollment requirements. If the provider is not located in California, they must be licensed in California, enrolled as a Medi-Cal rendering provider, and affiliated with a Medi-Cal enrolled provider group in California or a border community, as outlined in DHCS' Telehealth Policy Paper and the Medi-Cal Provider Manual. For more information on Telehealth requirements please review BHIN 23-018 for a complete rendering of Telehealth requirements.

Consent Process

Prior to initial delivery of covered services via telehealth, as required by BHIN 23-018, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to beneficiaries:

- The beneficiary has a right to access covered services in person.
- Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access Medi-Cal covered services in the future.
- Non-medical transportation benefits are available for in-person visits.
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

Providers must also document the beneficiary's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The beneficiary's consent must be documented in their medical record and made available to DHCS and/or El Dorado County Quality Assurance upon request.

A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement:

- Specifically mentions the use of telehealth delivery of covered services;
- Includes the information described above;
- Is completed prior to initial delivery of services; and
- Is included in the beneficiary record.

DHCS has created model verbal and written consent language, which can be found on the DHCS website here.

AMERICAN SOCIETY OF ADDICTION MEDICINE CRITERIA (ASAM)

To ensure that beneficiaries have access to the full continuum of care for substance use disorder treatment, the array of benefits offered through the DMC-ODS are modeled after the ASAM criteria, which is the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of beneficiaries with addiction and co-occurring conditions.

ASAM Assessment

Regular review of the beneficiary's appropriate placement in the correct Level of Care is required

to assure fidelity to ASAM. The review of all 6 dimensions is documented at admission and discharge using the ASAM and should be included in the beneficiary's file. This review is to be clearly documented in the progress notes and should identify any increase or decrease in problem severity and risk rating for each ASAM Dimension.

Regular reviews of the beneficiary's treatment needs are important to gauge progress in treatment and to identify any new problem areas, including potential social determinants of health (SDOH) and substance use disorder impairments, to ensure the beneficiary is placed in the "least restrictive environment" for treatment; however, the criteria also direct the counselor to ensure the beneficiary is receiving the appropriate LOC for their needs.

The ASAM must be completed whenever there is a change in condition. This includes changes in levels of care, whether to more intensive or less intensive services or to transfer to another clinic.

The ASAM Criteria shall be used to determine placement into the appropriate level of care for all beneficiaries and is separate and distinct from determining medical necessity.

- For beneficiaries 21 and over, a full assessment using the ASAM Criteria must be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor.
- For beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM Criteria must be completed within 60 days of the beneficiary's first visit with an LPHA or registered/certified counselor. A full ASAM Criteria assessment is not required to deliver prevention and early intervention services for beneficiaries under 21; a brief screening ASAM Criteria tool is sufficient for these services (see below regarding details about ASAM level of care 0.5).
- If a beneficiary withdraws from treatment prior to completing the ASAM Criteria assessment and later returns, the time period starts over.
- A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
- A full ASAM assessment does not need to be repeated unless the beneficiary's condition changes.
- These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

Beneficiary placement and level of care determinations shall ensure that beneficiaries are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition.

DOCUMENTATION REQUIREMENTS

El Dorado County Practice Guidelines were developed to be used in conjunction with the CalMHSA documentation guides and El Dorado County Documentation Companion Guide found here and include:

- Documentation guide for AOD counselors
- Documentation guide for LPHA
- EDC Documentation Companion Guide

DESCRIPTION OF COVERED SERVICES

The following are descriptions of various treatment services available to members served within the EDC DMC-ODS system of care. These services are available to beneficiaries' receiving outpatient, intensive outpatient, residential, residential withdrawal management and opioid treatment services and their descriptions have been updated to reflect those in BHIN 24-001.

Individual Counseling

Individual counseling sessions between a LPHA or Registered/Certified Counselor and a beneficiary are to be conducted in a confidential setting where individuals not participating in the counseling session cannot see or hear the comments of the beneficiaries, LPHA, or counselor. Individual counseling sessions can be provided in person in an office, home, or community setting or via telephone or telehealth as long as confidentiality and informed consent requirements are met.

- Individual counseling sessions are available at all levels of care.
- Individual counseling sessions are designed to support direct communication and dialogue between the staff and beneficiary. Sessions will focus on psychosocial issues related to substance use and goals outlined in the Problem List
- A progress note must be written for each session and documented in the beneficiary's chart.
- The frequency of individual counseling sessions, in combination with other treatment services shall be based on medical necessity and individualized needs rather than a

prescribed program required for all beneficiaries.

Group Counseling

Group counseling sessions are face-to-face treatment services offered between an LPHA or Registered/Certified counselor and between 2-12 other Beneficiaries simultaneously. Group counseling occurs in a confidential setting where individuals not participating in the counseling session cannot see participants or hear the comments of the beneficiary or LPHA/Counselor.

- Group counseling sessions are available at all levels of care.
- A separate Progress Note must be written for each beneficiary and documented in the beneficiary's chart.
- Group sign-in sheets must include signatures and printed names of beneficiaries and group facilitators, date, start/end times, location, and group topic. The frequency of group counseling sessions in combination with other treatment services shall be based on medical necessity and individualized beneficiary needs rather than a prescribed program required for all beneficiaries.

Crisis Intervention Counseling

Crisis intervention counseling must be provided face-to-face between an LPHA or a Registered/Certified Counselor and a beneficiary in a crisis. A crisis must be an actual relapse or an unforeseen event or circumstance causing imminent threat of relapse. Crisis intervention services mush include a focus on alleviating crisis challenges and must be limited to stabilization of the beneficiary's emergency situation.

- 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 beneficiary's biopsychosocial functioning and well-being after a crisis.
- Crisis interventions are provided when there is a relapse or an unforeseen event or circumstance causing imminent threat of relapse.
- 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
- A progress note must be written for each session and documented in the beneficiary chart.

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

Care Coordination

Care coordination was previously referred to as "case management." Care coordination shall be provided to a client in conjunction with all levels of treatment. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care coordination can be provided in clinical or non-clinical settings (including the community) and can be provided face-to-face, by telehealth, or by telephone. Care coordination includes one or more of the following components.

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
- For guidance on claiming for care coordination within a level of care or as a standalone service, please refer to the most current DMC-ODS Billing Manual.

Clinician Consultation

Clinician Consultation replaces and expands the previous "Physician Consultation" service referred to in the Section 1115 STCs that were used to describe the DMC-ODS program during the years 2015-2021. Clinician Consultation consists of DMC-ODS LPHAs consulting with LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.

Clinician Consultation is not a direct service provided to DMC-ODS beneficiaries. Rather,

Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries. For more information please refer to BHIN 24-001.

Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)

Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21. Any beneficiary under the age of 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services. As noted above, this does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, to include a CMS ICD-10 diagnosis code. For more information, please refer to BHIN 24-001 or most updated version of DHCS Billing Manual.

Outpatient Treatment Services (ASAM Level 1)

Outpatient treatment services (also known as Outpatient Drug Free or ODF) are provided to beneficiaries when medically necessary (offering up to nine hours a week for adults, and six hours a week for adolescents). Services may exceed the maximum based on individual medical necessity. Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers are required to either offer medications for addiction treatment (MAT, also known as medication-assisted treatment) directly, or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient treatment services if not provided on- site. Providing a beneficiary, the contact information for a treatment program is insufficient). Outpatient treatment services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services

- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

Intensive Outpatient Treatment Services (ASAM Level 2.1)

Intensive Outpatient Treatment Services are provided to beneficiaries when medically necessary in a structured programming environment (offering a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents). Services may exceed the maximum based on individual medical necessity. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving intensive outpatient treatment services if not provided on-site. Providing a beneficiary, the contact information for a treatment program is insufficient). Intensive Outpatient Treatment Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)

All Residential and Inpatient Treatment services provided to a client while in a residential or inpatient treatment facility may be provided in person, by telehealth, or telephone. Telehealth and telephone services, when provided, shall supplement, not replace, the in-person services and the in-

person treatment milieu; most services in a residential or inpatient facility shall be in-person. Residential Treatment Services are delivered to beneficiaries when medically necessary in a short-term residential program corresponding to at least one of the following levels:

- Level 3.1 - Clinically Managed Low-Intensity Residential Services
- Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
- Level 3.5 - Clinically Managed High Intensity Residential Services

These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. Each client 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. Providers are required to either offer MAT directly or have effective referral mechanisms in place to clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving residential treatment services if not provided on- site. Providing a beneficiary, the contact information for a treatment program is insufficient). For more information on residential treatment services including applicable laws and requirements please refer to BHIN 24-001.

Narcotic Treatment Services

Narcotic Treatment Providers (NTP), also described in the ASAM criteria as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), disulfiram, and naloxone. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication. The NTP shall offer the beneficiary a minimum of fifty minutes of counseling services per calendar month. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, Title 9, Chapter 4, Division 4, and Title 42 of the

CFR. Counseling services provided in the NTP modality can be provided in person, by telehealth, or by telephone. However, the medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) must be conducted in-person. NTP Services include the following service components).

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medical Psychotherapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

While most DMC-ODS providers are expected to adopt problem lists as described in BHIN 22-019, treatment plans continue to be required for some services in accordance with federal requirements.

NTPs: As noted in BHIN 22-019, NTPs are required by Federal law to create treatment plans for their beneficiaries. NTP requirements for documentation are not impacted by BHIN 22-019 and NTPs must continue to comply with federal and state regulations regarding treatment plans and documentation.

Withdrawal Management Services

Withdrawal Management Services are provided to beneficiaries experiencing withdrawal in the following outpatient and residential settings:

Withdrawal Management Services may be provided in an outpatient, residential or inpatient setting. If beneficiary is receiving Withdrawal Management in a residential setting, each beneficiary shall reside at the facility. All beneficiaries receiving Withdrawal Management services, regardless in which type of setting, shall be monitored during the detoxification process. Providers are required to either offer MAT directly or have effective referral mechanisms to the most clinically appropriate MAT services in place (defined as facilitating access to MAT off-site for beneficiaries

while they are receiving withdrawal management services if not provided on-site. Providing a beneficiary, the contact information for a treatment program is insufficient).

Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)

Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting)

Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)

Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits)

Level 4-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability).

Withdrawal management services are urgent and provided on a short-term basis. When provided as part of withdrawal management services, service activities, such as the assessment, shall focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided.

A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate. If it has not already been completed in relation to the Withdrawal Management episode, the full ASAM Criteria assessment shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor for non-Withdrawal Management services (or 60 days for beneficiaries under 21, or beneficiaries experiencing homelessness), as described above.

El Dorado County DMC-ODS is required to, at a minimum, provide one of the five levels of

withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or LPHA as medically necessary. El Dorado County meets this standard by providing Level 3.2 WM. Providers need to ensure that all beneficiaries receiving withdrawal management services are provided in an outpatient, residential or inpatient setting. If beneficiary is receiving withdrawal management in a residential or inpatient setting, each beneficiary shall reside at the facility. All beneficiaries receiving Withdrawal Management services, regardless in which type of setting, shall be monitored during the detoxification process.

Providers must ensure observation be conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

Withdrawal Management Services include the following service components: assessment, care coordination, medication services, MAT for QUO, MAT for AUD and non-opioid SUDs, observation, and recovery services. Providers offering Withdrawal Management Services must ensure that all staff are trained to meet minimum requirements as detailed in BHIN 24-001 and 21-001 or superseded BHINs.

Providers shall either offer MAT directly or have effective referral mechanisms to the most clinically appropriate MAT services in place (defined as facilitating access to MAT off-site for beneficiaries while they are receiving withdrawal management services if not provided on-site). Providing a beneficiary, the contact information for a treatment program is insufficient. All information on WM services can be found on BHIN 24-001.

Recovery Services

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary'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 beneficiaries. Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Services may be provided in person, by telehealth, or

by telephone. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care. For more information on Recovery Services please refer to BHIN 24-001 and BHIN 22-005.

Medication-Assisted Treatment within All Levels of Care

Medications for Addiction Treatment (also known as medication-assisted treatment or MAT) Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving intensive outpatient treatment services if not provided on-site. Providing a beneficiary, the contact information for a treatment program is insufficient).
MAT includes all FDA-approved medications and biological products to treat AUD, OUD, and any SUD. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care. MAT services can include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

For more information on DMC-ODS MAT Policy please refer to BHIN 24-001.

EVIDENCE BASED PRACTICES (EBP) COMPLIANCE

As a requirement of El Dorado DMC-ODS, each provider must implement—and assess fidelity to—at least two of the following Evidenced Based Practices per modality:

1. Motivational Interviewing: A beneficiary -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 beneficiaries ' past successes.

2. 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.
3. 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.
4. Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
5. Psychoeducation: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives; to instill self- awareness, suggest options for growth and change identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Tips for Ensuring Fidelity of EBPs

Programs should have an EBP treatment fidelity plan. The plan should include:

- A method for ensuring that treatment "dose" (intensity, frequency, length of contact) is consistent among beneficiaries with similar diagnoses.
- A protocol for the delivery of EBP that outlines accurate and consistent delivery.
- A method for determining that the clinicians are adhering to the protocol.
- A method for identifying areas for course correction (drift) and provide an outline for implementation of course correction.
- A training schedule and description of the training for clinicians (through documentation). Required elements to ensure they have been satisfactorily trained to deliver the intervention are:
  - ❖ Standardization of training upon hire: ensuring all clinicians are trained in the same manner.
  - ❖ Skill acquisition: should include didactic sessions, modeling, use of video materials, training manuals, role plays.

- ❖ Measurement of clinician skill: determining performance criteria that include a rating for a "demonstrated understanding of key concepts" and documentation of review.
- ❖ Maintenance of skill over time: continued training and EBP documented with performance reviews.

Regularly and randomly performed, documented, assessments should be kept by the program and made available to monitors. The assessment should include:

- A list of current scripted intervention protocols.
- A list of current treatment manuals that are utilized.
- A list of current staff training for each EBP implemented.
- A Performance review rating(s) for each clinician understands of EBP (self-assessment tool).
- A Self-report anonymous questionnaire from beneficiary's (a way to measure a beneficiary's comprehension: understand and perform treatment related behavioral skills and cognitive strategies) also referred to as "Treatment Receipt."
- Qualitative interviews with clinician and beneficiaries alike.
- Direct observation of a clinician from a performance reviewer.

SPECIAL TOPICS

Suicide Protocol

Counselors must complete the Suicide Potential Protocol threat assessment and Safety Plan when a beneficiary presents with a risk of self-harm. The counselor must clearly document in the progress note that a risk assessment was done, the nature of the intervention and the development of a written Safety Plan in collaboration with the beneficiary to address suicide risk. For youth beneficiaries, the counselor also is also required to document that the beneficiary's guardian and/or emergency contact were notified.

Threats of Violence

The counselor must use reasonable efforts to inform the victim and contact law enforcement. In so doing, they should disclose only that protected health information which is necessary to enable the potential victim to recognize the seriousness of the threat and to take proper precautions to protect him or herself. For more information on these requirements please review the Tarasoff Statute here.

Child Abuse and Elder Abuse

Please refer to CCR Title 11, Article 1: §901 for child abuse guidelines and CCR § 15630 for guidelines for reporting elder abuse and your agency Policy and Procedures. Again, assessment, intervention, and plan must be clearly documented. The actual report or copy should never be placed in the beneficiary chart.

Incident reports

Unusual incidents, defined as an event or occurrence involving a person that is not consistent with routine operations, policies, and procedures, or the person's care or service plan, occurs at all levels of care. When and unusual incident involving El Dorado beneficiaries occurs, providers are required to complete and send an Unusual Incident Report to Quality Assurance staff securely at sudsqualityassurance@edcgov.us.

In the event there is an incident report, it must be documented in the progress note that an incident report was made and submitted to Compliance Officer. The actual incident report or copy should never be placed in the beneficiary chart.

Indian Health Care Providers

American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted into the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). Please refer to BHIN 22-053 for additional guidance.

Intersection with the Criminal Justice System

El Dorado beneficiaries involved in the criminal justice system are often harder to treat for SUD. While research has shown that the criminal justice population can respond effectively to treatment services, the beneficiary may require more intensive services. El Dorado DMC-ODS recognizes the importance of educating staff and collaborative partners that Parole and Probation status is not a barrier to DMC-ODS. El Dorado DMC-ODS and its providers shall ensure that beneficiaries may receive recovery services immediately after incarceration regardless of whether or not they received SUD treatment during incarceration.

Other

The medical record chart is a confidential and protected legal document and can be subpoenaed by courts. No other beneficiary names should be included in another beneficiary's chart. Names of family members or friends should not be recorded except as required for Emergency Contact information, minor/parent involvement, etc. It is best to refer to the relationships as, "mother", "father", "friend" and not to use names. If names are used, then only first name or initials should be used for clarification. In circumstances that involve other beneficiaries, such as a Tarasoff report, and the use of another beneficiary's name, that person should not be identified as a substance use or mental health beneficiary.

TREATMENT PERCEPTIONS SURVEY (TPS)

As part of the DMC-ODS, counties are required to have their network of providers administer the client Treatment Perceptions Survey. The information collected will be used to measure adult clients' perceptions of access to services and the quality of care. The TPS is required to fulfill the county External Quality Review Organization (EQRO) requirement related to having a valid client survey. The data may also be used by counties (and service providers) to evaluate and improve the quality of care and client experience. Beneficiary Satisfaction: DMC-ODS Providers shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS).

DELIVERY OF INDIVIDUALIZED AND QUALITY CARE COORDINATION SERVICES

EDC Policy for Coordination and Continuing Care requires that Drug Medi-Cal ODS plan beneficiaries must have an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating services. Beneficiaries shall be provided information on how to contact their designated person or entity. For more information on care coordination policies please review County policies that can be found by accessing our website here.

Care Coordination Procedures

Plan beneficiaries will be assessed and have access to a full continuum of SUD services with an emphasis on engaging the beneficiary in the right care, at the right time, with the right provider, utilizing the principles of the American Society of Addition Medicine (ASAM) Placement Criteria. Beneficiaries shall be linked to care through known treatment providers. Beneficiary's treatment services shall be coordinated across the Levels of Care (LOC) by following the continuity of care procedures.

Coordination with Mental Health

Plan beneficiaries whose mental health symptoms/diagnoses meet the criteria for specialty mental health care receive co-occurring care as appropriate. For plan beneficiaries with mild to moderate mental health diagnoses, mental health care is provided from one of 3 Medi-Cal managed care plans:

- California Health and Wellness
- Anthem
- Kaiser Permanente

EDC DMC ODS care coordinators and contracted network providers, acting within their scope of practice, shall ensure coordination of care for beneficiaries with co-occurring mental health and SUD conditions using:

- Screening and assessment procedures/tools to accurately determine when an individual is presenting with co-occurring SUD and MH condition(s).
- Written procedures for linking/coordinating plan beneficiaries with needed MH services. Care for beneficiaries with severe MH conditions is to be coordinated to MH.
- Designated El Dorado County Drug Medi-Cal ODS staff responsible for ensuring linkage/care coordination.
- Integrated care must be documented in the beneficiary's EHR.

Care Coordination includes coordination along with multi-discipline team meetings, peer supports, and the utilization of natural supports. Beneficiaries with co-occurring MH-SMI needs should be referred for treatment as appropriate to those EDC BH groups:

- Women's Co-Occurring Recovery Group
- Dual Recovery Anonymous-Peer Support Group
- Men's Co-Occurring Recovery Group
- Refuge Recovery
- Drop in group opportunities as available through the Wellness Center.

Coordination with Physical Health

In order to coordinate physical health services, EDC DMC-ODS utilizes screening, referral and care coordination activities outlined in the MOU between EDC DMC-ODS and Anthem, CA Health and Wellness and Kaiser Permanente. In addition, Care Coordination services are provided as needed. DMC-ODS Provider Contracts shall include initial minimum care coordination requirements, goals, and monitoring including but not limited to:

- Written screening and assessment procedures/tools to identify physical health care needs (within scope of practice), and to determine primary care provider linkage needs.
- Written procedures for linking/coordinating plan beneficiaries' physical health services, including, but not limited to, ensuring the individual has a primary care provider.
- Written procedures for care coordination with physical health providers, whether internally at a DMC-ODS provider site or externally, including identifying the position(s) responsible for ensuring care coordination.

Continuity of Care Expectations

Care Coordinator Point of Contact:

- Beneficiaries shall have an ongoing source of care appropriate to their needs with a SUD provider designated as primarily responsible for coordinating the services.
- The beneficiary will be informed on whom and how to contact their designated provider upon linkage with the Care Coordinator.
- The care coordinators contact information shall be made available to beneficiaries as part of the intake and linkage process.

The coordination of services shall be furnished to the beneficiaries:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
- With the services the beneficiary receives from any other managed care organizations.
- With the services the beneficiary receives in FFS Medicaid.
- With the services the beneficiary receives from community and social support providers.

Access to Care

Beneficiaries shall access care through the following access points:

- EDC DMC-ODS 24-hour Toll Free Access Phone Line
- EDC Behavioral Health SUDS Office Phone Line
- Walk-In to EDC Behavioral Health SUDS Locations
- Referrals received by EDC Behavioral Health SUDS
- Walk-In to Contract Provider WM Facilities, NTP's, and Outpatient Clinic locations

Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be documented within three (3) business days of the service.

At every access point in El Dorado County, beneficiaries shall be triaged for risk (suicidality, homelessness, emergency physical health needs, and detoxification services) and will be advised of the benefits to which they are entitled under the DMC-ODS. Initial screenings shall be completed using a universal screening tool based on the ASAM dimensions (Brief ASAM Tool or other SUDS-approved Brief ASAM Screening Tool) by trained screening staff.

Upon screening, the beneficiary shall be referred and linked to the appropriate ASAM level of care (LOC) to ensure engagement in services. Placement considerations include findings from the screening, geographic accessibility, threshold language needs and the beneficiaries' preferences. The beneficiary shall be referred to DMC-ODS network providers for an intake appointment for the following services.

- Outpatient, Intensive Outpatient
- Narcotic Treatment Program Services
- Residential Withdrawal Management Services
- Residential Treatment Services
- Recovery Services
- Care Coordination Services

DMC-ODS and its' subcontracted providers may share with DHCS or other managed care organizations serving the beneficiary the results of any identification and assessment of the beneficiary's needs to prevent duplication of those activities.

Each provider furnishing services to beneficiaries shall maintain and share, as appropriate, a beneficiaries' health record in accordance with professional standards.

In the process of coordinating care, each beneficiary's privacy shall be protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

Special Health Care Needs

Beneficiaries having special health care needs shall be assessed to identify any ongoing special conditions of the beneficiary that may require a course of treatment or regular monitoring. The assessment shall indicate such in the Problem List and shall ensure linkage to the appropriate providers.

For beneficiaries with special health care needs determined through assessment to need a course of treatment or regular care monitoring, the provider shall ensure beneficiaries have access to a specialist as appropriate for the beneficiary's condition and identified needs through referral to a managed care plan, primary care provider, or Federally Qualified Health Center.

Access to Services

Initial Assessment and Services Provided During the Assessment Process

Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA), registered/certified counselor, or Peer Support Specialist whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary withdraws from treatment. prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.

The initial assessment shall be performed face-to-face, by telehealth (“telehealth” throughout this document is defined as synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home. If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate 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.

For more information on how to document this process, including use of z codes, please review EL Dorado County Documentation Manuals found here.

DMC-ODS Access Criteria for Beneficiaries After Assessment

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:

- Have at least one diagnosis from DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
- Have had at least one diagnosis from the 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.

Beneficiaries under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and 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.

EL DORADO COUNTY DMC-ODS ACCESS PROCESSES

Screening

Initial Screening

Screening via EDC DMC-ODS 24/7 access line

- Beneficiaries will be able to access SUD services through any contact within DMC-ODS, local managed care plans, community health clinics or other health/human services providers.

- The 24/7 toll-free access line will be provided to any beneficiary seeking or identified as needing any level of SUD services. Using this "no wrong door" approach will ensure that beneficiaries will be directed to the point of access for SUD services immediately upon identification of need.
- Community based SUD treatment providers will be another point of access where screening and referral can occur. Initial screenings of each beneficiary's needs shall be conducted upon first contact.

Procedures for Screening via EDC DMC-ODS 24/7 access line

1. Determine individual's Medi-Cal eligibility; base data will be collected for entry into the EHR.
2. Conduct screenings for SUD and MH services, if needed, using approved scripts and brief screening instrument based on ASAM criteria and approved MH screening tool
3. If MH screening indicates further assessment for SMI is indicated, refer individual to MHP Access Team and document in beneficiary file
4. Schedule appointment **within 10 business days** for a full bio-psychosocial assessment with ASAM criteria assessment with SUDS staff.
5. Determine whether the individual should be referred directly to DMC ODS outpatient or intensive outpatient services. Contact network provider to obtain an appointment for beneficiary. Beneficiaries **mus**t receive an appointment **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing

NOTE: The brief screening must rule out the need for emergency interventions. Emergencies shall be immediately referred for services at the most appropriate local hospital. Urgent Conditions requiring immediate attention but that do not require hospitalization are screened for ASAM Levels of Care, 3.1, 3.5, or 3.2-WM using in person assessments within 72 hours.

Screening via SUD Network Provider

- Beneficiaries will be able to access SUD services by calling or by walk-in request for services at the Plan contract outpatient provider program during business hours.

- The 24/7 toll-free access line will be available on the contract provider voicemail and posted on the front door of the provider facility for times provider is closed.

Procedures for screening via SUDS Network Provider

1. Verify Medi-Cal eligibility.
2. In instances when the individual requests services from the SUDS outpatient contract provider without a scheduled appointment, a qualified staff beneficiary will conduct the initial brief assessment, if available. If no qualified staff person is available, the individual will be given an appointment to return for a face-to-face appointment, at the earliest time available, for the individual to complete a full assessment and screening for MH needs. The next available appointment will be offered. Beneficiaries **must** receive an appointment **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing
3. If the network provider's full assessment determines that the individual does not meet medical necessity and that the individual is not entitled to any DMC-ODS services, refer matter to EDC DMC ODS for review and issuance of eligibility notice and appeal rights information to individual as appropriate.
4. Following the full assessment, determine appropriate ASAM level of care
5. Initiate Service Authorization Request to EDC DMC ODS for residential levels of care including residential withdrawal management.
6. If the network provider does not offer the identified level of care, the network provider will offer referrals to the individual for the appropriate care level and documents the referral.
7. If MH screening indicates further assessment for SMI is indicated, refer individual to County MH Dept. and document in beneficiary file.

In instances where the network provider is unable to begin service delivery within the required 10-day time period due to non-budget related capacity issues, interim services shall be offered. In addition, the network provider must offer referrals to other network providers, when available, to ensure timely access to services.

Referral Process

To Outpatient (ODF)/Intensive Outpatient (IOT)/Opioid/Narcotic Treatment Program (OTP/NTP)

1. Beneficiaries will be provided a list of SUD network providers to contact for treatment. County DMC-ODS Access staff will contact the SUD network provider of the beneficiary's choice to schedule an intake appointment.
2. Beneficiaries **must** receive an appointment **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing
3. Access line staff will provide appointment information to the beneficiary.
4. Access line staff will forward screening information to the chosen network provider.
5. SUD network providers will schedule a full intake/assessment with ASAM **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing of receipt of referral.

To Residential Levels of Care – *please see Residential Authorization section of this procedure*

Referrals to primary care, mental health and other agencies will be provided as needed to beneficiaries requesting SUD services. These referrals will be noted in the HER

Intake and Placement

Intake Assessment and ASAM Level of Care Determination Procedure

1. The selected agency from the initial contact and brief screening (either ODS Staff or a SUD Network Provider) will meet with the beneficiary and complete the full assessment to provide additional information for determining the diagnosis, medical necessity, and appropriate ASAM level of care.
2. In instances when the beneficiary requests services from the treatment SUD Network Provider without a scheduled appointment, a qualified staff will conduct the initial assessment, if available.

3. If no qualified staff person is available, the beneficiary will be given an appointment to return for a face-to-face appointment, at the earliest time available, for the beneficiary to complete a full assessment. An appointment must be made **within 10 business days** for outpatient treatment and **within 3 business days** for Opioid Treatment Program
4. The assessment will be conducted by a Licensed Practitioner of the Healing Arts (LPHA), or certified /registered Drug and Alcohol Counselor. Services are available in English and Spanish.
5. The assessment, diagnosis, and medical necessity will be clearly documented in the beneficiary's electronic health record (EHR) and/or medical record. For adults, the diagnosis will include at least one DSM Substance-Related and Addictive Disorder (excluding Tobacco Related and/or non-Substance-related disorders). For beneficiaries under the age of 21, the diagnosis may also include an assessed risk for developing a SUD. Assessments will be conducted by a Licensed Practitioner of the Healing Arts (LPHA) or a certified /registered Drug and Alcohol Counselor.
6. Medical necessity will be determined for all beneficiaries entering the DMC-ODS. The beneficiary must be diagnosed with a DSM/ICD 10 Substance Related Disorder by a licensed LPHA, licensed physician, or Medical Director. DMC Title 22 requires that all SUD Network Providers include documentation of medical necessity in the beneficiary's file.
7. Once the assessment process is complete, the diagnosis, placement recommendations, and information about treatment services will be authorized and discussed during a face-to-face meeting with the beneficiary by an LPHA.

If the assessment determines that the beneficiary does not meet medical necessity and that the beneficiary is not entitled to any DMC-ODS substance use disorder treatment services, then a written Notice of Adverse Beneficiary Determination (NOABD) will be issued in accordance with 42 CFR 438.404.

ASAM Outpatient Level of Care Placement Procedure

1. The SUD Network Provider will determine the appropriate level of care. If services other than outpatient services are indicated, the SUD Network Provider will provide a copy of the full ASAM to ODS Staff and request service authorization.
2. If the SUD Network Provider does not offer the identified level of care, the SUD Network Provider will immediately refer the beneficiary to another DMC-ODS SUD Network Provider that offers the indicated ASAM level of care, or link the beneficiary to the ODS Staff, for linkage to the appropriate care.
3. The SUD Network Provider and the ODS staff will document the referral and the outcome of the linkage to the appropriate level of care.
4. DMC-ODS SUD Network Providers will provide an appointment **within 10 business days** for outpatient services and **within 3 business days** for opioid treatment programs. In instances where the SUD Network Provider is unable to begin service delivery within the required 10-day time period due to non-budget related capacity issues, interim services will be offered. In addition, the SUD Network Provider will make referrals to other SUD Network Providers, when available, to ensure timely access to services.

ASAM Residential Level of Care Placement and Authorization Process

- When higher levels of care (such as residential, or inpatient services) are identified by the county Access line screening beneficiary will be assigned to county ODS staff.
- When higher levels of care are indicated by the SUD Network Provider full assessment, provider will initiate the request for authorization with ODS staff.
- ODS Staff will complete the full assessment or review the provider treatment authorization request and determine/verify and document diagnosis and medical necessity for the appropriate level of care and submitting a TAR packet to DMC-ODS QA staff, for clinician review.

Contract Provider Authorization Process

- For provider submitted treatment authorizations requests ODS staff will provide one of the following responses to the requesting provider within 24 hours.

- Approved
- Pending – Requesting additional information
- Denied

- SUD Network provider will have 24 hours to respond to county requests for additional information for requests in a Pending status.
- Upon authorization for services, the beneficiary will be given a list of SUD Network Providers and ODS Staff will contact the selected SUD Network Provider to schedule an appointment for the beneficiary.
- ODS Staff will securely send the selected SUD Network Provider information regarding the beneficiary, including the completed assessment and ASAM, the treatment authorization, and confirmation of the appointment time and date.
- If an authorization request is denied, a written Notice of Action will be sent to the beneficiary notifying them of the authorization decision. ODS Staff will also refer the beneficiary to the appropriate ASAM Level of Care.
- If the beneficiary's selected SUD Network Provider is not available within 10 business days, linkage with other SUD Network Providers will be offered.

Extension Request Authorization Process

- Seven (7) business days prior to expiration of the previous authorization, the provider will submit the Extension Request Packet, which includes the following:
  - Treatment Extension Request form
  - Verification of EDC Medi-Cal benefits
  - Current Problem List
  - Documentation of current moderate or severe level substance use disorder
  - Continuing care ASAM assessment and LOC recommendation with LPHA signature
  - Document describing what medically necessary services the beneficiary requires that cannot be provided at an outpatient or intensive outpatient level
  - Document describing goals that have not yet been met and a timeline for expected implementation and completion of the goals that have not yet been met.

Extension Request – Late Request Form required if request is not submitted before seven (7) business days prior to expiration of previous authorization.

The QA/UR Clinician will review the extension authorization request and make a re-authorization determination within three (3) business days.

Continuing Services Assessments

Re-assessments are conducted in order to ensure that beneficiaries are served at the most appropriate level of care, and that beneficiary's response to treatment, current level of functioning and severity is evaluated. Reassessments no longer occur at specific timeframes, but rather shall occur every time there is a change in condition. In addition, beneficiaries shall still be re-assessed for reauthorization of medical necessity no sooner than 5 months and no longer than 6 months (except for NTP services which require annual reauthorization).

Medical Necessity of Services

DMC-ODS services must be medically necessary. Pursuant to W&I Code section 14059.5(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and 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. (Section 1396d(r)(5) of Title 42 of the United States Code; W&I Section 14059.5(b)(1)).

Transition to Other Levels of Care

When it is determined that a beneficiary is in need of an increase or decrease in level of care, the SUD Network Provider will make a referral to the appropriate level of treatment. Placement transitions to other levels of care will occur within 5-10 business days from the date of reassessment. The exception to this will be when a beneficiary requires residential treatment. Provider will then follow the ASAM Residential Level of Care Placement Procedure.

Coordination with Out of Network Providers

There may be instances where beneficiary services must be obtained by providers that are not contracted providers to the EDC DMC ODS plan. EDC DMC ODS provides medically necessary DMC services when identified services are not available internally from EDC DMC ODS resources a provider contracting with the plan.

EDC DMC ODS shall make the determination whether medically necessary DMC services are not available through the EDC DMC ODS plan or a provider contracting with the plan. EDC DMC ODS may authorize Out-of-Network Services under the following circumstances:

- When plan beneficiary is out of county and develops an urgent condition and no providers contracting with the EDC DMC ODS reasonably available based on EDC DMC ODS's evaluation of the needs of the beneficiary, especially in terms of timeliness of service.
- When there are no providers contracting with EDC DMC ODS reasonably available to the beneficiary based on the EDC DMC ODS's evaluation of the needs of the beneficiary, the geographic availability of providers.
- When EDC DMC ODS determines that services cannot be provided through the EDC DMC ODS or the EDC DMC ODS's network of contract providers.

EDC DMC ODS shall only authorize out-of-network services that would be considered a covered service if it were provided by EDC DMC ODS or a contracted provider and for as long as EDC DMC ODS is unable to provide the identified services.

EDC DMC ODS requires out-of-network providers coordinate authorization and payment with the EDC DMC ODS. The cost for services provided out of network shall be no greater than if the services were furnished by EDC DMC ODS contract provider.

Out of Network Approval Procedure

1. The beneficiary's treating provider shall identify in writing the medically necessary services that are not available through EDC DMC ODS or contracted provider.
2. The written request shall be forwarded to the SUDS QA/UR Supervisor by the treating provider.
3. The SUDS QA/UR Supervisor shall review the treatment request to determine if the requested services are available through the EDC DMC ODS or contracted providers.
4. If the service category is available through the EDC DMC ODS or contracted provider, the request for an Out-of-Network Service shall be denied.
5. If the service category is not available through the EDC DMC ODS or contracted provider, the request for an Out-of-Network Service shall be approved.
6. The SUDS QA/UR Supervisor shall coordinate authorization and payment with the Out-of-Network Provider, the beneficiary/authorized beneficiary representative, and the Health and Human Services Agency Administration and Finance Division.

STAFFING REGULATIONS AND REQUIREMENTS

Training information and Procedure

The purpose of this procedure is to meet the requirements of state and federal law regarding the education and ongoing training requirements of El Dorado County Behavioral Health-Alcohol and Drug Program (DMC-ODS-SUDS) staff and contract providers of substance use disorder (SUD) services.

Training Requirements

DMC-ODS-SUDS require that SUD staff and providers complete specific training upon hire/contract execution, and at least annually thereafter.

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

Licensed staff is required to have appropriate experience and any necessary training at the time of hiring, relevant to their scope of practice. DMC-ODS-SUDS may assign additional training upon hire/contract (prior to performing assigned duties), and annually thereafter.

Documentation of trainings, certifications, and licensure is maintained by the DMC-ODS-SUDS Quality Improvement (QI) Supervisor, in specific personnel training files for county staff. Providers shall maintain provider staff's training documentation in personnel files at provider site.

Training Plan

DMC-ODS-SUDS maintain a written plan, updated annually, that outlines the training requirements of staff and providers. The Training Plan lists the types of training that staff and providers are required to complete, and includes the topics, frequency, and target staff and providers. The Training Plan may also indicate when a specific training offers CEUs. Training curricula and a complete reading of the training plan can be found on El Dorado DMC-ODS website at https://edcgov.us/Government/MentalHealth/Pages/SUD-Training.aspx

DMC-ODS Provider Credentialing

In order to ensure delivery of the highest quality of services, El Dorado DMC-ODS is committed to selecting and retaining qualified providers that meet standards and regulations surrounding professionalism; client care; availability of services; cultural competence; and client rights. The process, as described below, is based on El Dorado County BH Policy number BH-134.

Selection Criteria

The following categories of providers are eligible to provide DMC-ODS/SUD services through DMC-ODS (counseling services may only be provided by individuals registered or certified under CA regulation, or by LPHAs acting within their scope of practice

- SUD Peer Counselors (delivering peer-to-peer substance abuse assistance services as a component of recovery services)
- Registered and certified SUD counselors
- Licensed Practitioners of the Healing Arts (LPHAs), which include:
    - Physicians (licensed as MDs or DOs by the Medical Board of California and are

registered with the DEA).

- Psychiatrists (licensed as MDs or DOs by the Medical Board of California, are registered with the DEA, and have successfully completed a psychiatric residency).
- Nurse Practitioners (licensed by the CA Board of Registered Nursing).
- Physician Assistants (licensed by the Medical Board of California and are registered with the DEA).
- Registered Nurses (licensed by the CA Board of Registered Nursing).
- Registered Pharmacists (licensed by the CA Board of Pharmacy).
- Licensed Clinical Psychologists (licensed by the CA Board of Behavioral Sciences).
- Licensed Clinical Social Workers (licensed by the CA Board of Behavioral Sciences).
- Licensed Professional Clinical Counselors (licensed by the CA Board of Behavioral Sciences).
- Licensed Marriage and Family Therapists (licensed by the CA Board of Behavioral Sciences); and
- License Eligible Practitioners working under the supervision of Licensed Clinicians.

In addition to the specific standards above, individual and group providers must also:

- Possess the necessary California license or certification to practice independently. Each individual practicing as part of a group must possess the necessary license or certification.
- Maintain a safe facility.
- Store and dispense medications in compliance with all applicable state and federal laws and regulations.
- Maintain client records in a manner that meets state and federal standards.
- Meet the standards and requirements of the DMC-ODS Quality Improvement Program; and
- Meet any additional requirements that are established by DMC-ODS as part of a credentialing or evaluation process.

In addition to the general standards, organizational providers must also:

- Possess the necessary California license to operate.
- Provide for appropriate supervision of staff.

- Have as Head of Service a licensed mental health professional or other appropriate individual as described in state regulations.
- Possess appropriate liability insurance.
- Maintain a safe facility.
- Store and dispense medications in compliance with all applicable state and federal laws and regulations.
- Maintain client records in a manner that meets state and federal standards.
- Meet the standards and requirements of the DMC-ODS Quality Improvement (QI) Program.
- Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to state code; and
- Meet any additional requirements that are established by DMC-ODS as part of a credentialing or evaluation process, including an on-site review at least every three (3) years.

Retention Through Monitoring

El Dorado DMC-ODS routinely monitors and regularly engages with contract providers to ensure their retention. The purpose of identifying and addressing potential contractual issues as soon as possible reduces the likelihood of contract non-renewal and loss of providers due to poor performance or non-compliance.

Credentialing

"Credentialing" is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. Credentialing ensures that providers are licensed and certified as required by state and federal law.

- Prior to contracting, DMC-ODS reviews the full credentials of potential providers.
- At least every three (3) years, DMC-ODS reviews the full credentials of existing contract providers.
- Monthly, DMC-ODS reviews contract providers against various exclusion and status lists.

Initial Credentialing Documentation

Prior to contract execution, DMC-ODS requests and reviews the following documentation from its contract providers, as relevant to the type of provider:

1. Credentials and Historical Information:

- The appropriate license and/or board certification or registration, as required for the provider type (from a primary source*).
- Evidence of graduation or completion of any required education, as required for the provider type (from a primary source*).
- Proof of completion of any relevant medical residency and/or specialty training, as required for the provider type (from a primary source*).
- Satisfaction of any applicable continuing education requirements, as required for the provider type (from a primary source*).
- National Provider Identifier number.
- Current Drug Enforcement Administration (DEA) identification, as applicable.
- Current liability or malpractice insurance certificate and policy limits per provider type.
- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network.
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.
- Current W-9; and
- Photocopy of current El Dorado County Business Tax Certificate, if applicable.

*Primary Source refers to an entity, such as a CA licensing agency, with legal responsibility for

originating a document and ensuring the accuracy of the document's information. The requirements listed above are not applicable to all provider types. When applicable to the provider type, the information has been previously verified by the applicable licensing, certification, and/or registration board.

Signed Attestation

For all network providers who deliver covered services, each provider must submit a signed and dated statement, attesting to the following:

a. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
b. A history of loss of license or felony conviction.
c. A history of loss or limitation of privileges or disciplinary activity.
d. A lack of present illegal drug use; and
e. The application's accuracy and completeness.

The attestation also includes assurance that the provider will complete annual training in the following areas:

a. Cultural Competency
b. HIPAA, 42 CFR Part 2, privacy, confidentiality, and security standards
c. Law and Ethics
d. Compliance

Additional Agreements

In addition, providers agree to the following when contracting with DMC-ODS:

a. Permit DMC-ODS to make a site visit to the provider's office to ensure that they are maintaining a safe facility.
b. Allow DMC-ODS to review client records to ensure that there is documentation of service provided.
c. Participate in the client/provider satisfaction process determined by DMC-ODS.
d. Agree to Primary Source Verification by the DMC-ODS Director or designee, if applicable.

e. Sign a conflict-of-interest statement if they are employed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) or a SAMHSA contract program, if applicable.
f. Sign a conflict-of-interest statement if they are employed by Center for Mental Health Services (CMHS) program or a CMHS contract program, if applicable.
g. Agree to the DMC-ODS Code of Ethics included with the contract.

4. DMC-ODS requires that selected providers consent to criminal background checks as a condition of enrollment, including fingerprint checks when applicable.

3-Year Recredentialing / Retention Process

- DHCS requires DMC-ODS to verify and document at a minimum every three (3) years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing documentation listed above.
- DMC-ODS requires that each provider submits any updated information needed to complete the re-credentialing process, as well as a new signed attestation, including compliance with the annual training requirements.
- In addition to the initial credentialing requirements, re-credentialing should include documentation that DMC-ODS has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

Exclusion and Status List Checks

- In addition to the initial credentialing and recredentialing every three (3) years, DMC-ODS conducts a review of various exclusion and status lists, to ensure that its providers have not been barred or suspended.
- All individuals and entities that have access to the DMC-ODS Electronic Health Record (EHR) and/or are involved in Medi-Cal billing, including DMC-ODS staff, are verified on

The following primary sources for the status indicated for each list, at the frequencies indicated:

- Social Security Number Verification Service (SSNVS)
    - https://www.ssa.gov/employer/ssnv.htm

        - Upon contract/hire, verify the individual's social security number.

- National Plan and Provider Enumeration System (NPPES) – National Provider Identifier (NPI)
    - https://npiregistry.cms.hhs.gov/
        - During certification/recertification and upon hire, verify that the NPI number(s) and related information are accurate, for both individual and organizational/entity providers.

- Federal OIG List of Excluded Individuals and Entities (LEIE):
    - https://oig.hhs.gov/exclusions/index.asp
        - Prior to hire/contract, and monthly thereafter, verify that the individual/organization is NOT an excluded individual or entity.

- Excluded Parties List System (EPLS) via the System Award Management (SAM) system
    - https://www.sam.gov/
        - Prior to hire/contract, and monthly thereafter, verify that the individual/organization is NOT an excluded individual or entity.

- CA Medi-Cal List of Suspended and Ineligible Providers:
    - https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx
        - Prior to hire/contract, and monthly thereafter, verify that the individual is NOT a suspended or ineligible provider.

- California Licensing Boards
    - https://www.breeze.ca.gov
        - Prior to hire/contract, and monthly thereafter, verify that the provider's license has NOT expired and that there are NO current limitations on the license.

- California Revoked and/or Suspended Substance Use Counselor List https://www.dhcs.ca.gov/provgovpart/SUD-LCR/Pages/C-SUS-REV.aspx
        - Prior to hire/contract, and monthly thereafter, verify that the individual is NOT a suspended or ineligible provider.
- California Association of DUI Treatment Programs (CADTP).

    - https://cadtpcounselors.org/verify-credentials/
        - Prior to hire/contract, and monthly thereafter, verify that the provider's certification has NOT expired and that there are NO current limitations on the certification.

- California Consortium of Addiction Programs and Professionals (CCAPP)
    - https://ccappcredentialing.org/index.php/verify-credential
        - Prior to hire/contract, and monthly thereafter, verify that provider's certification has NOT expired and that there are NO current limitations on the certification.

The entirety of the El Dorado DMC-ODS Selection and Retention Policy can be found on El Dorado SUDS website or by clicking here.

Eligible DMC-ODS Staff Categories and Definitions

Licensed Practitioner of the Healing Arts (LPHA) Non-Physician:

Professional staff must be licensed, registered, certified, or recognized under California State 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. Non-Physician LPHAs include: 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.

LPHA Physician:

Physicians are a sub-category of the LPHA definition and must be licensed, registered, certified, or recognized under California State scope of practice statutes. Physicians shall provide services within their individual scope of practice.

Counselors:

"Certified Counselor" means an individual certified by a certifying organization as defined in Section 13005(a)(2) or 13005(a)(8) of Title 9 of the California Code of Regulations. "Registered Counselor" means an individual registered with a certifying organization as defined in Section 13035(f)(1) of Title 9 of the California Code of Regulations.

DMC-ODS STAFF SERVICE CATEGORIES

Revised March 2018

	LPHA Physician	LPHA Non-Physician	Counselor	Peer
PHYSICIAN ONLY				
Physician-to-Physician Consultation • DMC physician consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists *(Note: Counties may contract with one or more physicians or pharmacists to provide consultation services)*	x			
NTP Medication Psychotherapy: • Face-to-face discussion conducted by the Medical Director of the NTP/OTP on a one-on-one basis with the patient	x			
LPHA (PHYSICIAN AND NON-PHYSICIAN) ONLY				
Intake and Assessment: • Determination of Medical Necessity	x	x		
Medication Services • Prescribe and Dispense Medication by staff authorized to provide services within their scope of practice or licensure • Buprenorphine, naloxone and disulfiram reimbursed for onsite administration and dispensing at NTP programs • Long-acting injectable naltrexone reimbursed for onsite administration • Ordering, prescribing, administering, and monitoring of medication assisted treatment reimbursed	x	x		

LPHA + COUNSELOR				

Intake • Assessment of Treatment • Development of Client Plan • Prepare individualized treatment plan	x	x	x	
Counseling • Individual • Group (min 2, max 12)	x	x	x	
Family Therapy • Incorporating family into treatment process	x	x		
Patient Education • Research based education	x	x	x	
Collateral Services • Sessions with therapists to support treatment goals	x	x	x	
Crisis Intervention Services • Stabilization of beneficiary emergency situation	x	x	x	
Discharge / Referral Services • Prepare beneficiary for referral • Prepare beneficiary to return to community • Link to community treatment	x	x	x	
Withdrawal Management Services • Monitoring course of withdrawal	x	x	x	

Care Coordination Services • Transferring patient to a higher or lower level of care • Development and periodic revision of a client plan that includes service 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	x	x	x	
Recovery Services • Recovery coaching, monitoring via telephone and internet • Providing linkages to life skills, employment services, job training, and education services • Providing linkages to childcare, parent education, child development support services, family/marriage education; • Providing linkages to self-help and support, spiritual and faith-based support • Providing linkages to housing assistance, transportation, case management, individual services coordination	x	x	x	
LPHA + COUNSELOR + PEER				
Substance Abuse Assistance • Peer-to-peer services and relapse prevention	x	x	x	x