Scope of Service Reference Guide:

Including Documentation and Coding Information

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Introduction

The Department of Behavioral Health (DBH) is contracted with the California Department of Health Care Services (DHCS) as the Behavioral Health Plan (BHP) for San Bernardino County. As the BHP, DBH is responsible for certifying that claims for covered services meet federal and state requirements. This manual is intended to support and assist in providing excellence in behavioral health care service delivery, including successful compliance with all governing regulations, rules, and billing policies.

The Scope of Service Reference Guide applies to all non-inpatient services whose medical records are governed by Medi-Cal requirements, providing guidance for Specialty Mental Health Services (SMHS) and Substance Use Services (herein referred to as Substance Use Disorder and Recovery Services). This includes all of the BHP's outpatient, day treatment, case management, medication, and substance use services. All services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency.

California Advancing and Innovating Medi-Cal

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS aims to address Medi-Cal members' needs across the continuum of care, ensure that all members receive coordinated services, and improve member health outcomes. The goal of CalAIM is to ensure that members have access to the right care in the right place at the right time.

BHPs are required to provide or arrange for the provision of medically necessary Specialty Mental Health Services (SMHS) for members who meet access criteria as described in DHCS Behavioral Health Information Notice (BHIN) 21-073, "*Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements."*

This current manual revision incorporates documentation and billing changes resulting from the CalAIM initiative, specifically Behavioral Health Documentation Redesign and Behavioral Health Payment Reform.

Goal of Documentation

- Improve member experience
- Effectively document treatment goals and outcomes
- Promote efficiency to focus on delivering member-centered care
- Promote safe, appropriate, and effective member care
- Address equity and disparities
- Ensure quality and program integrity

Purpose of Documentation

- Provide a written record of member care
- Assist care providers in identifying problem areas and facilitate planning and evaluating care
- Create a venue for communication between care providers
- Provide evidence for reimbursement
- Provide legal protection for the care provider and DBH
- Assist in research or quality improvement activities

Documentation Expectations

Documentation should:

- Be clear and concise
- Provide supporting detail
- Be accurate and nonjudgmental
- Be logical and sequential in recording events
- Include the review of documentation of care provided by others to ensure continuity of care
- Document assessment of risk, provider interventions, and disposition or resolution
- Use only approved abbreviations
- Be free of blank lines
- Include the name of the person providing the information when documenting information reported by others, and include use of quotation marks, as applicable

Manual Priority

This manual governs the outpatient service charting, record keeping, billing and coding for all DBH clinics and contracted providers.

The manual does not reflect all potential services and/or codes but rather represents a consolidated reflection of the most common services and codes within the DBH system of care.

Manual Maintenance

The Department's Quality Management Division (QMD) maintains the Manual, in consultation with the Compliance Unit. Revisions are issued periodically and as needed.

If there are items in the Manual that are not clear or provider cannot find them, please inform QMD: DBH-QualityManagementDivision@dbh.sbcounty.gov.

Contact Information

Quality Management Division

The Department of Behavioral Health Quality Management Division provides contract agencies and DBH clinics with direct access to a central office to address chart documentation questions.

Contact information is as follows:

Department of Behavioral Health Quality Management Division

303 E. Vanderbilt Way San Bernardino, CA 92415
Phone: (909) 386-8227

http://wp.sbcounty.gov/dbh/for-providers/qm/

DBH-QualityManagementDivision@dbh.sbcounty.gov

Office of Compliance

The Department of Behavioral Health Office of Compliance provides contract agencies and DBH clinics with direct access to a central office to address coding and discipline/taxonomy questions.

Contact information is as follows:

Department of Behavioral Health – Office of Compliance
303 E. Vanderbilt Way San Bernardino, CA 92415
Phone: (909) 383-2240
Coding: DBH-ComplianceCodingQuestions@dbh.sbcounty.gov
Discipline/Taxonomy: DBHComplianceStaffMaster@dbh.sbcounty.gov

PART I:
MENTAL HEALTH

Screening Tools

The DHCS Screening Tools are designed to determine the appropriate delivery system referral for members who are not currently receiving mental health services when they contact their Managed Care Plan (MCP) or Behavioral Health Plan (BHP) seeking mental health services.

Adult Screening Tool for Medi-Cal Mental Health Services (DHCS 8765 A)

Youth Screening Tool for Medi-Cal Mental Health Services (DHCS 8765 C)

The Screening Tools are not required or intended for use with members who are currently receiving mental health services. The Screening Tools are also not required for use with members who contact behavioral health providers directly to seek mental health services. Behavioral health providers who are contacted directly by members seeking services should begin the assessment process and may provide some services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy (QM6055).

Screening Tools are not intended for use if a practitioner refers a member specifically to the BHP for specialty mental health services (SMHS) based on an understanding of the member's needs and using their own clinical judgment. If a practitioner refers a member directly to the BHP for SMHS, the BHP should follow existing protocols for referrals in these scenarios.

Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a member is referred to the MCP or BHP, they shall receive an assessment from a provider in that system to determine medically necessary services. If a member is referred to the BHP based on the score on the Screening Tool, the BHP ***must provide a timely clinical assessment*** to the member without requiring an additional screening.

Overriding the Screening Tool Score

In certain circumstances, the BHP may override the Screening Tool score when the result is inconsistent with the member's clinical presentation (e.g., the Screening Tool score does not capture the need for SMHS in members who are unable to respond to the Screening Tool questions due to serious mental health symptoms).

Overriding the Screening Tool score shall only be conducted by specified practitioners:

- Registered Nurses
- Physician Assistants
- Licensed Physicians
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Clinical Counselors
- Licensed Marriage and Family Therapists
- Licensed Occupational Therapists
- Waivered, Registered, or Clinical Trainees

The BHP practitioner shall provide their rationale and information supporting the rationale for overriding the Screening Tool score based on the following two options:

- Additional information was provided during the screening indicating a higher level of services than Non-Specialty Mental Health Services (NSMHS) is needed. The BHP should refer the member to an SMHS practitioner for a timely assessment.
- Additional information was provided during the screening indicating a lower level of services than SMHS is needed. The member should be referred to their MCP so the MCP can coordinate a timely assessment.

BHPs must record overrides as well as the practitioner's rationale through the BHP's preferred monitoring method (e.g., EHR, excel spreadsheet, etc.) and share this information when referring a member to the appropriate Medi-Cal mental health delivery system following the administration of the Screening Tool. Overrides of the Screening Tools are subject to auditing and BHPs must provide the records, including the override rationale (e.g., EHR, excel spreadsheet, etc.), to DHCS upon request.

Transition of Care Tool

The Transition of Care Tool for Medi-Cal Mental Health Services (hereafter referred to as the Transition of Care Tool) ensures that members who are receiving mental health services from one delivery system receive timely and coordinated care when either:

- Member's existing services need to be transitioned to the other delivery system, or
- Services need to be added to member's existing mental health treatment from the other delivery system

Transition of Care Tool for Medi-Cal Mental Health Services (DHCS 8765 B)

Completion of the Transition of Care Tool is not considered an assessment. BHPs are required to use the Transition of Care Tool to facilitate transitions of care to MCPs for all members, including adults ages 21 and older and youth under age 21, when their service needs change.

A copy of the completed Transition of Care Tool should be included in the member's chart.

No Wrong Door for Mental Health Services

Clinically appropriate and covered SMHS are covered and reimbursable Medi-Cal services when one or more of the following conditions are met:

- Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met
- The member has a co-occurring mental health condition and substance use disorder (SUD)
- NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated

Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the member does not meet criteria for SMHS.

Concurrent Non-Specialty Mental Health Services (NSMHS) and Specialty Mental Health Services (SMHS)

Members may concurrently receive NSMHS via a DHCS Fee-for-Service (FFS) or MCP provider and SMHS via a BHP provider when the services are clinically appropriate, coordinated and not duplicative (QM6055).

When a member meets criteria for both NSMHS and SMHS, the members should receive services based on individual clinical need and established therapeutic relationships.

Any concurrent NSMHS and SMHS for adults, or children under 21 years of age, must be coordinated between MCPs and BHPs to ensure member choice. BHPs must coordinate with MCPs to facilitate care transitions and guide referrals for members receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a member-centered shared decision-making process.

Timely Access to Mental Health Services

DHCS has set standards for timely access to services for new members:

Timely Access Standards for SMHS

Service Type	Standard*
Outpatient Non-Urgent Non-Psychiatric SMHS	Offered an appointment within 10 business days of request for services.
Psychiatric Services	Offered an appointment within 15 business days of request for services.
All Urgent SMHS Appointments	Urgent Appointments** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[30]
*The above standards apply unless the waiting time for an appointment is extended pursuant to HCS 1367.03(a)(5)(H) or 28 CCR section1300.67.2.2(c)(5)(H). ** Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.[31]	

Initial Intake Forms

There are several forms provided to the member during the initial intake process. These forms assist service providers in gathering relevant information to understand the member's resource needs, in addition to identifying needs as they relate to the member's mental or physical health. Forms should be completed in the member's preferred language if member and/or support person prefer to communicate in an alternate language. A copy of the form (English version, preferred language) should be included in the clinical record for auditing purposes.

- **Consent for Outpatient Treatment** – This form should be provided at the initial contact with member. This form explains certain conditions of treatment, including circumstances in which confidential information may be disclosed without the member's consent.
    - The form should be signed by the member or responsible guardian/conservator before member receives services, if at all possible, or as soon as possible thereafter.
- **Consent for Treatment of Minors** – Minor members, twelve (12) years of age or older, receiving treatment for behavioral health may give consent for their own treatment, if the minor meets both of the following requirements (CHD0316):
    - Age 12 or older, and
    - Mature enough to participate intelligently in treatment.
        - It is the expectation of the law that a minor accessing behavioral health services will do so within the context of the member's significant family relationships. ***It is the exception*** that a minor will access behavioral health services without the parent or guardian involvement.
        - Even if a minor consents to treatment, the parents or guardians shall be involved in the minor's treatment unless the provider determines, after consulting with the minor, the involvement would be inappropriate.

    NOTE: When utilizing this form there must be a Consent Witness, an adult other than the individual providing consent, to confirm that a consent signature has been properly obtained on the treatment consent form.

For members that are in a school setting: A minor 12 years of age or older is able to consent to their own mental health treatment if determined to be mature enough to participate intelligently in that treatment. Minors younger than 12 years of age must have parent/guardian signature. If the minor consents to their own treatment, authorization must be obtained from the minor to release/disclose any information related to treatment.

For members that are in foster care: Consents should be signed by the Supervising Social Service Practitioner (SSSP) when appropriate and legally able. Attempts to contact SSSP should be documented until signature(s) are obtained, so as not to delay the provision of services to the member.

NOTE: If the Consents, Authorizations, and Release were not completed within an Electronic Health Record (EHR) system, then a paper-version of the forms should be completed and filed/uploaded into the member's chart.

Advance Care Directive (if applicable and member is 18+): The Advanced Care Directive questionnaire should indicate whether the member has or has not prepared an Advanced Health Care Directive (COM0903).

Preferred Language: Consent forms are required to be in the member's preferred language. A copy of the English version should be present when the original is in an alternative language (CUL1013).

Telehealth Consent

If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal member. The consent process should include:

- An explanation that members have the right to access covered services that may be delivered via telehealth through an in person, face-to-face visit.
- An explanation that the use of telehealth consent for the use of telehealth can be withdrawn at any time by the Medi-Cal member without affecting their ability to access covered Medi-Cal services in the future.
- An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted, and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.
- The provider must document in the member's record the provision of this information and the member's verbal or written acknowledgment that the information was received.

NOTE: For additional information, please refer to the DBH Standard Practice Manual, Telehealth Policy (MDS2027) and Telehealth Procedure (MDS2027-1).

Co-Occurring Treatment

Co-occurring treatment, also known as dual diagnosis treatment, refers to an integrated approach to addressing both mental health and substance use disorders that present simultaneously. Co-occurring treatment recognizes that mental health and substance use disorders frequently co-exist and interact, influencing each other's severity and progression.

Co-occurring treatment is based on the understanding that treating one condition while ignoring the other can lead to incomplete recovery and an increased risk of relapse. By providing co-occurring treatment, providers can deliver comprehensive and coordinated care that addresses both the mental health and substance use aspects of the wellbeing of a person in care.

Under CalAIM, the No Wrong Door policy aims to ensure that beneficiaries have access to the right care at the right time. The No Wrong Door Policy specifies that clinically appropriate SMHS are covered and reimbursable even when the member has a co-occurring substance use disorder. Similarly, clinically appropriate, and covered DMC and DMC-ODS services are covered by DMC and DMC-ODS plans even when the member has a co-occurring mental health disorder. Co-occurring diagnoses can interact and influence each other, leading to more complex treatment. By recognizing and understanding the interplay between co-occurring diagnoses, providers can provide more effective treatment tailored to the member's needs.

Required Intake Forms

- **Care Necessity Form** – This form is utilized to determine what criteria qualifies the member to receive Specialty Mental Health Services (SMHS).
    - Completing the Care Necessity form - The form should be reviewed and boxes checked based on the area(s) that the member meets criteria. If the form is provided to a member or their support person, service provider should review the form for completion and accuracy.
    - If using a paper version of this form, it should include the member's printed name, signature and date of signature, as well as the printed name, signature and date of the service provider.
- **CSI Assessment/Initial Contact Form** – This form is utilized to obtain relevant member identifying information, referral information, and reason for seeking treatment. This form should be completed when meeting with the member for the first time.
    - Completing the form – The form should be reviewed and responses checked or written in as appropriate.
    - If using a paper version of this form (Initial Contact Form), service providers should ensure that member or support person has filled out the form completely, redirecting them to complete any missed questions. Additionally, service providers should ensure that a member handbook and provider list have been provided to the member or support person and ensure the box is checked confirming this information.
- **Consent for Sound and/or Photographic Recordings** – This form is used to obtain member's consent to record member sessions using sound or photographic recordings.
    - Completing the form - The purpose of the recording should be identified based on the prompts provided.
    - If using a paper version of this form, the member or Other Responsible Person's signature should be obtained as well as a date next to their signature. Additionally, a witness' name, signature and date of signature should appear on the form as well.

        NOTE: If at any time, the member wishes to withdraw their consent for sound and/or photographic recordings, the signature of the member or Other Responsible Person should be obtained with the date of signature.
- **Authorization to Release Protected Health Information (PHI), if applicable**- When a third-party requests DBH medical records, a Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Regulations (C.F.R. Part 2) compliant authorization (DBH Authorization for Release of Protected Health Information (PHI) [COM001]) must be signed by the member or member's legal representative. The form must be completed thoroughly with specified records to be shared, a designated time frame and expiration date, as well as a signature by the member or legal representative. If the form is signed by a legal representative, proof from the court system designating legal representation must accompany the request.

- **Acknowledgement of Receipt of Notice of Privacy Practices** – A copy of the current Notice of Privacy Practices should be provided to each member upon initial contact. This document outlines how service providers are responsible for protecting the member's confidentiality, privacy and security surrounding their Protected Health Information.

    - Completing the form – This form should be completed to demonstrate that the member has received a copy of the Notice of Privacy Practices. The form should include the member's printed name, signature, and date of signature. If another person signs on the member's behalf, their signature and relationship to member, should be documented on the line that states, 'If signed by other than member, indicate relationship.'
    - There are additional prompts on the form to indicate why a member may have received a form without signing the acknowledgement or why the member did not receive a copy of the Notice of Privacy Practices. This section should only be completed if a signature by the member or other responsible person was not able to be obtained or if the member did not receive a copy of the Notice of Privacy Practices.
- **Member Episode Summary Form -** This form is used for both the Episode Opening and Episode Closing for a member. The purpose of this form is to identify the diagnostic codes and other factors specific to the member such as living situation, employment status, and legal information upon opening the member for treatment as well as when closing the member from a program assignment. There is an explanation of the prompts on the second page of the form. This form should be used in conjunction with the 'Episode Opening & Closing Codes' form for accurate completion.
    - Completing the form – The diagnostic codes that best reflect member's clinical presentation at time of opening an episode or closing an episode should be reflected. Additionally, responses for the other prompts should be reflective of member's presentation at time of completion. Responses are not required to match for opening and closing episodes.

Assessment

Timely assessments for Specialty Mental Health Services (SMHS) and Drug Medi-Cal-Organized Delivery System (DMC-ODS):

- To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.
- Assessments shall be updated as clinically appropriate, such as when the member's condition changes.
- Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, during the assessment, or prior to determination of whether SMHS, DMC, or DMC-ODS access criteria are met, even if the assessment ultimately indicates the member does not meet the access criteria for the delivery system in which they initially sought care.

SMHS Crisis Assessments

Crisis assessments completed during the provision of SMHS crisis intervention or crisis stabilization, or a SMHS Mobile Crisis Services encounter, need not meet the comprehensive assessment requirements outlined above. However, crisis assessments are not a replacement for a comprehensive assessment. When a member who has received a crisis assessment subsequently receives other SMHS, an assessment shall be completed in accordance with the requirements indicated in the previous section.

For assessment and documentation requirements specific to Medi-Cal Mobile Crisis Services, please refer to section on Crisis Intervention.

SMHS Assessments

The assessment may be in any format so long as the assessment domains and components are included, and the assessment information is comprehensive, consolidated, and can be produced and shared as appropriate to support coordinated care.

The assessment shall include the licensed provider's recommendations for medically necessary services and additional provider referrals, as clinically appropriate.

The assessment must be completed by a provider operating within their scope of practice, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional.

SMHS Assessment Domain Requirements

Providers are required to conduct a Standardized Assessment that includes the seven domains identified below for all members seeking SMHS. A domain is a reference to categories of information that should be captured within the SMHS assessment. All components listed within each of the domains shall be included as part of a comprehensive assessment.

Domain 1:
Presenting Problem/Chief Complaint (current and history of): Should indicate why the individual is seeking care, in their own words, if appropriate. Include when the presenting problems began and what behaviors or circumstances led to the need for the present assessment. When appropriate, include the collateral source's descriptions of problem(s), current and historical state of the presenting problem(s), and impact of problem on member in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact. Include the member's age. The presenting problem section must contain frequency of behaviors/ mental health symptoms.

- Current Mental Status - The member's mental state at the time of the assessment.
    - Must be completed by a master's level clinician or higher. Refer to the table below for appropriate allowable disciplines.
        - The Mental Status Exam (MSE) should include:
            - Thought process: The general quality and adequacy of understanding, reasoning, planning, and other cognitive processes.
            - Delusions: Troublesome thought content, including delusions, is described under thought content and delusions.
            - Hallucinations: Perceptual problems and hallucinations are described in perceptual processes and hallucinations.
            - Mood: A longer-lasting emotional state, while affect is the instantaneous emotional "feel" or "coloring" of what is expressed. Be sure to differentiate appropriately between mania and hypomania, as applicable.

- Member-Identified Impairment(s) - The member and collateral sources should identify the impact/impairment such as level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning.

Domain 2:
Trauma: Information on traumatic incidents, the member's reaction to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. It is not necessary in every setting to document the details of traumatic incidents in depth.

- Trauma Exposures – A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.).
- Trauma Reactions – The member's reaction to stressful situations (i.e., avoidance of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors.
- Trauma Screening - The results of the trauma screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACEs}), indicating elevated risk for development of a mental health condition.
- Systems Involvement – The member's experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.

Domain 3:
Behavioral Health History: History of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem.

- Mental Health History – Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included.
- Previous Services – Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications, therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication Assisted Treatment [MAT]), length of treatment, and efficacy/response to interventions.
- Co-occurring Substance Use/Abuse – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.

Domain 4:
Medical History and Medications: Integrates medical and medication items into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides an important context for understanding the needs of the members served.

- Physical Health Conditions – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help-seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.
- Medications – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.
- Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger).

Domain 5:
Social and Life Circumstances

- Family - Family history (including medical and mental health history), current family involvement, significant life events within family (e.g., loss, divorce, births). Names of siblings or any individuals other than the member **cannot** be included in the member's documentation as it presents the potential for privacy violations. They should only be referred to as brother, sister, mother, father, etc.
- Social and Life Circumstances – Current living situation, daily activities, social supports/networks, legal/justice involvement, military history, community engagement, description of how the member interacts with others and in relationship with the larger social community.
- Culture/ Religion/ Spirituality - Cultural factors, linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other (LGBTQ+) and/or Black, Indigenous and People of Color (BIPOC) identities, gender identifications, spirituality and/or religious beliefs, values, and practices.

Domain 6:
Strengths, Risk Behaviors, and Protective Factors: Explores areas of risk for the individuals we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Clinicians should explore specific strengths and protective factors and understand how these strengths mitigate risks that the individual is experiencing.

- Strengths and Protective Factors – Personal motivations, desires and drives, hobbies and interests, positive coping skills, availability of resources, opportunities and supports, interpersonal relationships.
- Risk Factors and Behaviors – Behaviors that put the member at risk of danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/planning/intent, aggression, inability to care for self, recklessness, etc. Documentation should include triggers or situations that may result in risk behaviors, history of previous attempts, family history of or involvement in risks, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse), willingness to seek/obtain help. May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used.
    - A risk assessment for danger to others must be conducted. Sometimes members have paranoid delusions or command hallucinations which may put others at risk. There does not need to be an intended victim for the member to be considered high risk. However, if there is an intended victim, then the Duty to Warn and Protect Third Parties in Response to a Member Threat (Tarasoff) Policy (CLP0819) and Duty to Warn and Protect Third Parties in Response to a Member Threat (Tarasoff) Procedure (CLP0819-1) must be followed. If the risk is high, there needs to be consideration for psychiatric hospitalization.
- Safety Planning – Safety plans should be developed to address any identified risk behaviors, including actions to take and trusted individuals to call during crisis. Providers should also identify and supply resources to support the member and/or family members in the event of a crisis. A copy of the safety plan should be in the chart after completion.

Domain 7:
Clinical Summary and Recommendations - Provides clinicians an opportunity to clearly articulate a working theory about how the member's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis.

- Clinical Impression – Summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below).
- Diagnostic Impression – Clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified).
- Treatment Recommendations – Recommendations for detailed and specific interventions and service types based on clinical impression and overall goals for care.

Standardized Assessment Requirements
The Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) are required with the Clinical Assessment. The CANS is to be completed for members between the ages of six and 20.

The CANS and the ANSA are multi-purpose tools developed for behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS or ANSA should be updated every 6 months, or as clinically indicated. The CANS should be updated every 60 days for Therapeutic Behavioral Services (TBS) and Children's Intensive Residential Services (ChRIS) providers.

- Adult Needs and Services Assessment (ANSA) – to be completed for members that are age 21 and older.
- Child and Adolescent Needs and Strengths (CANS-SB) Assessment – For members under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool is required. An initial CANS shall be completed or an existing CANS shall be updated by a CANS certified provider.

Criteria for Subsequent Assessments
The criteria listed below is to be utilized as a guide to determine the medical necessity and clinical need to conduct and document a reassessment. Clinical judgment should be used to determine the need to reassess members.

NOTE: There is no longer a separate document for reassessment of a member. Reassessments should include information outlined in the Assessment requirements below and include the seven (7) domains.

Triggers for an updated assessment include, but are not limited to:

- Hospitalizations (especially if the hospitalization was for symptoms not previously identified).
- An unexplained significant change in the diagnosis.
- Occurrence of significant clinical features of another diagnosis (not previously identified, considered, and ruled out), or considered upon initial assessment and ruled out.
- To determine the ongoing effectiveness of treatment or ongoing ineffectiveness of an engaged treatment plan to an expected degree of progress or stabilization.
- Significant psychosocial stressors (e.g., arrest, lost housing, physical disability, job loss, etc.) impacting the current level of functioning or impairing the progress toward treatment goals.
- Developmental milestones and/or significant life changes (e.g. transitioning from elementary to middle school/middle school to high school/high school to college). Child/youth changing foster homes or being adopted. For elder adults, loss of independence, decline in cognitive functioning, increase in physical health symptoms.
- Loss of significant other, or primary support person(s), through death, divorce, or other separation (other instances that potentially increase the degree of personal isolation may be included here as well).
- Significant healthcare changes/medical conditions. This would include an unexplained weight gain or loss, an unexplained change in sleep pattern or the appearance of previously non-identified sleep disturbances, and/or unexplained significant deterioration of cognitive functioning.
- Occurrences of "danger to others" (such as those which require a determination of the issuance of a "Tarasoff" warning).
- An unscheduled/unexplained or extended gap in services.

NOTE: Providers should be mindful of the need to update the Problem List based on any changes in the clinical presentation of the member.

ALL sections of the Clinical Assessment must be completed for the assessment. Enter "N/A", 'Unknown, or "Not Available" if the information is unknown or not available (e.g., because the member or collateral persons cannot give the information).

Billing Services Prior to Assessment
Clinically appropriate services include prevention, screening, assessment, and treatment services (e.g., therapy, rehabilitation, collateral, case management, medication support, etc.) and are covered and reimbursable under Medi-Cal, even when services are provided prior to diagnosis determination during the assessment process, or prior to SMHS access criteria determination.

While a mental health diagnosis is not a prerequisite for accessing covered services, and a person may access required services prior to being diagnosed, a provisional diagnostic impression and corresponding ICD-10 code must be assigned to submit a service claim for reimbursement. Listed below are ICD-10 codes a Licensed Professional of the Healing Arts (LPHA) may use prior to diagnosis determination, if there is a suspected disorder based on LPHA assessment:

- "Other Specified" or "Unspecified" are available for use
- Z03.89 - "Encounter for observation for other suspected diseases and conditions ruled out"
- As appropriate, a LPHA and non-LPHA may use Z55-Z65 - "Persons with potential health hazards related to socioeconomic and psychosocial circumstances"

Allowable Disciplines, Modifiers, Timeframes and Place of Service

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Code
90791 Psychiatric Diagnostic evaluation ***MH Psychiatric Diagnostic Eval**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	59, 93, 95, AH, AJ, GC, HK, HL, HP, HV, HW	31 – 1,440 minutes Claims greater than 68 minutes must use T2024 (Assessment substitute) – configured in *myAvatar*	02, 03, 04, 09,10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99
90792 Psychiatric Diagnostic	MD/DO MD/DO-Clerks NP	59, 93,95, GC, HK, HL, HP, HV, HW	31 – 1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15,

Evaluation with Medical Services ***MH Psych Diag Eval W/Med Servs**	NP-CT		Claims greater than 68 minutes must use T2024 (Assessment substitute) – configured in *myAvatar*	16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99
90885 Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, for medical diagnostic purposes ***MH Psychiatric Eval of Hospital Record**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	59, 95, AH, AJ, GC, HK, HL, HP, HV, HW	31 – 1,440 minutes Claims greater than 68 minutes must use T2024(Assessment substitute) – configured in *myAvatar*	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99
H0031 Mental health assessment by nonphysician ***MH Assessment by Non- Physician**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN	AH, AJ, HK, HP, HV, HW, SC, TD	8 – 1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

	RN-CT			

*myAvatar Service Code Description

Diagnosis

- The completion of the assessment should inform the diagnosis. The diagnosis will capture clinical information about the member's mental health needs and other conditions.
- Diagnostic specifiers from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) shall be included with the diagnosis, when applicable.
- The diagnosis must be completed by a provider, operating within their scope of practice under California state law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional.
- If there is a change in diagnosis, there should be a progress note documenting the justification for the change.
- Any time there is a change or update to the diagnosis, ensure that it is added/removed from the Problem List in the member's chart.
- Providers may use the following options during the assessment phase of a member's treatment when a diagnosis has yet to be established.
    - **ICD-10 codes Z55-Z65**, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate, including a Mental Health Rehabilitation Specialist (MHRS) or other qualified staff, during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA).
    - **ICD-10 code Z03.89**, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during the assessment phase of a person's treatment when a diagnosis has yet to be established.
    - In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA, which may include Z codes. LPHAs may use any clinically appropriate **ICD-10 code**. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

Medical Necessity for Specialty Mental Health Services

1) **Definition of Medical Necessity**

Medical Necessity: refers to the service being provided to the member. Medical necessity is separate from the criteria that needs to be met for member to receive Specialty Mental Health Services.

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 as set forth in Welfare and Institutions Code section 14059.5.

For individuals **under 21 years of age**, mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

A diagnosis is not a prerequisite for accessing needed or medically necessary SMHS or DMC/DMC-ODS services (in other words, services rendered in good faith are reimbursable prior to the determination of an official diagnosis). See **Billing Services Prior to Assessment** section for more information.

2) Criteria to Access the Specialty Mental Health Services (SMHS) Delivery System

Criteria to access SMHS: refers to the criteria that must be met by the individual seeking services. It is not the same as medical necessity.

For members **21 years of age or older**, a county Behavioral Health Plan shall provide covered specialty mental health services for members who meet **both** of the following criteria, (1) and (2) below:

(1) The member has ***one or both*** of the following:

a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The member's condition as described in paragraph (1) is due to ***either*** of the following:

a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
b. A suspected mental health disorder that has not yet been diagnosed.

For members **under age 21**, covered specialty mental health services shall be provided to members who meet ***either*** of the following criteria, (1) or (2) below:

(1) The member has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness, or

(2) The member meets both of the following requirements in a) and b), below:

a) The member has at least one of the following:

i. A significant impairment.
ii. A reasonable probability of significant deterioration in an important area of life functioning.
iii. A reasonable probability of not progressing developmentally as appropriate.
iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide, and

b) The member's condition as described in subparagraph (2) above is due to one of the following:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
ii. A suspected mental health disorder that has not yet been diagnosed.
iii. Significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

*** If a member under age 21 meets the criteria as described in (1) above, the member meets criteria to access SMHS; it is not necessary to establish that the member also meets the criteria in (2) above.

Note: A neurocognitive disorder (e.g., dementia) or a substance -related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a member meets criteria for access to the SMHS delivery system. However, BHP's must cover SMHS for members with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described above.

Notice of Adverse Benefit Determination (NOABD)

A Notice of Adverse Benefit Determination (NOABD) is issued when the county denies, modifies, or delays any health care service eligible for coverage and payment. Changes must be communicated to the member in writing. The specific NOABDs that can be issued are:

- **Denial of Authorization for Requested Services**
  - Issued when county denies a request for services by a treatment provider.
- **Denial of Payment for a Service Rendered by a Provider**
  - Issued when provider denies, in whole or in part, for any reason, a treatment provider's request for payment for a service that has already been delivered to the member.
- **Delivery System**
  - Issued when provider has determined that the member or potential member does not meet criteria to be eligible for Specialty Mental Health or Substance Use Disorder services through the BHP or DMC-ODS.
- **Modification of Requested Services**
  - Issued when DBH modifies or limits a provider's request for a service (e.g., reduction in frequency of services, duration of services, approval of alternative treatments/services).
- **Termination of a Previously Authorized Service**
  - Issued when provider terminates, reduces, or suspends a previously authorized service.
- **Delay in Processing Authorization of Services**
  - Issued when DBH identifies a delay in processing a treatment provider's request for authorization of specialty mental health services or Substance Use Disorder residential services.
- **Failure to Provide Timely Access to Services**
  - Issued when provider observes a delay in providing the member or potential member with timely services.
- **Dispute of Financial Liability**
  - Issued when DBH denies a member or potential member's request to dispute financial liability, including cost-sharing and other member financial responsibilities.
- **Failure to Timely Resolve Grievances and Appeals**
  - Issued when the Mental Health Plan does not meet required timeframes for the standard resolution of grievances and appeals.

Please refer to the Notice of Adverse Benefit Determination (NOABD) Procedure (Department of Behavioral Health Standard Practice Manual, QM6029-4) for further guidance regarding additional issuance requirements

No individual, other than a ***licensed physician*** or a ***licensed mental health professional*** who is competent to evaluate the specific clinical issues involved in the SMHS requested by a member or a provider, may deny, or modify a request for authorization of SMHS for a member for reasons related to ***medical necessity***.

A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for the BHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Problem List

The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the service provider during that service encounter and subsequently added to the problem list. The provider responsible for the member's treatment creates and maintains the problem list. The problem list includes diagnoses, identified concerns of the member, and issues identified by other service providers, and other treatment team members. The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the member's needs, including current diagnoses, key health and social issues.

Problem List Requirements

The provider(s) responsible for the member's care shall create and maintain a problem list.

- The problem list may include symptoms, conditions, diagnoses, social drivers,
    - and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
- The problem list shall be updated on an ongoing basis to reflect the current
    - presentation of the member. Providers, within their scope of practice, shall add
    - to, amend, or resolve problems from the problem list when there is a relevant
    - change to a member's condition.
        - DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time.

The problem list shall include, but is not limited to, the following:

- Diagnosis/es identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders shall be included with the diagnosis, when applicable.
- Current International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) codes.
- Problems identified by a provider acting within their scope of practice.
- Problems identified by the member and/or significant support person, if any.
- The name and title/credentials of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.
- A problem identified during a service encounter (e.g., crisis intervention encounter) may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.

  NOTE: *Providers shall not bill for the creation of a Problem List. Time spent collaborating with the member to create/update the Problem List should be captured in the provision of another SMHS billable service.*

Treatment Plan Requirements

DHCS no longer requires standalone member plans for Medi-Cal SMHS, or standalone treatment plans for services. Care planning is an ongoing, interactive component of service delivery rather than a one-time event.

There are some programs, services, and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities:

- Children's Crisis Residential Programs (CCRP)
- Community Treatment Facilities (CTF)
- Enhanced Care Management (ECM)
- Mental Health Rehabilitation Centers (MHRC)
- Mental Health Services Act Full-Service Partnership (FSP)/ Individual Services and Supports Plan (ISSP)
- Peer Support Services
- Short-Term Residential Therapeutic Programs (STRTPs)
- Social Rehabilitation Programs (SRPs)
    - Short-Term Crisis Residential Treatment
    - Transitional Residential Treatment
    - Long-Term Residential Treatment
- Targeted Case Management (TCM); Intensive Care Coordination (ICC) Therapeutic Behavioral Services (TBS)

Progress Notes

Progress notes are used as a basis for planning care and treatment among practitioners and across programs. Each progress note should be understandable when read independent of other progress notes. Documentation should provide an accurate picture of the member's condition, treatment provided, and response to care at the time the service was provided.

Progress notes are considered a legal record describing treatment provided for reimbursement purposes. The progress note is used for verification of billed services. As such, there must be sufficient documentation of the intervention, what was provided to or with the member, in order to justify payment.

Progress notes are also used to communicate with other care providers. Abbreviations should be spelled out unless included on the DBH Acronyms List to facilitate clear and accurate communication across providers and for when notes are used for legal or other reasons. The member has legal privilege to their medical record and may review the medical record documentation at any time. They should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Progress notes should never be completed in advance of a service. Each progress note shall provide sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s).

Required Progress Note Information:

- The type of service rendered.
- The date that the service was provided to the member.
- Duration of direct patient care for the service.
- Location/place of service.
- A typed or legibly printed name, signature of the service provider, and date of signature.
- A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).
- Next steps, including but not limited to, planned action steps by the provider or by the member; collaboration with the member; collaboration with other provider(s); referrals; and discharge and continuing care planning.
- Multiple Providers:
    - Should more than one provider render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one provider.
    - The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service.
- For group services:
    - In addition to the requirements above, group services must include:
        - A list of members is required to be documented and maintained by the provider.
        - Every member shall have a progress note in their clinical record that documents the service encounter and their attendance in the group.
        - A brief description of the member's response to the service.

- Progress Note Expectations: The contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described, but the nature and extent of the information included may vary based on the service type and the member's clinical needs. Some notes may appropriately contain less descriptive detail than others. If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note.

- Bundled Services: Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e., bundled services), such as Crisis Residential Treatment, Adult Residential Treatment, DMC/DMC-ODS Residential Treatment, and day treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation).
    - If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.

Progress Notes Timelines
Documentation should be completed in a timely manner to support the practitioner's recall of the specifics of a service. Below are timeliness expectations determined by DHCS:

- **Routine outpatient services:** Documentation should be completed within **three (3) business days.** The day of the service shall be considered day zero (0).
    - **Example:** If a provider renders a service on Friday at 10am:
        - If service rendered was a routine outpatient service, the progress note should be completed by the following Wednesday.
- **Crisis services:** Documentation should be completed within **one (1) calendar day.**
    - **Example:** If a provider renders a service on Friday at 10am:
        - If service rendered was a Crisis service, the progress note should be completed by close of business on Saturday.

NOTE*: If a note is submitted outside of the three business days, it is good practice to document the reason the note is delayed.*

Disallowances in audits will occur when there is evidence of fraud, waste, or abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this manual are necessary steps to promote compliance.

Signatures on progress notes and other clinical documentation
For trainee and registered disciplines, printed name should include professional designation written out in order to use the abbreviation with their signature.

- Example:
    - John Smith, Registered Associate Marriage Family Therapist (printed name)
    - John Smith, AMFT (signature)
- Example:
    - Sally Johnson, Licensed Clinical Social Worker Trainee (printed name)
    - Sally Johnson, LCSW-CT (signature)

Prior Authorization and Concurrent Review of Specialty Mental Health Services

Prior Authorization is required for the following Specialty Mental Health Services. ***These identified services must not be billed or reimbursed without prior authorization.***

No prior authorization shall be required for mental health assessment services, nor for outpatient services other than those services listed below. Contact the Quality Management Division – Authorization Unit for more information:

Prior Authorization Request:	Submission/Question Inbox
Adult Residential Treatment **(ART)**	DBH-ResidentialCR@dbh.sbcounty.gov
Crisis Residential Treatment **(CRT)**	DBH-ResidentialCR@dbh.sbcounty.gov
Day Rehabilitation **(DR)** and Day Treatment Intensive **(DTI)**	DBH-priorAuthReq@DBH.sbounty.gov
Intensive Home-Based Services **(IHBS)**	DBH-priorAuthReq@DBH.sbounty.gov
Therapeutic Behavioral Services **(TBS)**	DBH-priorAuthReq@DBH.sbounty.gov
Therapeutic Foster Care **(TFC)**	DBH-priorAuthReq@DBH.sbounty.gov
SB785 Service Authorization Request **(SAR)**	DBH-SB785@dbh.sbcounty.gov

Required form(s):

- Therapeutic Behavioral Services (TBS) Prior Authorization Request
- Intensive Home-Based Services (IHBS) Prior Authorization Request (CHD023)
- Therapeutic Foster Care (TFC) Prior Authorization Request (CHD022)
- Adult Residential Treatment (ART) and Crisis Residential Treatment (CRT) Concurrent Review Request (CLP047)

These forms must be included in the member's medical record to verify that services have been authorized by the DBH Authorization Unit.

Authorization Timeframes:

Type of Service Authorization	Maximum Length of Stay	Initial Authorization	Extension/ Re-Authorization
Adult Residential Treatment Long-Term	Eighteen (18) months	Nine (9) months	Nine (9) months
Adult Residential Transitional	Twelve (12) months	Nine (9) months	Nine (9) months
Crisis Residential Treatment (CRT)	Ninety (90) days	Sixty (60) days	Thirty (30) days
Intensive Home-Based Services (IHBS)	Twelve (12) months	Six (6) months	Six (6) months
Therapeutic Behavioral Services (TBS)	N/A	Three (3) months	Three (3) months
Therapeutic Foster Care (TFC)	N/A	Ninety (90) days	Ninety (90) days
SB785 Service Authorization Requests (SAR)	N/A	Six (6) months or One (1) year	Six (6) months or One (1) year
Day Treatment Intensive	N/A	Three (3) months	Three (3) months
Day Rehabilitation	N/A	Six (6) months	Six (6) months

Adult Residential Treatment (ART)

Adult Residential Treatment services are rehabilitative services provided in a non-institutional residential setting for members who would be at risk of hospitalization or other institutional placement if they were not in a residential treatment program.

- The chart needs to contain the Admission Agreement signed by the member or an authorized representative and program representative upon entry. The agreement should include a description of the services provided, the expectations and rights of the member regarding house rules, member involvement in the program, and fees. A copy should be given to the member.

Chart Documents:

- Clinical Assessment – Please see Assessment section for further guidance.
- Treatment Plan – Please see Treatment Plan section for further information.
- Daily AM and PM Progress Notes.
- Discharge Summary prepared by staff and member upon discharge.

- Service activities may include but are not limited to assessment, plan development, therapy, collateral, and rehabilitation.
- Concurrent review request.

Crisis Residential Treatment (CRT)

Crisis Residential Treatment is a therapeutic or rehabilitative service provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for members experiencing an acute psychiatric episode or crisis, which do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, 7 days a week.

Chart Documents:

- Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, and crisis intervention.
- Prior Authorization.
- AM and PM progress notes.
- Concurrent review request.

Intensive Home-Based Services (IHBS)

Intensive Home-Based Services are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that impact the child/youth's functioning. The services are aimed at the development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living. Services are provided to members under 21 who are eligible for full scope Medi-Cal and who meet medical necessity criteria.

Chart Documents:

- Service activities including assessment, treatment plan and progress notes.
- Treatment Plan.
- Prior Authorization.

Service	Procedure Code	Modifier
IHBS	Multiple *Code will depend on type of service being provided	HK *Services must be billed using the HK modifier

Therapeutic Behavioral Services (TBS)

Therapeutic Behavioral Services are intensive, one-to-one, short-term outpatient services for members up to age 21 designed to help members, their parents/caregivers, foster parents, group home staff or school staff reduce and manage their challenging behaviors. TBS utilizes short-term, measurable goals based on the members' needs. Must include: one to one service, collateral service with family members, caregivers and other significant people in life, development of a plan that identifies targeted behaviors to work on. TBS is not a stand-alone intervention as it is utilized in conjunction with other mental health interventions.

Chart Documents

- Prior Authorization
- Clinical Assessment
- Treatment Plan
- Progress Notes

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
H2019 Therapeutic behavioral services, 15 minutes ***MH Therapeutic Behavioral Servs**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MA MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	AH, AJ, GC, HK, HL, HP, HV, SC, TD	8 – 1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

*myAvatar Service Code Description

Therapeutic Foster Care (TFC)

Individualized specialty mental health services (SMHS) for children up to age 21 who have complex emotional and behavioral needs. This is a short-term, intensive, highly coordinated, trauma-informed, and individualized intervention, provided by a TFC Resource Parent to a child or youth who has complex emotional and behavioral needs. Children and youth receiving TFC also must receive Intensive Care Coordination (ICC) and other medically necessary SMHS, as set forth in the member plan.

- There must be a Child and Family Team (CFT) in place to guide and plan TFC service provision.

Chart Documents:

- Services include plan development, rehabilitation, collateral, and crisis intervention.
- Prior Authorization.
- Daily progress notes are required by the TFC Resource Parents.

Code	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
S5145 Therapeutic Foster Care ***Therapeutic Foster Care**	HE	0 – 1,440 minutes	03, 11, 12, 16

*myAvatar Service Code Description

SB785 Service Authorization Requests (*Does not apply to Presumptive Transfer*)
Process for facilitating the provision of medically necessary Specialty Mental Health Services (SMHS) to Medi-Cal members with an Adoptions Assistance Program (AAP) or Kinship Guardianship Assistance Payment (KinGAP) aid code who are residing outside of their County of Jurisdiction, by authorizing, documenting, reimbursing, and being reimbursed for services in accordance with Title 9, CCR §1830.220 (b)(4)(A).

Chart Documents:

- Service Authorization Request (SAR)
- Clinical Assessment
- Client Plan (if applicable)
- Progress notes (Day Rehab), if applicable
- Progress notes (Day Treatment Intensive), if applicable
- Organization Provider Agreement for Foster Children Placed Out-of-County (if applicable)

Day Treatment

"Day Rehabilitation" is a structured program of rehabilitation and therapy to improve, maintain, or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of members. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

"Day Treatment Intensive" is a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the member in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

	Half Day	Full Day Program
Minimum hours of operation (continuous therapeutic milieu)	3	More than 4
Minimum average daily hours of service components (Psychotherapy, process groups, skill building groups and adjunctive therapies groups) must be made available	2	3

Treatment Plan
Requirement based on Federal regulations.

Progress Notes
Documentation for day treatment services must clearly delineate the amount of time spent by the member in each group (e.g., 1 hr., 2 hrs). The group and Progress Note must match the program schedule.

- Note content must focus on the mental health condition and staff interventions. Daily activity logs are not Progress Notes and are not acceptable forms of documentation for any Medi-Cal billing purpose. Content that does not focus on alleviating targeted impairments (i.e., helping member achieve treatment plan goals) related to the mental health condition does not support medical necessity for the service and the service will be disallowed.
- Progress notes must include enough information to give a clear picture of the member's responses to interventions.
- Documentation must illustrate which staff was directly involved with each of the services provided.
- Day Treatment notes should include clear notations of the exact time allotted for breaks and lunch and make clear that these times are not part of the billing for the day.
- All entries shall contain the dated signature of the provider providing the service (or electronic equivalent); the provider's type of professional degree, licensure or job title, and the relevant identification number, if applicable.

Administrative

- Day Treatment program schedules must include clear break out of the time allotted for breaks and lunch. It should be clear that these blocks of time are not included in the billing for the day.
- It is required that there be daily sign in/sign out sheets for each member to support member’s attendance in the program.
- Daily schedules will include all categories of groups required of the Programs' daily service, as well as a definition of the group (i.e., skills building group, process group, adjunctive therapies, etc.). Service providers scheduled to provide those groups must appear on daily schedules. Each group must have a sign-in and sign-out log.
- Community meetings are to be identified on the schedule and in the program description with a description of the meeting.
- Staffing requirements for the Program (i.e., Day Treatment Intensive, Day Treatment Rehabilitation) must be evidenced by Staff Attendance sign-in logs (or other means) which clearly identify which staff were present on a given day. It is not adequate to merely have a

staffing schedule. For any unforeseen absences, there must be a clear and documented audit trail as to what staff provided coverage, and that the service coverage was provided within their Scope of Practice.

- Persons providing Day Treatment Intensive services who do not participate in the entire Day Treatment Intensive session, whether full-day or half-day, may be utilized according to program need, but shall only be included as part of the ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. There must be a clear audit trail of the number and identity of the staff that provide Day Treatment Intensive services and function in other capacities.
- Staff providing Day Treatment Intensive services must document any period of time in which a member is not present during a session. Unavoidable absent times must be properly documented. Members attending another scheduled appointment does not qualify as unavoidable. Generally, only unforeseen crisis or emergency types of events are considered unavoidable. Note: The above guidelines are applicable and must be followed for Day Treatment Rehabilitation Services as well.

Code	Required Procedure Modifier 1	Required Procedure Modifier 2	Mode of Service	Service Function
H2012 Day Treatment Intensive: Half Day *** MH Day Treatment Intensive/Rehab**	**HE**	**TG**	**10**	**81-84**
H2012 Day Treatment Intensive: Full Day *** MH Day Treatment Intensive/Rehab**	**HE**	**TG**	**10**	**85-89**
H2012 Day Rehabilitation Half Day ***MH Day Treatment Intensive/Rehab**	**HE**	**N/A**	**10**	**91-94**
H2012 Day Rehabilitation Full Day ***MH Day Treatment Intensive/Rehab**	**HE**	**N/A**	**10**	**95-99**

***myAvatar Service Code Description**

Service Delivery Types

Plan Development
Plan Development means a service activity that consists of one or more of the following: development of treatment plans, approval of treatment plans and/or monitoring of a member's progress.

Allowable Disciplines, Modifiers, Timeframes and Place of Service

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Code
H0032 Plan Development ***MH Srvc Plan Dev by Non-MD**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	AH, AJ, GC, HK, HL, HP, HV, SC, TD	8 – 1,440 minutes	02, 03, 04, 09, 10,11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Psychotherapy with Patient

Service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a member in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or a group of members and may include family therapy directed at improving the member's functioning and at which the member is present.

Allowable Disciplines, Modifiers, Timeframes and Place of Service

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Code
90832 Psychotherapy, 30 minutes with patient ***MH Psychotherapy with Patient 16-37**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	22, 59, 93, 95, AH, AJ, GC, HK, HL, HP, HV	16 – 37 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 56, 57, 58, 99
90834 Psychotherapy, 45 minutes with patient ***MH Psychotherapy**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC	22, 59, 93, 95, AH, AJ, GC, HK, HL, HP, HV	38 – 52 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

with Patient 38-52	APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD			
90837 Psychotherapy, 60 minutes with patient ***MH Psychotherapy with Patient 53-60**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	22, 59, 93, 95, AH, AJ, GC, HK, HL, HP, HV	53 – 1,440 minutes Claims greater than 68 minutes must use T2021 (Therapy substitute) – configured in myAvatar	02, 03, 04, 09,10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Psychosocial Rehabilitation (Rehab/ADL)

A recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member.

Psychosocial rehabilitation includes:

- Assisting members to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies.
- Therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the member in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings.
- Support resources, and/or medication education.
- Psychosocial rehabilitation may be provided to a member or group of members.

Allowable Disciplines, Modifiers, Timeframes and Place of Service

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Code
H2017 Psychosocial Rehabilitation (Individual) ***Psychosocial Rehab**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MA MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	AH, AJ, GC, HK, HL, HP, HV, SC, TD	8 – 1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**
Group Therapy

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Code
H2017 **Psychosocial Rehabilitation (group)** ***Use the HQ modifier to indicate that this service was provided in a group setting**** ***MH Psychosocial Rehab – GROUP**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MA MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	AH, AJ, GC, HK, HL, HP, HQ, HV, SC, TD	8 – 1,440 minutes	02, 03, 04, 09,10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99
90847 **Family Psychotherapy (with patient present)** ****HQ modifier not needed**** ***MH Family Psychotherapy w/PT Present**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT	59, 93, 95, AH, AJ, GC, HK, HL, HP, HV	26 – 1,440 minutes Claims greater than 58 minutes must use T2021 (Therapy substitute) – configured in *myAvatar*	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

	PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD			
90849 **Multiple-family group psychotherapy** ****HQ modifier not needed**** ***MH Multi-Fam Group Psychotherapy**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	59, 93, 95, AH, AJ, GC, HK, HL, HP, HV	43 – 1,440 minutes Claims greater than 92 minutes must use T2021 (Therapy substitute) – configured in *myAvatar*	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99
90853 **Group psychotherapy (other than multiple-family group **HQ modifier not needed**** ***MH Group Psychotherapy**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	59, 93, 95, AH, AJ, GC, HK, HL, HP, HV	26 -1,440 minutes Claims greater than 58 mins must use T2021 (Therapy substitute) – configured in *myAvatar*	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99
H0025 **Behavior health prevention education service [Peer Support group session]** ****HQ modifier not needed**** ***MH Behav Health Prevention Edu Serv**	Certified Peer	HK, SC	8 -1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Targeted Case Management (Case Management/Brokerage/Linkage)
Services that assist a member to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of member progress.

Targeted Case Management (TCM) services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. The TCM care plan includes all of the following:

- Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the member.
- Includes activities such as ensuring the active participation of the member and working with the member (or the member's authorized health care decision maker) and others to develop those goals.
- Identifies a course of action to respond to the assessed needs of the member.
- Includes the development of a transition plan when the member has achieved the goals of the care plan.

Allowable Disciplines, Modifiers, Timeframes and Place of Service

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
T1017 Targeted Case Management ***MH Targeted Case Management**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MA MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	AH, AJ, GC, HK, HL, HP, HV, HW, SC, TD	8 -1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Short-Term Residential Therapeutic Program (STRTP)
Residential facility that provides an integrated program for specialized, intensive care, service and supports, mental health care and 24-hour supervision for youth. Member must meet medical necessity, be assessed as emotionally disturbed, need level of care provided by the STRTP or need emergency placement.

Chart Documents:

- Clinical Assessment
- Daily Progress Notes
- Treatment Plan
- Needs and Service Plan
- Child and Family Team Meeting (CFTM)

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
H2000 Comprehensive multidisciplinary evaluation, 15 minutes ****Must use HK modifier**** ***MH Comprehensive Multidiscip Eval (15 min)**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MA MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	AH, AJ, GC, HK, HL, HM, HP, HV, HW, SC, TD	8 – 1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Intensive Care Coordination (ICC)

Intensive Care Coordination services are intended to link members to services provided by other child services, facilitate team meetings and coordinate mental health.

- Case management service that facilitates assessments, care planning and care coordination for members under the age of 21who are eligible for the full scope of Medi-Cal services and who meet criteria for this service.
- Interventions include assessing member's current services, frequency of services, progress of services, transition and discharge.
- Child and Family Team Meetings are necessary.
- Requires a Treatment Plan.
- The ICC care coordinator supports parent or caregiver in meeting member's needs, helps establish CFT and provides ongoing support, and facilitates collaborative relationship among member and their family and supportive system.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
T1017 Targeted case management, 15 minutes **Must use HK modifier *Targeted Case Management (ICC)**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MA MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	AH, AJ, GC, HK, HL, HP, HV, HW, SC, TD	8 – 1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Peer Support Services
Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities to set recovery goals and identify steps to reach those goals.

Peer support services may be provided face-to-face, by telephone or by telehealth with the member or significant support person(s) and may be provided anywhere in the community. Peer support services are based on an approved plan of care.

- **Therapeutic Activity**: A structured non-clinical activity provided by a certified Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the member and others providing care or support to the member, family members, or significant support persons.
- **Engagement:** Peer Support Specialist - led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions between levels of care and supporting members in developing their own recovery goals and processes.
- **Educational Groups:** Providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the member achieve desired outcomes. These groups should promote skill building for the member in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- **Collateral:** A service activity to a significant support person or persons in a member's life for the purpose of providing support to the member. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the member in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the member; and family counseling with the significant support person(s) to improve the functioning of the member. The member must be present for this service activity.

Allowable Disciplines, Modifiers, Timeframes and Place of Service

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
H0025 Behavior health prevention education service [Peer support group session] ***MH Behav Health Prevention Edu Servc**	Certified Peer	HK, SC	8 – 1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99
H0038 Self-help/peer services (individual) ***MH Self-Help/Peer Services**	Certified Peer	HK, SC	8 – 1,440 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

*myAvatar Service Code Description

Collateral

A service activity to a significant support person or persons in a member's life for the purpose of providing support to the member in achieving treatment goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the member in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the member; and family counseling with the significant support person(s) to improve the functioning of the member. The member may or may not be present for this service activity.

Effective with the transition to CalAIM claiming on 7/1/2023, collateral services cannot be claimed as a stand-alone service. Claiming for collateral contacts will be dependent on the provision of a covered service. A collateral claim must be submitted together within the claim for the covered service, or it will be denied. Counties can claim for collateral-type services and are advised to identify codes that best describe the activity performed by the staff when billing for those services. *HCPCS codes that that may be used for collateral-type contacts are available in every category* ***except*** *Therapy.*

Crisis Intervention
A service lasting less than 24 hours, for a condition which requires more timely response than a regularly scheduled visit. Crisis intervention is an unplanned, expedited service, to or on behalf of a member to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a member to cope with a crisis, while assisting the member in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. Crisis intervention may be provided face-to-face, by telephone or by telemedicine with the member and/or significant support persons and may be provided in a clinic setting or anywhere in the community. Service activities may include but are not limited to assessment, collateral, and therapy. Note that billing for crisis intervention services is limited to 8 hours per occurrence.

Allowable Disciplines, Modifiers, Timeframes and Place of Service

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
90839 **Psychotherapy for crisis; first hour** ***MH Psychotherapy for Crisis First 30-74 Min**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	59, 93, 95, AH, AJ, GC, HL, HP, HV	30 – 74 minutes Claims greater than 75 minutes must use 90840 – configured in *myAvatar*	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99
H2011 **Crisis intervention service** ***MH Crisis Intervention Service**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MD/DO	AH, AJ, GC, HL, HP, HV, SC, TD	8 – 480 minutes	02, 03, 04, 09, 10, 11, 12, 14,16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

	MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT			

***myAvatar Service Code Description**

Medication Support Services
Services provided by medical, nursing, and allied staff which may include one or more of the following: medical evaluation, medical treatment for members—including prescribing, administering, dispensing and monitoring of medication—and other medical treatments, within a staff member's scope of practice, that may alleviate the member's symptoms and functional impairment(s) due to mental illness or related conditions (i.e., substance use disorders, treatments that may ameliorate side effects or other conditions related to a member's mental illness, and physical health conditions that may be caused by/contribute to a mental health condition).

Medication Support Services should begin with completion of a thorough assessment and evaluation of a member to ensure accurate diagnostic impression and treatment.

- Documentation elements of a Psychiatric Evaluation with Medical Services
    - Member name, DOB, Date of Evaluation, Place of Service, Modality Which Service Provided (i.e., in-person, audio-visual telehealth, audio telehealth only)
    - Length of time spent directly (face-to-face') with the member
    - History of present illness
    - Current medications (and compliance)
    - Biopsychosocial assessment
    - Mental status exam (at least 5 elements)
    - Risk assessment
    - Documentation of any laboratory testing or diagnostic studies, with results and interpretation.
    - Diagnosis and functional status
    - Recommended course of treatment, including prescribing of medications and plan for next visit
    - Name, credentials and signature of provider who completed assessment
- Additional documentation to be completed as part of initial psychiatric evaluation
    - Abnormal Involuntary Movement Scale [AIMS] - when prescribing antipsychotic (neuroleptic medication) medication
    - Medication consent (when prescribing medication)
    - Physician Care Coordination Form
    - Update to Diagnosis(es) AND Problem List
    - Diagnosis(es), Problem List, AIMS, medication consent, and physician care coordination form should be completed at initial evaluation and reviewed at least annually for updates and changes

- MSS Treatment Plan (applicable ONLY if member is enrolled in the following programs:
  - Children's Crisis Residential Programs
  - Community Treatment Facilities
  - DMC-ODS Residential Treatment Services and Withdrawal Management Services provided in DHCS LOC designated AOD Treatment Facilities
  - Enhanced Care Management
  - Mental Health Rehabilitation Centers
  - Mental Health Services Act Full Service Partnership (FSP) Individual Services and Supports Plan
  - Peer Support Services
  - Short-Term Residential Therapeutic Programs (STRTPs)
  - Social Rehabilitation Programs (Crisis Residential Treatment – CRTs, Transitional and Long-Term Residential Treatment – Adult Residential Services)
  - Substance Abuse Block Grant (SABG) Programs/Services
  - Targeted Case Management
  - Intensive Care Coordination
  - Therapeutic Behavioral Services (TBS)

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
90792 **Psychiatric Diagnostic Evaluation with Medical Services** ***MH Psych Diag Eval W/Med Servs**	MD/DO MD/DO-Clerks NP NP-CT	59, 93,95, GC, HK, HL, HP, HV, HW	31 – 1,440 minutes Claims greater than 68 minutes must use T2024 (Assessment substitute) – configured in *myAvatar*	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Documentation elements of an Outpatient Evaluation of New Member

- Member name,
- Date of Birth (DOB),
- Date of Evaluation,
- Place of Service,
- Modality Which Service Provided (i.e., in-person, audio-visual telehealth, audio telehealth only)
- Length of time spent directly ('face-to-face') with the member
- History of present illness
- Mental status examination of member; Physical exam findings, as clinically indicated (e.g., related to tardive dyskinesia)
- Current Mental Status - The member's mental state at the time of the assessment.

Must be completed by a master's level clinician or higher. Refer to the table below for appropriate allowable disciplines.

The Mental Status Exam (MSE) should include:

- Thought process: The general quality and adequacy of understanding, reasoning, planning, and other cognitive processes.
- Delusions: Troublesome thought content, including delusions, is described under thought content and delusions.
- Hallucinations: Perceptual problems and hallucinations are described in perceptual processes and hallucinations.
- Mood: A longer-lasting emotional state, while affect is the instantaneous emotional "feel" or "coloring" of what is expressed. Be sure to differentiate appropriately between mania and hypomania.
- Medical Decision-Making
- Care Coordination
- Diagnosis
- Initial recommended course of treatment, including prescribing of medications and plan for next visit
- Name, credentials and signature of provider who completed assessment.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
99202 **Office or other outpatient visit for the evaluation and management of a new patient** ***Offc or other Outpt Vst of New Pt 15-29 min**	MD/DO MD/DO-Clerks NP NP-CT	27, 59, 93, 95, GC, HK, HL, HP, HV	15 – 29 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 52, 55, 57, 58, 99
99203 **Office or other outpatient visit for the evaluation and management of a new patient** ***Off/other Outpt Vst New Pt 30-44 min**	MD/DO MD/DO-Clerks NP NP-CT	27, 59, 93, 95, GC, HK, HL, HP, HV	30 – 44 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 52, 55, 57, 58, 99
99204 **Office or other outpatient visit for**	MD/DO MD/DO-Clerks NP	27, 59, 93, 95, GC, HK, HL, HP, HV	45 – 59 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 52, 55, 57, 58, 99

the evaluation and management of a new patient ***Offc or Other Outpt Vst New Pt 45-59 min**	NP-CT			
99205 **Office or other outpatient visit for the evaluation and management of a new patient** ***Off or Other Outpt Vst New Pt**	MD/DO MD/DO-Clerks NP NP-CT	27, 59, 93, 95, GC, HK, HL, HP, HV	60 – 1,440 minutes Prolonged codes 99415 and 99416 are configured in myAvatar, as appropriate	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 52, 55, 57, 58, 99

***myAvatar Service Code Description**

- Documentation elements of a Psychiatric Follow-Up Visit
    - The 9921x codes (99212-99215) represent different levels of office visits for established members, and documentation requirements are primarily based on either medical decision-making (MDM) or total time spent on the encounter. If using MDM, the documentation must reflect the complexity of the medical decision-making process, including the number of problems addressed, the amount of data reviewed, and the risk assessment. Regardless of the method used, a medically appropriate history and examination should be documented.
    - Documentation elements are similar to that from a 90792 or 9920X evaluation but should focus on interim changes or updates since initial evaluation or last appointment, including response to treatment and medication compliance, if applicable.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
99212 **Office or other outpatient visit for the evaluation and management of an established patient** ***Offc/Other Outpt Vst Est Pt (10-19 min)**	MD/DO MD/DO-Clerks NP NP-CT	27, 59, 93, GC, HK, HL, HP, HV	10 – 19 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 52, 55, 57, 58, 99

99213 **Office or other outpatient visit for the evaluation and management of an established patient** ***Offc/other Outpt Vst Est Pt (20-29 min)**	MD/DO MD/DO-Clerks NP NP-CT	27, 59, 93, GC, HK, HL, HP, HV	20 – 29 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 52, 55, 57, 58, 99
99214 **Office or other outpatient visit for the evaluation and management of an established patient** ***Offc/Othr Outpt Vst Est Pt (30-39 min)**	MD/DO MD/DO-Clerks NP NP-CT	27, 59, 93, GC, HK, HL, HP, HV	30 – 39 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 52, 55, 57, 58, 99
99215 **Office or other outpatient visit for the evaluation and management of an established patient** ***Offc/other Outpt Vst Est Pt (40-54 min)**	MD/DO MD/DO-Clerks NP NP-CT	27, 59, 93, GC, HK, HL, HP, HV	40 – 1,440 minutes Prolonged codes 99415 and 99416 are configured in myAvatar, as appropriate	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 52, 55, 57, 58, 99

*myAvatar Service Code Description

Documentation elements of **Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, for medical diagnostic purposes**

- States the purpose of the review (e.g., establishing a diagnosis or treatment plan).
- Type of information reviewed.
- Specific findings or conclusions drawn from the records.
- Correlation of information in the records, reports, and tests to the member's current symptoms and overall clinical picture.
- Does not require any direct member interaction.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
90885 **Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, for medical diagnostic purposes** ***Psychiatric Eval of Hospital Record**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	59, 95, AH, AJ, GC, HK, HL, HP, HV, HW	31 – 1,440 minutes Claims greater than 68 minutes must use T2024 (Assessment substitute) – configured in *myAvatar*	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Medication Training and Support

H0034 services are documented via the Nursing progress note and include, but are not limited to, assessing member for refill request, education of member, or their designee regarding mental health or supportive services related to mental health and medication management. Face-to-face/direct service time that is captured in note reflects actual engagement with the member directly or their assigned caregiver.

Nursing progress notes with this code should include, but are not limited to the following information:

- The type of service rendered
- A narrative describing the service, including how the service addresses the member's behavioral health needs (e.g., symptoms, condition, diagnosis and/or risk factors).
- The date that the service was provided to the member
- The duration of the service.
- Location of the member in care at the time of receiving the service.
- Diagnosis of member which includes ICD 10 code.
- If medication was discussed, name of medication.
- Current Procedural Terminology (CPT) or Healthcare Common Coding System (HCPCS) code.
- The plan, or next steps, including, but not limited to, planned actions steps by the provider or by the member, collaboration with the member, collaboration with other provider(s), and any update to the problem list as appropriate.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
H0034 **Medication Training and Support, 15 minutes** ****Use the HQ modifier to indicate that this service was provided in a group setting**** ***Med Trng Suprt (15 min)**	AOD LPT LVN MA MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) RN RN-CT	GC, HK, HL, HP, HQ, HV, SC, TD	8 – 240 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Medication Administration and Direct Observation

H0033 services are documented via the Nursing progress note and are utilized to reflect the total time utilized for administration of injection if used by the LPT/LVN designation or as additional time if utilized by those with the RN designation to record other information not otherwise deemed required for the 96372. Face-to-face/direct service time that is captured in note reflects actual engagement with the member directly or their assigned caregiver.

Nursing progress notes with this code should include, but are not limited to the following information:

- The type of service rendered
- A narrative describing the service, including how the service addresses the member's behavioral health needs (e.g., symptoms, condition, diagnosis and/or risk factors).
- The date that the service was provided to the member
- The duration of the service.
- Location of the member in care at the time of receiving the service.
- Diagnosis of member which includes ICD 10 code.
- If medication was discussed, name of medication, modality of medication administration, if administered, if injection was administered, site location, lot umber of medication, and expiration date of medication and date of return, if necessary, if follow up administration is required.
- Current Procedural Terminology (CPT) or Healthcare Common Coding System (HCPCS) code.
- The plan, or next steps, including, but not limited to, planned actions steps by the provider or by the member, collaboration with the member, collaboration with other provider(s), and any update to the problem list as appropriate.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
H0033 **Medication administration, direct observation, 15 minutes** ***Med Admin Direct Obsrv (15 min)**	AOD LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LOT LPCC APCC PCC Candidate LPCC-CT LPT LVN MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	AH, AJ, GC, HK, HL, HM, HP, HV, SC,TD	8 – 240 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Therapeutic, Prophylactic, or Diagnostic Injections
96372 code is utilized for the administration of either a subcutaneous or intramuscular injection as administered by the discipline classification of RN or higher. The note will encompass the actual **administration of injection only**. Any additional time needed for ancillary/ education/ teaching/ assessment as it relates to injection will be documented with the corresponding time code of H0034 and as a separate note referencing the note written with the 96372 code. Progress notes with this code should include but are not limited to the following information:

- The date that the service was provided to the member.
- The duration of the service.
- Location of the member at the time of receiving the service.
- Diagnosis of member which includes ICD 10 code.
- Name of medication administered, modality of medication administration, site location, lot number of medication, and expiration date of medication and date of return, if necessary, if follow up administration is required.
- Current procedural terminology (CPT) or Healthcare Common Coding System (HCPCS) code.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
96372 **Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular, 1 - 15 minutes** ***MH Injection Subcutaneous or Intramuscu**	MA MD/DO MD/DO-Clerks NP NP-CT RN RN-CT	59, GC, HL, HP, HV, TD	1 – 15 minutes	03, 04, 09, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Discharge Planning

Mental health treatment should always begin with an understanding that recovery is possible. The discussion about discharge planning should be ongoing throughout treatment. A discharge plan should review how the member can continue to receive any necessary support in addition to how those needs will be addressed post-discharge. The plan should include how the member's needs will be addressed, prescribed medication information, type of care the member is expected to receive and with whom, crisis supports, and community resources available.

- The Discharge Summary describes briefly:
    - Reason for the member's treatment
    - Course of treatment
    - Member's condition upon discharge
- For members ages 6 through 20 a CANS is required to be completed at discharge, and a PSC-35 should be completed for members ages 3 through 18.
- For adult members, completion of an ANSA is required upon discharge.

A Discharge Summary must be completed as follows:

a. On all cases open more than two months.
b. For all cases, a progress note is written, at minimum, noting the discharge.

i. In cases open less than two months, the progress note should explain the reason for member's treatment, the course of treatment, and the condition of the member at the time of discharge.

c. As clinically indicated, next steps may include planned action steps by the provider or by the member; collaboration with the member; collaboration with other provider(s); goals and actions to address health, social, educational, and other services needed by the member; referrals; and discharge and continuing care planning.

Other Charting and Billing Considerations

Charting Interpretation and Service in Non-English Language
The member has a right to receive services in their preferred language. When the services are provided in an alternate language, it must be documented in the progress note.

- If the service is provided by the service provider in an alternate language, only the language that the service/session was conducted in must be reported on the note.
- If the service is provided with the assistance of a translator, then the language the service was provided in, and the name of the translator must be reported on the note.

Refer to the 'Language Service Guide for Translation' (CUL1013) for further guidance.

Claiming for Interpretation and Interactive Complexity
Sign language or oral interpretation and interactive complexity occur along with another service. Sign language or oral interpretation and interactive complexity must be submitted on the same claim as the primary service. Only one (1) unit of interactive complexity is allowed with any service it can modify. A claim for interpretation should be submitted when the provider and member cannot communicate in the same language, and the provider uses an on-site interpreter and/or individual trained in medical interpretation to provide medical interpretation.

Interpretation cannot be claimed during an inpatient or residential stay, as the cost of interpretation is included in the per diem rate. Interpretation cannot be claimed for automated/digital translation or relay services. Interactive complexity (90785) and interpretation (T1013) should not be claimed together.

Providers should not claim for interpretation when claiming for mobile crisis services, as the rate for mobile crisis incorporates interpretation.

Claims for interpretation may not exceed the claims for the primary service. One (1) unit of sign language or oral interpretation is equal to fifteen (15) minutes.

A claim for interpretation should include the taxonomy code and NPI of the individual who provided the primary service or the rendering provider.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
90785 **Interactive complexity** ***Interactive Complexity**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT LVN MA MD/DO MD/DO-Clerks MHRS (SWII, BSW, OTA, CT Trainee) NP NP-CT Other (CM, PP, Uncertified Peer, MHS) PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	59, 93, 95, AH, AJ, GC, HK, HL, HP, HV, HW, TD	Must be the exact time as the primary service billed	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

*myAvatar Service Code Description

Claiming for Interpretation or Explanation of Results

Code 90887 (Supplemental): Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons or advising them how to assist member.

The provider interprets the results of a member's psychiatric and medical examinations and procedures, as well as any other pertinent recorded data, and spends time explaining the member’s condition to family members and other responsible parties involved with the member’s care and well-being. Advice can also be given as to how family members can best assist the member.

Code	Allowable Disciplines	Allowable Modifiers	Billing Time Requirements	Place of Service Codes
90887 **Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, 50 minutes** ***Explain Results to Family/Other**	LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LOT LPCC-CT PCC Candidate APCC LPCC MD/DO MD/DO-Clerks NP NP-CT PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD RN RN-CT	59, 93, 95, AH, AJ, GC, HK, HL, HP, HV, HW, TD	26 – 50 minutes	02, 03, 04, 09, 10, 11, 12, 14, 15, 16, 20, 23, 27, 31, 33, 51, 52, 55, 56, 57, 58, 99

***myAvatar Service Code Description**

Care Coordination
Care coordination shall be provided to a member in conjunction with all levels of care.

Care coordination consists of activities to provide coordination of care, mental health, and medical care, and to support the member with linkages to services and supports designed to maintain or improve the member's daily functioning.

Care coordination services help to ensure a member-centered, whole person approach to wellness. Care coordination can be provided in a clinical or non-clinical setting. Services may be provided face –to-face, by telehealth, or by telephone.

Care coordination includes one or more of the following:

- Coordinating between mental health providers, psychiatric, medical services.
- Discharge planning, including coordinating support transitions between levels of care/services.
- Coordinating with ancillary services, 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.
- Care Coordination services may be provided by a Licensed Practitioner of the Healing Arts (LPHA), registered or certified counselor.

Claiming for Services
Only face-to-face time (direct member care) should be billed. Direct member care means time spent with the member for the purpose of providing healthcare.

Direct member care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in that are already included in the rate for the service code.

Licensed Practitioner of the Healing Arts (LPHA)
Licensed Practitioner of the Healing Arts (LPHA's) include Physician and Non-Physician:

- LPHA Physician must be licensed, registered, certified.
- LPHA non-physician
    - Nurse Practitioner
    - Physician Assistant
    - Registered Nurse
    - Registered Pharmacist
    - Licensed Clinical Psychologist
    - Licensed Clinical Social Worker
    - Licensed Marriage and Family Therapist
    - Licensed Professional Clinical Counselor
    - Licensed eligible practitioner working under the supervision of a licensed clinician.

Mandated Report Forms

Child Abuse Reporting Form: All actions taken by staff member when a suspected child abuse report is filed shall be documented in the member's medical record (CHD0303). After a required child abuse report has been made, a copy of the Child Abuse reporting form should be placed in the Legal section of the chart.

Dependent Adult/ Elder Abuse and Neglect Reporting Form: All actions taken by a staff member when a suspected dependent adult/ elder abuse and neglect report is filed shall be documented in the member's medical record (ADT103). After a required report has been made, a copy of the Elder Abuse reporting form should be placed in the Legal section of the chart.

Duty to Warn and Protect Third Parties (Tarasoff): All actions taken by a staff member when a Tarasoff notification is made shall be documented in the member's medical record (CLP06-0819 and CLP06-0819-1). A copy of the letters and return receipts shall be filed in the Correspondence section of the chart.

PART II: SUBSTANCE USE DISORDER AND RECOVERY SERVICES (SUDRS)

Access to Care

Access to care refers to biopsychosocial and physical access to the location where treatment services are rendered. There are many types of access barriers, including:

- Timely access barriers, such as delays in conducting the initial screening and assessment or placing prospective members on unofficial waitlists instead of assisting with connections to another appropriate and available Network Provider.
- Physical barriers, such as building design with steps but no ramp entrance for members with mobility limitations.
- Communication barriers, such as the lack of capabilities to engage with non-English monolinguals or those with Limited English Proficiency (LEP), hearing, or visually impaired people.
- Privacy barriers, such as the lack of soundproofing in counseling offices and the lack of privacy in assessment rooms.
- Business operation-influenced barriers, such as attitudes expressed by counselors or other staff that denote biases or communicate stigma to members, a lack of a diverse workforce, operational hours that restrict access to services, or a lack of opportunity for member input into the treatment they receive or program operations.
- Geographical barriers such as program locations that are inaccessible by public transportation, far from areas where members live, or where members do not feel safe**.**

In all cases, Network Providers are expected to implement practices specifically designed to overcome the above types of barriers, or minimize in terms of geographic barriers, to improve member access to care and comply with Federal, State, and local regulatory requirements. Importantly, access to medically necessary services, including all Food and Drug Administration (FDA) approved medications for opioid use disorders (OUDs), cannot be denied for members meeting the criteria for DMC-ODS services, and it is prohibited to put members on waitlists.

Providers meet standards for timely access to care and services, taking into account the urgency of need for services.

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

Provider shall post and record the Screening Assessment and Referral Center (SARC) 24-hour 7 days per week phone line (800) 968-2636 during hours of non-operation.

All members can access services by walking into a clinic or by calling the SARC 24/7 Member access line at (800) 968-2636.

All members requesting Substance Use Disorder (SUD) screening services shall be screened for need and American Society of Addiction Medicine (ASAM) level of care the same day or given an appointment for screening the next business day. The member shall complete the ASAM 6-dimension screening during the initial phone call, initial face-to-face interaction, or during the scheduled appointment.

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

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

Member preferences shall be considered such as cultural, geographical, gender, language and personal schedule. These preferences and special circumstances shall be documented in the provider member chart if applicable.

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

Timeliness and Access Standards

Ensuring timely access to services and engaging patients when they are ready to initiate treatment is essential to improving the specialty SUD system's outcomes. All DMC-ODS services are to be delivered with reasonable promptness in accordance with Federal Medicaid requirements and as specified in the contract and herein. In addition to time, distance to access treatment has been linked to member outcomes. Generally, the shorter the distance between a member and their treatment site, the better the member's outcome. Unless otherwise requested by the member, every effort must be made to refer the member to a treatment program that is Outpatient substance use disorder services (non-opioid treatment) up to sixty (60) miles or ninety (90) minutes from the member's place of residence. Opioid treatment programs up to forty-five (45) miles or seventy-five (75) minutes from the member's place of residence.

DMC-ODS Plan Service	Timely Access Standard
Outpatient/Intensive Outpatient (IOT)	Ten (10) Business Days
Narcotic Treatment Program (NTP) /Opioid Treatment Program (OTP)	Within three (3) Calendar Days
Residential Treatment	Ten (10) Business Days

Note: The referring or treating provider/health professional providing triage or screening services, acting within the scope of their practice and consistent with professionally recognized standards of practice, may extend the applicable substance use disorder appointment time standards if they have determined that a longer waiting time will not have a detrimental impact on the member's health. In such instances, the provider/health professional must notate in the member's record accordingly. The licensed treating substance use disorder acting within the scope of their practice and consistent with professionally recognized standards of practice may schedule periodic office visits in advance to monitor and treat the member's mental health status.

Timely Access Requirements

The following requirements shall be met when a request for services is made by a member:

If a/an…	Then…
Potential member calls a DBH/ contract agency/FFS provider to request DMC-ODS services	DBH/contract agency/ FFS provider must offer an appointment within ten (10) business days
Potential member submits a written request and/or referrals for DMC-ODS services	Provider must contact the potential member to offer an appointment within ten (10) business days
Existing member calls or walks into an NTP/OTP clinic to request services	Provider must offer an appointment within three (3) calendar days
Potential or existing member presents at a clinic with a detailed plan on how he/she will hurt him/herself	Provider must evaluate the potential or existing member's level of risk immediately

ICL Overview

The Initial Contact Log (ICL) is utilized to ensure DHCS timeliness standards are met by all providers.

The ICL shall be completed at each "initial" contact for a new episodic encounter. An example is an intake assessment/appointment that has been completed/scheduled.

Note: All providers shall log initial requests for services made by phone, in person or in writing, on the Initial Contact Log (ICL) as listed below.

ICL Required Information

Call info:

- Date/ Time of call
- Member Name
- Caller Name
- Contact Method
- Program Type
- Program (RU)
- Contact Reason
- Priority
- Contact is Member

Appointment info:

- Actions Taken
- Date of offered appointments- REQUIRED FOR ALL SCHEDULED INTAKES
- Date of Scheduled appointment- APPOINTMENT THAT MEMBER ACCEPTED
- Time of Scheduled Appointment
- Language Preference/Interpretation Services
- Outcome summary of call

Covered DMC-ODS LOC and Service Components

DMC-ODS services must be recommended by licensed practitioners of the healing arts, as defined in California's Medicaid State Plan, acting within the scope of their practice. DMC-ODS services must be provided by DMC-certified providers and based on medical necessity.

DMC-ODS covered services may be provided in person, by telehealth (synchronous audio-only and synchronous video interactions), or by telephone. Member choice must be preserved; therefore, members have the right to request and receive covered services in person. This requirement applies to the following DMC-ODS services and service components:

DMC-ODS services include the following comprehensive continuum of outpatient, residential, and inpatient evidence-based SUD services:

- Early Intervention Services (ASAM Level 0.5)
    - Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)
- Outpatient Treatment Services (ASAM Level 1)
- Intensive Outpatient Treatment Services (ASAM Level 2.1)
- Partial Hospitalization Services (ASAM Level 2.5) ***Level 2.5 not offered by San Bernardino County at this time.***
- Residential Treatment and Inpatient Services (ASAM Levels 3.1-4.0) ***Levels 3.7 and 4.0 not offered by San Bernardino County at this time.***
- Narcotic Treatment Program (NTP)/ Opioid Treatment Program (OTP)
- Withdrawal Management (WM)
- Medication for Addiction Treatment (MAT)
- Recovery Services
- Care Coordination
- Clinician Consultation
- Peer Support Services

Early Intervention Services (ASAM Level 0.5)

Early intervention services are covered DMC-ODS services for members under the age of 21. Any member 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. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (commonly known as Screening, Brief Intervention, and Referral to Treatment, or SBIRT) is not a DMC-ODS benefit. It is a benefit in Medi-Cal Fee-for-Service (FFS) and Medi-Cal managed care delivery system for members less than 21 years of age. An SUD diagnosis is not required for early intervention services. A full assessment utilizing the ASAM Criteria is not required for a DMC-ODS member under the age of 21 to receive early intervention services. An abbreviated ASAM screening tool may be used in lieu of a full ASAM for purposes of assessing for SBIRT or Early Intervention Services. A full ASAM assessment shall be performed, and the member under the age of 21 shall receive a referral to the appropriate level of care indicated by the assessment if the member's conditions or symptoms constitute diagnostic criteria for SUD.

Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services.

Chart Documents

- Screening/Assessment - please see Screening and Assessment section for further guidance.
- Diagnosis/ Z Code
- Intake /Consent forms - please see Intake, Admission, and Consent form section for further guidance
- Problem List – please see Problem List section for further guidance
- Progress Note – please see progress note section for further guidance
  - Medical Necessity
  - Individual
  - Group
  - Crisis
  - No Show
  - Care Coordination

Urinary Analysis (UA) documentation - please see Alcohol and Drug Testing section for further guidance.

Discharge Plan /Summary - please see Discharge Plan section for further guidance.

Outpatient Treatment Services (ASAM Level 1)

Outpatient treatment services (also known as Outpatient Drug Free or ODF) are provided to members when medically necessary. These services may be offered for up to nine (9) hours a week for adults, and six (6) hours a week for members under the age of 21. Services may exceed the maximum based on individual medical necessity.

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

Chart Documents

- Screening/Assessment - please see Screening and Assessment section for further guidance.
  - Diagnosis/ Z Code
- Intake /consent forms - please see Intake, Admission, and Consent form section for further guidance
- Problem List – please see Problem List section for further guidance
- Progress Note – please see progress note section for further guidance
  - Medical Necessity
  - Individual
  - Group

    - Crisis
    - No show
    - Care Coordination
- Urinary Analysis (UA) documentation - please see Alcohol and Drug Testing section for further guidance.
- Discharge Plan /Summary - please see Discharge Plan section for further guidance.

Intensive Outpatient Treatment Services (ASAM Level 2.1)

Intensive Outpatient Treatment Services are provided to members when medically necessary in a structured programming environment. These services may be offered for a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for members under the age of 21. Services may exceed the maximum based on individual medical necessity.

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

Chart Documents

- Screening/Assessment – please see Screening and Assessment section for further guidance.
    - Diagnosis/ Z Code
- Intake /consent forms – please see Intake, Admission, and Consent form section for further guidance
- Problem List – please see Problem List section for further guidance
- Progress Note – please see progress note section for further guidance
    - Medical Necessity
    - Individual
    - Group
    - Crisis
    - No show
    - Care Coordination
- Urinary Analysis (UA) documentation – please see Alcohol and Drug Testing section for further guidance.
- Discharge Plan /Summary – please see Discharge Plan section for further guidance.

Partial Hospitalization Services (ASAM Level 2.5)

Partial Hospitalization Services are optional for DMC-ODS plans.

Partial Hospitalization Services are clinically intensive programming designed to address the treatment needs of members with severe SUD requiring more intensive treatment services than can be provided at lower levels of care. Partial Hospitalization Services are delivered to members when medically necessary in a clinically intensive programming environment and consist of a minimum of twenty (20) hours of clinically intensive programming per week. Level 2.5 Partial Hospitalization Programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs that warrant daily monitoring or management, but that can be appropriately addressed in a structured outpatient setting.

Partial Hospitalization 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

***Currently not offered by San Bernardino County**

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

Residential Treatment Services are delivered to members 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

Inpatient Treatment Services are delivered to members when medically necessary in a short-term inpatient program corresponding to at least one of the following levels:

- **Level 3.7** – Medically Monitored Intensive Inpatient Services
- **Level 4.0** – Medically Managed Intensive Inpatient Services

Residential and Inpatient Treatment Services require a clearly established site for services and in-person contact with a member in order to be claimed. A member receiving Residential or Inpatient Services pursuant to DMC-ODS, regardless of the length of stay, is a “short-term resident” of the residential or inpatient facility in which they are receiving the services. These services are intended to be individualized to treat the functional deficits identified in the ASAM criteria. Each member 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.

Residential Treatment Services include the following services:

- 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 Services in ASAM Levels 3.1, 3.3., and 3.5 are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS and residential facilities licensed by the Department of Social Services. In order to participate in the DMC-ODS program and offer ASAM Levels 3.1, 3.3, or 3.5, residential providers licensed by a state agency other than DHCS must be DMC-certified.

Residential Treatment Services can be provided in facilities of any size. All facilities delivering Residential Treatment Services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria. Residential treatment facilities licensed by DHCS offering ASAM Levels 3.1, 3.3, and 3.5 must also have a DHCS Level of Care (LOC) Designation and/or an ASAM LOC Certification that indicates that the program is capable of delivering care consistent with the ASAM Criteria. Facilities licensed by a state agency other than DHCS must have an ASAM LOC Certification for each level of care provided by the facility under the DMC-ODS program.

Residential Treatment ASAM LOC 3.1, 3.3, and 3.5 is a 24-hour structure with available trained personnel.

ASAM LOC 3.1 requires a minimum of five (5) hours of clinical services per week.

ASAM LOC 3.3 and 3.5 require a minimum of twenty (20) hours of individual/group and /or structured therapeutic activities per week, 10 of which are clinical hours.

The statewide goal for the average length of stay for Residential Treatment Services provided by DMC-ODS plans is 30 days. The goal for a statewide average length of stay for residential services of 30 days is not a quantitative treatment limitation or hard “cap” on individual stays; lengths of stay in residential treatment settings shall be determined by individualized clinical need.

Chart Documents

- Prior Authorization- please see Authorization section for further guidance.
- Screening/Assessment – please see Screening and Assessment section for further guidance.
    - Diagnosis/ Z Code
- Prior Authorization- please see Authorization section for further guidance.
- Intake /Consent forms - please see Intake, Admission, and Consent form section for further guidance
- Problem List – please see Problem List section for further guidance
- Progress Note – please see progress note section for further guidance
    - Medical Necessity

    - Individual
    - Group
    - Crisis
    - Care Coordination
- Transportation Log and Note- see transportation section for further guidance.
- Urinary Analysis (UA) documentation - please see Alcohol and Drug Testing section for further guidance.
- Discharge Plan /Summary - please see Discharge Plan section for further guidance.

Inpatient Services (ASAM Level 3.7 and 4.0)

DMC-ODS plans may voluntarily cover and receive reimbursement through the DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals, Freestanding Acute Psychiatric Hospitals (FAPHs), or Chemical Dependency Recovery Hospitals (CDRHs). Regardless of whether the DMC-ODS plan covers ASAM Levels 3.7 or 4.0, the DMC-ODS County Implementation Plan must describe referral mechanisms and care coordination for ASAM Levels 3.7 and 4.0. DHCS All-Plan Letter 18-001 Voluntary Inpatient Detoxification, clarifies coverage of voluntary inpatient detoxification through the Medi-Cal FFS program.

In order to participate in the DMC-ODS program and offer ASAM Levels 3.7 and 4.0, inpatient providers licensed by a state agency other than DHCS must be DMC-certified.

Inpatient Treatment Services include the following services:

- 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

***Currently not offered by San Bernardino County.**

Narcotic Treatment Program (NTP)/ Opioid Treatment Program (OTP)

A Narcotic Treatment Program (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 for members 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 member to a provider capable of dispensing the medication.

Pursuant to California Code of Regulations (CCR), Title 9, Chapter 4 §10345(a), The NTP shall offer the member 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 member in choosing another medication for opioid use disorder (MOUD) and/or 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 Code of Federal Regulations (42 CFR).

Counseling services provided in the NTP modality may be provided in person, by telehealth (synchronous audio-only and synchronous video interactions), or by telephone. Member choice must be preserved; therefore, members have the right to request and receive in-person services. To provide synchronous audio-only counseling services without video capability, an NTP must submit a letter of need to DHCS by emailing dhcsntp@dhcs.ca.gov and requesting an exception to CCR, Title 9, Chapter 4 § 0345(b)(3)(A) upon the request of the member. The medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) must be conducted in-person requesting an exception to CCR, Title 9, Chapter 4 10345(b)(3)(A) upon the request of the member. The medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) must be conducted in-person.

NTP/OTP 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

Chart Documents

Screening/Assessment - please see Screening and Assessment section for further guidance.

- Diagnosis/ Z Code
- Physical Exam
- Intake /Consent Forms - please see Intake, Admission, and Consent Forms section for further guidance
- Progress Note – please see progress note section for further guidance
    - Medical Necessity
    - Medication Dosage Levels
    - Individual
    - Group
    - Crisis
    - No Show
    - Care Coordination
- Treatment Plan - please see Treatment Plan section for further guidance.
- Urinary Analysis (UA) documentation - please see Alcohol and Drug Testing section for further guidance.
- Discharge Plan/ Summary - please see Discharge Plan section for further guidance.

Withdrawal Management (WM) Services

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

- **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, 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.

Withdrawal Management Services may be provided in an outpatient, residential or inpatient setting. If a member is receiving Withdrawal Management in a residential setting, each member

shall reside at the facility. All members receiving Withdrawal Management services, regardless of setting, shall be monitored during the withdrawal management process.

Withdrawal Management Services include the following service components:

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Observation
- Recovery Services

Chart Documents

- Prior Authorization- please see Authorization section for further guidance.
- Screening/Assessment - please see Screening and Assessment section for further guidance.
    - Diagnosis/ Z Code
- Intake /Consent Forms - please see Intake, Admission, and Consent form section for further guidance
- Progress Note – please see progress note section for further guidance
    - Medical Necessity
    - Individual
    - Group
    - Crisis
    - Care Coordination
    - Physical Observation
- Transportation Log and Note - see transportation section for further guidance.
- Urinary Analysis (UA) documentation - please see Alcohol and Drug Testing section for further guidance.
- Discharge Plan /Summary - please see Discharge Plan section for further guidance.

Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT) includes all FDA-approved medications and biological products to treat alcohol use disorder (AUD), opioid use disorder (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 listed in the “Covered DMC-ODS Services” section.

MAT Services for Youth (age 17 and under): Research and clinical experience have not identified any age-specific safety concerns for addiction medications, and all treatment options should be considered for members of all ages. Providers treating youth (age 17 and under) with addiction medications should obtain parental/guardian consent when required to provide medication services. A minor 16 years of age or older may consent to OUD treatment that uses buprenorphine outside of an OTP setting, whether or not the minor also has the consent of their parent or guardian.

MAT may be provided with the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)

- Family Therapy
- Medication Services
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

Chart Documents

Screening/Assessment - please see Screening and Assessment section for further guidance.

- Diagnosis/ Z Code
- Intake /Consent Forms - please see Intake, Admission, and Consent form section for further guidance
- Problem List – please see Problem List section for further guidance
- Progress Note – please see progress note section for further guidance
    - Medical Necessity
    - Individual
    - Group
    - Crisis
    - Care Coordination
- Urinary Analysis (UA) documentation - please see Alcohol and Drug Testing section for further guidance.
- Discharge Plan /Summary - please see Discharge Plan section for further guidance.

Recovery Services

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the member to their optimal functional level. Recovery Services emphasize the member's central role in managing their health, use of effective self-management support strategies, and organizing internal and community resources to provide ongoing self-management support to members.

Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care. Recovery Services may be provided in clinical or non-clinical settings (including the community).

Members may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Members do not need to be diagnosed as being in remission to access Recovery Services. Members may receive Recovery Services while receiving other DMC-ODS services, including MAT and NTP services. Members may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD.

Recovery Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the member's SUD.
- Relapse Prevention, which includes interventions designed to teach members with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the member's SUD.

Chart Documents

- Screening/Assessment – please see Screening and Assessment section for further guidance.
  - Diagnosis/ Z Code
- Intake /consent forms – please see Intake, Admission, and Consent form section for further guidance
- Problem List – please see Problem List section for further guidance
- Progress Note – please see progress note section for further guidance
  - Medical Necessity
  - Individual
  - Group
  - Crisis
  - Care Coordination
- Urinary Analysis (UA) documentation – please see Alcohol and Drug Testing section for further guidance.
- Discharge Plan /Summary – please see Discharge Plan section for further guidance.

Contingency Management (CM)/ Recovery Incentives

The Recovery Incentives Program is intended to complement substance use disorder (SUD) treatment services and other evidence-based practices. Eligible Medi-Cal members will participate in a structured 24-week outpatient Contingency Management (CM) service, followed by six (6) or more months of additional treatment and recovery support services without incentives. The Recovery Incentives Program shall consist of two phases:

- CM treatment and
- CM continuing care

The initial 12 weeks of CM consists of a series of incentives for meeting treatment goals, specifically abstinence from stimulants objectively verified by urine drug tests (UDTs) negative for stimulant drugs (e.g., cocaine, amphetamine, and methamphetamine). The incentives consist of cash-equivalents (e.g., gift cards) consistent with evidence-based clinical research for treating SUD. CM should be offered alongside other therapeutic interventions, such as cognitive behavioral therapy and motivational interviewing that meet the definition of rehabilitative services as defined by §1905(a) of the Social Security Act and CFR 440.130(d)

Contingency Management may be provided with the following service components:

- Assessment
- Documentation
- Patient Education/Orientation
- Treatment Framework
- Incentives
- Harm Reduction

Chart Documents

- Screening/Assessment - please see Screening and Assessment section for further guidance.
  - Diagnosis/ Z Code
- Intake /Consent Forms - please see Intake, Admission, and Consent form section for further guidance
- Problem List – please see Problem List section for further guidance

- Progress Note – please see progress note section for further guidance
    - Medical Necessity
    - Individual
    - Crisis
- Urinary Analysis (UA) documentation - please see Alcohol and Drug Testing section for further guidance.
- Discharge Plan/Summary - please see Discharge Plan section for further guidance.

Care Coordination

Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the member with linkages to services and supports designed to restore the member to their optimal functional level.

Care coordination shall be provided to a member in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service. DMC-ODS plans shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a member-centered and whole-person approach to wellness.

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.

NOTE: Refer to the Billing and Coding section for further guidance.

Clinician Consultation

Clinician Consultation consists of DMC-ODS providers who are qualified to perform assessments consulting with providers, 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 members. 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 members. DMC-ODS plans may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services.

NOTE: Refer to the Billing and Coding section for further guidance.

Medi-Cal Peer Support Services

Medi-Cal Peer Support Services are defined as “culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach these goals. Services aim to prevent relapse, empower Medi-Cal members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery” (DHCS Behavioral Health Information Notice 25-010 *Medi-Cal Peer Support Services, Medi-Cal Peer Support Specialists, and Medi-Cal Peer Support Specialists Certification Program*). Medi-Cal Peer Support Services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting.

Medi-Cal Peer Support Services can be delivered and claimed as a standalone service or provided in conjunction with other DMC-ODS services or levels of care described in the “Covered DMC-ODS Services” section, including inpatient and residential services.

Medi-Cal Peer Support Services are limited to the following three service components (services provided shall fit within at least one of those service components):

- **Educational Skill Building Groups** - providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- **Engagement** - Medi-Cal Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions and in developing their own recovery goals and processes.
- **Therapeutic Activity** - a structured non-clinical activity provided by a Medi-Cal Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member’s treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member, promotion of self-advocacy, resource navigation, and collaboration with the members and other providers.

NOTE: Refer to the Billing and Coding section for further guidance.

Evidence-Based Practice Requirements

Providers shall implement at least two of the following evidenced-based treatment practices (EBPs), one of which must be Motivational Interviewing.

The EBPs are:

- **Motivational Interviewing (MI):** A member-centered, empathic, but directive counseling strategy designed to explore and reduce a member's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on member's past successes.
- **Cognitive-Behavioral Therapy (CBT**): Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
- **Relapse Prevention:** A behavioral self-control program that teaches members with SUD 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 a recovery services program to sustain gains achieved during initial SUD treatment.
- **Trauma-Informed Treatment:** Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
- **Psychoeducation:** Psychoeducation is designed to educate members about substance abuse and related behaviors and consequences. Psychoeducation provides information designed to have a direct application to members' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist members in recovery, develop an understanding of the process of recovery, and prompt people using substances to act on their own behalf. Psychoeducation can be provided to individuals and to groups.

Treatment Service Components

Group Counseling

Group Counseling sessions are designed to support discussion among patients, with guidance from the facilitator to support understanding and encourage participation in psychosocial issues related to substance use. This does not include recreational activities, skill-building sessions (e.g., employment, education, tutoring), or time spent viewing videos/DVDs (although discussion time is generally allowable). Group Counseling sessions need to incorporate techniques such as MI and CBT. To ensure that members are aware of upcoming Group Counseling and Patient Education sessions, a monthly calendar must be posted in areas accessible to members, including the topic, location, date, time, and facilitator. Group Counseling sessions are available at all Level of Cares (LOCs) and are defined as in-person or telehealth contact between registered or certified SUD counselors or LPHAs and 2-12 members at the same time. This includes family members and non-Medi-Cal participants. Only services to eligible members (Medi-Cal participants, or individuals participating in a County-funded program such as AB 109 receiving treatment) can be claimed to San Bernardino. Services are reported in 1-minute (1 unit) increments with sessions ranging from 60 to 90 minutes in length. A separate progress note must be written for each member. Group sign-in sheets must include the signatures and printed names of all participants and group facilitators, as well as the date, start/end times, location, and group topic. The frequency of Group Counseling sessions, in combination with other treatment services, needs to be based on medical necessity and individualized member needs rather than a prescribed program required for all participants.

NOTE: Youth (age 17 and under) and Young Adults (age 18-20) are only allowed to participate in the same Group Counseling sessions in school-based settings.

Patient Education

Patient Education sessions aim to teach members and encourage discussion on research-based educational topics such as SUDs, SUD treatment including MAT, recovery, and associated health consequences. The goal of these sessions is to minimize the harm of SUDs, lower the risk of overdose, and reduce the severity of substance use. This does not include recreational activities, skill-building sessions (e.g., employment, education, tutoring), or time viewing videos/DVDs (although discussion time is generally allowable). Patient Education sessions must include Evidence Based Practices (EBPs) that incorporate youth or adult learning styles and support information retention. An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth" is available for Youth (age 17 and under) and Young Adults (age 18-20) enrolled in Early Intervention services. All youth and young adult network treatment providers must complete the required Early Intervention Curriculum training before delivering the early intervention patient education sessions. To ensure that members are aware of upcoming Group Counseling and Patient Education sessions, a monthly calendar must be posted in areas accessible to members, including the topic, location, date, time, and facilitator name. Patient Education sessions are available at all LOCs and are defined as in-person, by telephone or by telehealth contact between up to two (2) registered or certified SUD counselors or LPHAs, and

- 2-12 members at the same time in non-residential settings, or
- 2-30 members at the same time in residential settings.

Patient Education sessions may include family members and legal guardians. Services are claimed in 15-minute increments, with sessions ranging from 60 to 90 minutes in length. A separate progress note documenting the Patient Education session must be written for each member and documented. Group sign-in sheets must include signatures and printed names of participants and group facilitators, date, start/end times, location, and group topic. The frequency of Patient Education sessions, in combination with other treatment services, needs to be based on medical necessity and individualized member needs rather than a prescribed program required for all participants.

Individual Counseling

Individual Counseling sessions are designed to support direct communication and dialogue between staff and members and focus on psychosocial issues related to substance use outlined in the member's individualized Problem List (non-OTP settings) or Treatment Plan (OTP settings). They need to incorporate techniques such as MI and CBT. Individual Counseling sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) registered counselor, certified counselor, or LPHA, and one (1) member. A trainee may observe for training purposes with member consent. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. Individual Counseling sessions of less than 8 minutes cannot be billed as they are less than the minimum requirement. If Individual Counseling sessions exceed 60 minutes, the Progress Note for that encounter must justify the exceeded time. If the counseling session is split into different services (e.g., Care Coordination, Crisis Intervention, etc.), a progress note must be written for each session and documented.

The frequency of Individual Counseling sessions, in combination with other treatment services, needs to be based on medical necessity and individualized member needs rather than a prescribed program required for all participants.

Crisis Intervention Crisis

Crisis Intervention sessions include direct communication and dialogue between the staff and member and are conducted when:

- A threat to the physical and/or emotional health and well-being of the member arises that is perceived as intolerable and beyond the member's immediately available resources and coping mechanisms; or
- An unforeseen event or circumstance occurs that results in or presents an imminent threat of serious relapse.

These sessions are immediate and short-term encounters that focus on:

- Stabilization and immediate management of the crisis, often by strengthening coping mechanisms; and
- Alleviating a member's biopsychosocial functioning and well-being after a crisis.

NOTE: Crisis Intervention sessions must incorporate techniques such as MI and CBT.

A component of this service includes linkages to ensure ongoing care following the crisis. Crises that are not responsive to intervention need to be escalated to urgent (e.g., urgent care clinic) or emergent (e.g., medical or psychiatric ER) care. Crisis situations should not be confused with emergency situations which require immediate emergency intervention, such as calling 911. Crisis Intervention sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) registered/certified counselor or LPHA and one (1) member. Services may, however, involve a team of care professionals. Services are reported in 1-minute increments. A progress note must be written for each session and documented in the EHR. Crisis Intervention sessions are not scheduled but need to be available to the member as needed during the agency's normal operating hours or according to after-hours crisis procedures.

Family Therapy

Family Therapy is a form of psychotherapy that involves both members and their family members and uses specific techniques and EBPs (e.g., family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit. Sessions must also incorporate techniques such as MI and CBT.

Family Therapy sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) therapist-level Licensed Practitioner of the Healing Arts (LPHA), one (1) member, and their family member(s). Services are claimed in 15-minute increments, with sessions ranging from 15 to 60 minutes. A progress note must be written for each session and documented.

The frequency of Family Therapy sessions, in combination with other treatment services, needs to be based on medical necessity and individualized member needs rather than a prescribed program required for all participants.

Collateral Services

Collateral Services are sessions between significant persons in the member's life (i.e., personal, not official, or professional relationship with the member) and SUD counselors or LPHAs. CalAIM has changed the format and billing for collateral services. Collateral services are only available as part of other services to the member, including assessment, individual counseling, and peer support services. Collateral may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. As such, collateral services must be documented and billed as part of the primary service being delivered to the member and is not a standalone service.

The frequency of Collateral Services sessions, in combination with other treatment services, needs to be based on medical necessity and individualized member needs rather than a prescribed program required for all participants.

Alcohol and Drug Testing (Urinary Analysis)

Alcohol and drug testing examines biological specimens (e.g., urine, blood, hair) to detect the presence of specific substances and determine prior substance use. While there is not a widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment effectiveness and progress to inform treatment decisions. The frequency of alcohol and drug testing should be based on the member's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued alcohol and/or drug use has been identified to be more common. In general, alcohol and drug testing should not exceed more than twice (2x) a week with a minimum of two tests monthly. Drug testing is best when administered randomly instead of scheduled, and the method of drug testing (e.g., urine, saliva) should ideally vary as well. When body fluid testing is performed, practitioners should balance the need to protect against the falsification and/or contamination of any urine sample with member privacy. Reasonable steps should be taken to ensure specimens are not switched, substituted, or adulterated before analysis. Direct observation specimen collection is not routinely necessary unless clinically indicated, such as when there is a discrepancy between a member's clinical examination and prior toxicology results.

Decisions about appropriate responses to positive drug tests and relapses should consider:

- Chronic nature of addiction.
- Relapse is a part of the condition for which people are seeking SUD treatment.
- Medications or other factors may, at times, lead to false or appropriately positive drug test results.

Alcohol and Drug Testing is allowable at all LOCs. While it is not a reimbursable service, documentation must be completed for each test and the service reported.

NTP/OTP Urinary Analysis (UA) documentation

Each NTP/OTP program shall maintain in every member's file the following information:

- The date the member's body specimen was collected;
- The test or analysis results; and
- The date the program received the results of the test or analysis.
    - All test or analysis records for illicit drug use shall be from a laboratory in compliance with Section 10320.

Medication Assisted Treatment (MAT) Services:

The use of medication approved by the United States (U.S.) Food and Drug Administration (FDA) for treatment of substance use disorder (SUD).

Every member admitted to a treatment agency's care shall have access to all required addiction medications, either directly or through referral to external partners.

Members seeking MAT services must be assessed by a physician at an approved Department of Behavioral Health (DBH) SUD treatment facility using a biopsychosocial assessment. Members can request or be referred for MAT services through one of the following methods: The Screening Assessment and Referral Center (SARC), referrals from hospitals, direct DBH SUD Clinic contact, treatment court, correctional facility, or other programs.

Transportation Services

Providers must make every effort to provide transportation or make arrangements for transportation to and from medically necessary, but non-emergent, treatment. Transportation services may be covered by the member's Medi-Cal Managed Care health plan. Transportation services may require pre-authorization from the health plan, and the member's care coordinator is responsible for arranging for services ahead of time. The time spent coordinating transportation services is billable under Care Coordination, but not the transportation services.

Transportation services are available for members receiving behavioral health services.

There are two (2) types of transportation in the Medi-Cal program:

- Non-medical transportation (NMT) for members who do not need medical assistance during transit.
- Non-emergency medical transportation (NEMT) for when the member's medical and physical condition is such that transport by ordinary public or private means is medically contraindicated.

NMT and NEMT services may be covered by the patient's Medi-Cal Managed Care plan for the following situations:

- Transportation to medical, dental, or behavioral health appointments for all Medi-Cal services (available to members receiving outpatient, inpatient, or residential services).
- Transportation after discharge.

For each network provider with a DMC Perinatal Contract and site certification. Non-emergency transportation is billable under Perinatal Transportation (up to 80 miles per month) at every LOC.

Discharge Planning

Discharge planning is the process of preparing the member for referral to another LOC, post-treatment return, or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services. The discharge planning process should be initiated at the onset of treatment services to ensure sufficient time to plan for the member's transition to subsequent treatment or Recovery Services (RS) or the next step in their recovery journey. It also helps to convey that recovery is an ongoing life process, not a unit of service. Transition to RS needs to be included in this process. Discharge planning should identify a description of the member's triggers, a plan to avoid relapse for each of these triggers, and an overall support plan.

Discharge planning sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) registered counselor, certified counselor, or LPHA and one (1) member. A progress note must be written for each session and documented. The Discharge Plan must be completed and signed on the day of the last in-person treatment/telephonic contact, dispensed or administered medication (OTP) for all LOCs unless the member's discharge is unplanned. If a member's discharge is unplanned, the Discharge Summary must be completed within 7 calendar days of the last day that services were provided. A Discharge Summary must be completed for each member whether the discharge was voluntary or involuntary.

Culturally and Linguistically Appropriate Services

Culturally and Linguistically Appropriate Services focuses on addressing members' cultural and linguistic needs by promoting understanding and respect for the diverse ways language and culture (inclusive of race, faith, ethnicity, abilities, gender identity, class, sexual orientation, housing, and education) shape individual experiences and interactions. This approach is essential for providing high-quality SUD services. Treatment agencies must ensure that their policies, practices, and procedures support culturally, developmentally, linguistically, and population-appropriate services. These principles should be integrated into both organizational and daily operations. Research shows that inadequate diversity, inclusivity, and cultural relevance in service design and delivery can lead to poor outcomes in access, engagement, treatment receptivity, help-seeking behaviors, treatment goals, and family response. Essential practices for cultural competence and humility include:

- Developing member-centered attitudes, beliefs, values, and skills among providers.
- Implementing policies and procedures that outline quality of care and consistency requirements (e.g., Notice of Non-Discrimination, language taglines).
- Ensuring administrative structures and procedures are ready and available to support these commitments (e.g., leadership and staff that reflect the primary populations, staff training).

San Bernardino County is dedicated to fostering a service delivery system that respects members' language, culture, ethnicity, gender identity, age, sexual orientation, development stage, and any physical, psychiatric, or cognitive disabilities.

Services for Persons with Disabilities

Providers must comply with all elements of the Americans with Disabilities Act of 1990 (ADA). This includes access to alternate access technologies (e.g., TTY/TVR, magnification, audio, etc.) and policies for allowing service animals. Providers must accommodate the communication needs of all qualified individuals and be prepared to facilitate alternative format requests for braille, audio format, large print, and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services, as appropriate.

Language Assistance Services

San Bernardino County and its contracted providers shall ensure compliance with all requirements for ensuring access to language assistance services (e.g., oral interpretation, sign language, written translation, etc.) at no cost for members who are monolingual, non-English speakers, or Limited English Proficiency (LEP).

A qualified interpreter is an individual who:

- Adheres to generally accepted interpreter ethics principles, including member confidentiality; and
- Can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.

Billing Services Prior to Assessment: DMC-ODS/SUDRS

Clinically appropriate DMC-ODS/SUDRS services include prevention, screening, assessment, and treatment services (e.g., individual, group, recovery services, etc.) and are covered and reimbursable under Medi-Cal, even when services are provided prior to diagnosis determination during the assessment process.

While a person may access covered services prior to being diagnosed, a provisional diagnostic impression, and corresponding International Classification of Diseases-10 (ICD-10) code, must be assigned to submit a service claim for reimbursement.

Listed below are ICD-10 codes a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP) may use prior to diagnosis determination, if there is a suspected disorder based on LPHA or LMHP assessment:

- F-Code – including “Other Specified” or “Unspecified” are available for use, or
- Z03.89 - “Encounter for observation for other suspected diseases and conditions ruled out” may also be used.

Note: As appropriate, a LPHA or LMHP and/or non-LPHA may use Priority Z55-Z65 - “Persons with potential health hazards related to socioeconomic and psychosocial circumstances.”

Service Delivery Options

Field-Based Services

Field- Based Services (FBS) provides SUD services to members in nontraditional settings such as schools, community locations, county departments, and where members reside (e.g., encampments, shelters, residential care facilities, interim or permanent housing). FBS aims to increase access to treatment services, promote member’s motivation and engagement, and better serve hard-to-reach populations. The DMC-ODS benefit allows for the provision of FBS as a method of service delivery for Outpatient services as classified by ASAM.

Telehealth:

Method of delivering behavioral health, either clinical or nonclinical services, via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a member's behavioral health care while the member is at an originating site, and the health care provider is at a distant site.

Informed consent must be obtained from a member prior to rendering a telehealth service. Verbal or written consent from the member accepting delivery of services via telehealth shall be documented in the member's medical record. Consent is only required to be obtained/documented once during the entire duration of treatment services with DBH and must explain the following to members:

- The member 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 member's ability to access Medi-Cal covered services in the future.

Telemedicine:

Provision of medical or clinical services from a distance is facilitated through the use of electronic communication and information technologies to provide and support health care when distance separates the participants. Telemedicine is a component of telehealth.

The following elements must be satisfied when rendering telehealth services:

- Benefits or services are clinically appropriate;
- Benefits or services utilize evidence-based theories, medicine and/or best practices;
- All laws regarding confidentiality of health care information and a member's right to their medical and/or behavioral health information are continuously met;
- The equipment used must be either an interactive audio, video, or data telecommunications system that permits real-time communication between the health care provider and member;
- Member consent to telehealth services is obtained (see Consent for further guidance),
- Services occur via a HIPAA compliant mechanism.

Note: While delivering telehealth, service provider must ensure privacy and security safeguards are maintained including, but not limited to: provider stating their name and credentials at the beginning of the encounter, confirming member's identity at the beginning of each encounter, ensuring encounter is conducted in a private area (distant and originating site) to ensure confidential information is not overheard by others, use of issued devices, etc.

Charting and Documentation

Clinical documentation refers to anything in the member's record that describes the care provided to that member and the reasoning for any services delivered. All progress notes are to be observational and narrative in content as they tell the story of the member that is being served. Clinical documentation is a critical component of quality care delivery and serves multiple purposes including but not limited to helping to ensure comprehensive and quality care, ensures an efficient way to organize and communicate with other providers, protects against risk and minimizes liability, complies with legal, regulatory and institutional requirements.

The provider shall establish, maintain, and update as necessary, an individual member record for each member admitted to treatment and receiving services. Each member's individual record shall include documentation of personal information.

Documentation of personal information shall include all of the following:

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

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

- Date of the original treatment service was provided
- SUD Screening
- Medical Necessity
- Intake and admission data, including, if applicable, a physical examination;
- Problem List
- Treatment Plan (OTP)
- Progress notes (Group, Individual, etc.)
- Continuing services justifications
- Laboratory test orders and results
- Referrals (if any)
- Discharge plan
- Discharge summary
- Contractor authorizations for residential services
- Monthly Medi-Cal eligibility printouts
- Any other information relating to the treatment services rendered to the member

Intake and Admission

Overview

Intake is the process of determining if a member meets the criteria to enter SUDRS treatment, determining the best level of care and treatment location, and initiating SUDRS treatment.

Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

Establishing a comprehensive and standardized intake and admission process that balances the need for information with the need to create a streamlined and patient-centered experience is important. The sections below describe essential components of the intake process.

At the intake appointment, the member completes all necessary consent and authorization forms. Clinic staff conduct a program orientation and intake evaluation.

Intake: Admission and Consents Forms

- CalOMS Admission (AVATAR)
- Admission-Outpatient (AVATAR)
- Medi-Cal Eligibility Verification – ongoing monthly verification
- Referral
- Consent for Treatment

- Release of Information (ROI) Emergency contact, all others (ex: referred parties, family members, probation etc.)
- Notice of Privacy Practices
- Member Admission Agreement
- Title 22 Fair Hearing Rights
- Notice of Personal/Civil Rights
- Member consent to Follow-up
- Program Rules and Regulations
- CFR 42 Confidentiality
- DMC-ODS Handbook Summary and Acknowledgement Form
- Fee Payment Agreement

All forms that the member has signed and/or filled out during the intake process are filed in the member's medical record and any regulatory postings and information the member requests a physical copy (e.g., Title 22 Fair Hearing Information, etc.)

**Documents required to be completed in San Bernardino County electronic health record during the admission and discharge process.

****Admission**

- CalOMS Admission (AVATAR)
- Admission-Outpatient (AVATAR)
- Level of Care (LOC)
- Initial Contact Log (ICL)
- Diagnosis
- Women's Health History (Complete only if pregnant within 12 months)
- Sexual Orientation and Gender Identity (SOGI)

**** Discharge**

- CalOMS Administrative Discharge
- CalOMS Standard Discharge
- CalOMS Youth-Detox Discharge

Screening and Assessment

Providers shall only admit San Bernardino County residents directly for County funded programs and work cooperatively with San Bernardino County Substance Use Disorder and Recovery Services (SUDRS) to form an integrated network of care for members experiencing substance use disorder problems. Provider shall use the County American Society of Addiction Medicine (ASAM) initial screening tool or a County approved screening tool to determine member Level of Care placement based on the ASAM Criteria.

The process for walk-in screenings and call-in screenings shall be identical. When a member calls by telephone, they will receive a complete County approved SUD screening. Once the predetermination of the ASAM level of care is made, the member shall be scheduled with a County clinic or a provider for a complete assessment to determine diagnosis and medical necessity.

Member information must be entered into the County EHR system and member placed in an appropriate ASAM level of care, including pretreatment education classes and individual

prevention services and the member shall be linked to an appointment before the end of the call. See Initial Call Log (ICL) for further details.

The provider must verify Medi-Cal eligibility of the individual. When the provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the County prior to payment for services. A registered/certified substance abuse counselor, or licensed clinician shall be available to screen members.

The goal of screening is to identify members who have or are at risk for developing a substance use disorder and identify members who need further assessment to diagnose their substance use disorders and develop plans to treat them. All DBH clinics and contracted providers must use DBH-approved standardized Adult and Adolescent Screening, Level of Care, and Transition Tool forms which use the American Society of Addiction Medicine (ASAM) Criteria.

Providers shall admit on a priority basis:

Any treatment services provided with Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) funds must follow the priority population treatment preference established in 45 CFR 96.131:

- Pregnant injecting drug users;
- Pregnant substance users;
- Injecting drug users; and
- All others.

When a SUD treatment provider cannot admit a pregnant and parenting woman because of insufficient capacity, the provider will provide or arrange for interim services within 48 hours of the request, including a referral for prenatal care.

Outpatient and Intensive Outpatient programs shall provide interim services to members who cannot be placed in comprehensive treatment within ten (10) days. The provider shall ensure that they provide members interim services as defined in 45 CFR § 96.121 and ensure that a mechanism is developed for maintaining contact with the members awaiting admission to a program within reasonable time and geographic area.

Residential providers shall work with the Screening, Assessment and Referral Center (SARC) to coordinate treatment. Residential providers shall also ensure that they consult the placement lists so that members on placement lists are admitted at the earliest possible time.

Placement (Screening, Assessment, and Referral Center (SARC))

Placement is the selection of a clinically driven level of service and treatment location based on the assessment of the member’s individual needs and preferences.

While placement for residential treatment (with or without withdrawal management) can only be conducted by Screening, Assessment, and Referral Center (SARC) staff, outpatient placement may be conducted by either the provider or SARC.

Authorization Policy for Residential/Inpatient Levels of Care

DMC-ODS plans shall provide independent review of authorization requests for residential and inpatient services (excluding withdrawal management services) and notify the provider of the plan’s decision within 24 hours of the submission of the request by the provider.

DHCS does not require DMC-ODS plans to obtain a complete assessment or diagnosis to authorize residential treatment. DMC-ODS plans must review sufficient information, including

DSM and ASAM Criteria, to ensure that the member meets the requirements for the service, and must communicate authorization policies to network providers. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by an individual who has appropriate expertise in addressing the member's medical and behavioral health.

Prior Authorization

Residential Treatment requires DBH to authorize services prior to admittance.

A potential member or provider will contact DBH's Screening, Assessment, and Referral Center (SARC) to request evaluation and authorization for placement in a residential treatment facility.

SARC staff will verify Medi-Cal eligibility and conduct a telephone screening to determine the potential member's need for treatment and appropriate level of care.

If determined that residential treatment is appropriate, SARC staff will coordinate with SUDRS contracted residential treatment providers to find placement for the member.

If pre-authorization for services is necessary, the provider will utilize File Transfer Protocol (FTP) or encrypted e-mail procedures to exchange the necessary information and/or documentation in a secure manner.

Initial Assessment

Assessments consist of member evaluation, measurement, and documentation to determine diagnosis and service needs. In the treatment of persons with SUDs, assessments are an ongoing process and are essential to identify member needs and help the provider focus their services to best meet those needs. Assessments are also important opportunities for member engagement and developing a Plan of Care. Assessments are generally performed in the initial phases of treatment, though not necessarily during the initial visit.

In accordance with W&I Code §14184.402(e), providers must use the criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service for DMC members. However, a full assessment utilizing the ASAM criteria is not required for a DMC member to begin receiving covered and reimbursable SUD treatment services. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

The provider shall ensure a Registered/Certified Counselor or Licensed Practitioner of the Healing Arts (LPHA) completes a personal, medical, and substance use history for each outpatient member within thirty (30) days for adults 21 years and over or sixty (60) days for adolescents 20 years and younger and documented homeless. The LPHA and/or registered/certified counselor may conduct the assessment in person, by video conferencing, or by telephone. If the member withdraws from treatment prior to completing the assessment, and later returns, the time period starts over.

For residential a multidimensional assessment is done within 72 hours of admission, and for Narcotic Treatment Program (NTP) day one.

Assessment for all members shall include at a minimum:

- Drug/alcohol use history
- Medical history
- Family history

- Psychiatric/psychological history
- Social/recreational history
- Financial status history
- Educational history
- Employment history
- Criminal history, legal status
- Previous SUD treatment history

The Medical Director or LPHA shall review each member's personal, medical, and substance use history. If the assessment of the member is completed by a registered or certified counselor, then an LPHA shall review that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

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

Reassessment

Reassessment (continuing services) for Outpatient

Continuing services shall be justified for care coordination, outpatient services, intensive outpatient, and Naltrexone treatment by re-assessing the member utilizing the County Transitional ASAM.

For each member, no later than six (6) months after the member's admission to treatment date or the date of completion of the most recent ASAM/ Transitional ASAM the LPHA or counselor shall review the member's progress and eligibility to continue to receive treatment services, and recommend whether the member should or should not continue receiving treatment services at the same level of care.

The Medical Director, or LPHA, shall determine medical necessity for continued services for the member. The determination of medical necessity shall be documented by the Medical Director or LPHA in the member's record and shall include documentation that all of the following have been considered:

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

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

Re-Assessments at the Residential Level of Care

Although there is no state requirement for a member to be re-assessed at any specific point, the licensing and certification requirements indicate the need for a review of the member's treatment plan/Problem List every thirty (30) calendar days. Although a standalone treatment plan is not required, one of the ways to demonstrate that the member's progress has been reviewed and any modifications to the course of treatment have been considered or made would be through a re-assessment. The re-assessment will also demonstrate continued medical necessity. Providers shall re-assess every thirty (30) days no later than forty-five (45) days from the date of admission for Residential Treatment to align with the statewide goal for the average length of stay of thirty (30) days at the residential levels of care. The length of stay is based on member's clinical need.

The re-assessment will determine treatment progress and justify the member's continued need for the residential level of care or readiness to transition member to another level of care as needed. The re-assessment/ Transitional ASAM document and Medical Necessity note shall be on file in the member's chart as evidence of the member's appropriateness for the residential level of care.

Documents Required to complete a full ASAM Screening and Assessment:

- Immediate Need Profile
- ASAM Level of Care Screening
- Substance Use Disorder and Recovery Services Intake Assessment (SUDRS025)
- Client Health Questionnaire and Initial Screening Questions (SUDRS060)
- Women's Health History (Complete only if pregnant within 12 months)
- Fagerstrom Test for Nicotine Dependance (SUDRS053)
- Tuberculosis (TB) Screening Questionnaire

ASAM Dimensions

The ASAM Criteria uses multidimensional assessments to determine an appropriate Level of Care (LOC). The ASAM Criteria assesses members using six dimensions to determine the best course of care.

Dimension One (1)

- Acute intoxication and/or withdrawal
- Potential exploration of past and current experiences of substance use and withdrawal
- Drug and/or alcohol use history
- Previous SUD treatment history
- Tolerance- needing to use more to get the same effect, using the same amount but not getting the same effect, using more or for longer than anticipated

Dimension Two (2)

- Biomedical conditions and complications, exploration of health history and current physical condition
- Medical history (including whether the member has received a physical exam within the 12 months prior to the member's admission)
- Keep using even when it is physically dangerous to do so
- Keep using even though the member knows that there are physical problems caused by or made worse by the use

Dimension Three (3)

- Emotional, behavioral, or cognitive conditions and complications
- Exploration of thoughts, emotions, and mental health issues
- Psychiatric/psychological history
- Keep using even when it is psychiatrically dangerous to do so
- Keep using even though the member knows that there are psychological problems caused by or made worse by the use

Dimension Four (4)

- Readiness to change, exploration of readiness and interest in changing
- Previous SUD treatment history (as it relates to motivation and willingness for treatment)
- Family history, social/recreational history, financial status/history, educational history, employment history, and/or criminal history, legal status (as it relates to severity of problems impacting desire to change)
- Ongoing use impacting work, school, home; interpersonal problems
- Keep using despite knowing it is causing problems
- Desire to discontinue, but unable to

Dimension Five (5)

- Relapse, continued use, or continued program potential, exploration of unique relationship with relapse or continued use or problem potential
- Previous SUD treatment history (as it relates to occurrences of relapse)
- Desire to discontinue, but unable to
- Keep using despite knowing it is causing problems or is a danger
- Inability to tolerate withdrawal (using to avoid withdrawals)

Dimension Six (6)

- Recovery/living environment, exploration of recovery or living situation, and the surrounding people, places, and things
- Family history
- Social/recreational history
- Financial status/history
- Educational history
- Employment history
- Criminal history, legal status
- School, work, home situation that has suffered as a result of use
- Not following through or taking care of responsibilities at home, school, or work because of use
- A lot of time and energy going towards trying to get, use, or recover from the use

Diagnosis/Assessment Phase

Diagnoses shall be established and updated as clinically appropriate by an LPHA within their licensed scope of practice when a member's condition changes, to accurately reflect the member's needs. During the initial assessment period (between 30 to 60 days depending on the population), provisional diagnoses may be used prior to the determination of a diagnosis or in cases where suspected SUD has not yet been diagnosed.

While an SUD diagnosis is not required to provide Early Intervention services, claims for Early Intervention services must include a CMS-approved ICD-10 diagnosis code.

DMC-ODS programs and providers may use the following options during the assessment phase of a member's treatment when a diagnosis has yet to be established (DHCS Behavioral Health Information Notice 23-068 Documentation Updates to Specialty Mental Health, Drug Medi-Cal and Drug Medi-Cal – Organized Delivery System services):

ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA)".

ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during the assessment phase of a member's treatment when a diagnosis has yet to be established."

Services are reimbursable even when:

- Services are provided prior to the determination of a diagnosis or prior to the determination of whether access criteria are met.
- The assessment determines that the member does not meet the DMC-ODS access criteria after the assessment.
- The member has a co-occurring mental health disorder.

Medical Necessity

DMC-ODS services must be medically necessary. Pursuant to Welfare & Institutions 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.

To meet medical necessity criteria, patients must meet the following two (2) criteria:
Members 21 years and older qualify for DMC-ODS services after the initial assessment process, if they meet one of the following criteria:

- Have at least one diagnosis from Diagnostic and Statistical Manual (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.
- Medical necessity refers to the applicable evidence-based standards applied to justify the level of services provided to a member so the services can be deemed reasonable, necessary and/or appropriate. It is imperative that medical necessity standards are consistently and universally applied to all members.

The Diagnosis and Medical Necessity **must** be documented in member file and completed by the Medical Director or **LPHA** acting within their scope of practice. Must include the following:

- Review of assessment & intake information including personal, medical and substance use history.
- Identification of level of care based on ASAM Criteria.
- Diagnosis using:
    - Diagnosis-specific specifiers from current DSM, including the appropriate specific language description.
    - Current International Classification of Diseases (ICD) code.
- Documentation of the basis for diagnosis within ten (10) days of admission for Residential & thirty (30) days of admission for Outpatient, sixty (60) days for members under 21 years or homeless.

- If a member's assessment and intake information are completed by a counselor through a face-to-face review, telephone, or telehealth, the Medical Director or LPHA shall evaluate each member's assessment and intake information with the counselor to establish whether the member meets medical necessity criteria.

DMC-ODS Problem List:

- The provider(s) responsible for the member's care shall create and maintain a problem list.
- The problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

The problem list shall include, but is not limited to, the following:

- Diagnosis/es identified by a provider acting within their scope of practice. Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders and descriptive language shall be included with the diagnosis.
- Current International Classification of Diseases (ICD) Clinical Modification (CM) codes.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems identified by the member and/or significant support person, if any.
- The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.

A problem identified during a service encounter (e.g., crisis intervention encounter) may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.

The problem list shall be updated on an ongoing basis to reflect the current presentation of the member. Providers, within their scopes of practice, shall add to, amend, or resolve problems from the problem list when there is a relevant change to a member's condition.

DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable timeframe and in accordance with generally accepted standards of practice.

- Developed within ten (10) days for residential and 30 days for Outpatient.
- Must be reviewed a minimum of every thirty (30) days and documented in the progress note.

Treatment/Care Plans

Treatment /Care Plan Requirements - DHCS no longer requires prospectively completed, standalone member plans for DMC and DMC-ODS services. The intent of this change is to affirm that care planning is an ongoing, interactive component of service delivery rather than a one-time event. Where possible, DHCS has modified, or may modify, state-level requirements for care, member, service, and treatment plans. There are some programs, services, and facility types for which federal or state law continues to require the use of treatment/ care plans and/or specific care planning activities. For DMC, and DMC-ODS services, programs, or facilities for which treatment/ care plan requirements remain in effect:

- Providers must adhere to all relevant treatment/care planning requirements in state or federal law.
- The provider shall document the required elements of the treatment/care plan within the member record. For example, required treatment/care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated treatment/care plan template.
- To support delivery of coordinated care, the provider shall be able to produce and communicate the content of the treatment/care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws.
- Medi-Cal behavioral health delivery systems shall not enforce requirements for the location, format, or other specifications for documentation of the treatment/care plan.

Providers that choose to implement standalone treatment plans shall attempt to engage the member to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.

The initial treatment plan and updated treatment plans shall include all of the following:

- A statement of problems to be addressed.
- Goals to be reached which address each problem.
- Action steps which will be taken by the provider, and/or member to accomplish identified goals.
- Target dates for the accomplishment of action steps and goals.
- A description of the services, including the type of counseling to be provided and the frequency thereof.
- The assignment of a primary therapist or counselor.
- The member's diagnosis.

Treatment/Care Plan shall be reviewed and/or updated within a reasonable amount of time and generally accepted standards of practice include:

- Developed within ten (10) days for Residential & thirty (30) days for Outpatient.
- Reviewed a minimum of every thirty (30) days and documented in the progress note.

NOTE: The provider shall document the required elements of the care plan (type & frequency) within the member record.

NTP/OTP Treatment Plans

Detoxification Treatment Plan

The primary counselor shall enter in the members record the name and the date member was assigned to the counselor.
Detoxification Treatment Plan Requirements. Programs shall develop an individualized treatment plan for each member which shall include:

- Provisions to assist the member to understand illicit drug addictions and how to deal with them.
- Provisions for furnishing services to the member as needed when the period of detoxification treatment is completed.
- The treatment services required and a description of the role they play in achieving the stated goals.
- The type and frequency of scheduled counseling services.

Maintenance Treatment Plan

Programs shall develop an individualized treatment plan for each member. Prior to developing a member's initial maintenance treatment plan, the primary counselor shall complete and document in the member's record a needs assessment for the member which shall include:

- A summary of the member's psychological and sociological background, including educational and vocational experience.
- An assessment of the member's needs for:
    - Health care as recorded within the overall impression portion of the physical examination
    - Employment
    - Education
    - Psychosocial, vocational rehabilitation, economic, and legal services

Within 28 calendar days after initiation of maintenance treatment, the primary counselor shall develop the member's initial maintenance treatment plan which shall include:
Goals to be achieved by the member based on the needs identified and with estimated target dates for attainment in accordance with the following:

- Short-term goals are those which are estimated to require ninety (90) days or less for the member to achieve.
- Long-term goals are those which are estimated to require a specified time exceeding ninety (90) days for the member to achieve.
- Specific behavioral tasks the member must accomplish to complete each short-term and long-term goal.
- A description of the type and frequency of counseling services to be provided to the member.
- An effective date based on the day the primary counselor signed the initial treatment plan.

The primary counselor shall evaluate and update the member's maintenance treatment plan whenever necessary or at least once every three months from the date of admission. The updated treatment plan shall include:

- A summary of the member's progress or lack of progress toward each goal identified on the previous treatment plan.

- New goals and behavioral tasks for any newly identified needs, and related changes in the type and frequency of counseling services.
- An effective date based on the day the primary counselor signed the updated treatment plan.

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

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

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

Physical Examination

Physical examinations are required to ensure that members are medically stable and receive the physical health services they need to facilitate biopsychosocial well-being. Members are required to have a physical examination within the last twelve (12) months on file. The Physician, Nurse Practitioner (NP), or Physician Assistant (PA) is responsible for reviewing documentation of the most recent physical examination within 30 calendar days of the member's admission to treatment. In accordance with CCR Title 22, if the physician is unable to acquire or review a member's physical exam that has been conducted in the last twelve (12) months, the provider (registered/certified counselor or LPHA) must include a progress note detailing efforts made to obtain this documentation. If a physical examination is not on file, it must occur within thirty (30) calendar days of the members admission, or documentation to support the goal of obtaining a physical examination within a specified date of completion.

NTP/OTP Physical Examination includes:

- An evaluation of the member's organ systems for possibility of infectious diseases; pulmonary, liver, or cardiac abnormalities; and dermatologic sequelae of addiction;
- A record of the member's vital signs (temperature, pulse, blood pressure, and respiratory rate);
- An examination of the member's head, ears, eyes, nose, throat (thyroid), chest (including heart and lungs), abdomen, extremities, skin, and general appearance;
- An assessment of the member's neurological system; and
- A record of an overall impression that identifies any medical condition or health problem for which treatment is warranted.

DMC-ODS Progress Notes

Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Each progress note shall provide sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description.

For valid Medi-Cal claims, appropriate ICD diagnostic codes, as well as HCPCS/CPT codes, must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note. However, current ICD codes and HCPCS/CPT codes are not required to be included in the progress note narrative.

Progress notes for all non-group (individual) services shall include:

- The type of service rendered.
- The date that the service was provided to the member.
- Duration of direct member care for the service.
- Location/place of service.
- A typed or legibly printed name, signature of the service provider, and date of signature.
- A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk). For example, as clinically indicated the brief description may include activities or interventions that occurred during the service event, issues discussed, and progress toward treatment goals or other treatment outcomes. factors.
- A brief summary of next steps. For example, as clinically indicated next steps may include planned action steps by the provider or by the member, collaboration with the member, collaboration with other provider(s), goals and actions to address health, social, educational, and other services needed by the member, referrals, and discharge and continuing care planning.

Group services

- When a group service is rendered, a list of participants is required to be documented and maintained by the provider (see group sign-in sheets below).
- Every member shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in (2) (i-v) above.
- The progress note for the group service encounter shall also include a brief description of the member's response to the service.

Group Sign-In Sheets

A sign-in sheet is required for every group counseling session (residential treatment included):

- LPHA/Certified Counselor conducting group must type or legibly print, sign and date the sign–in sheet on the same day of the session.
- By signing, the LPHA/Counselor is certifying the sign-in sheet is accurate and complete.
- Must include date, topic, and start & end time of counseling session.
- Must include typed or legibly printed participant names and identify if they attended.
- Sign-in sheet must be signed at the start of or during session.
- Clinical groups limited to 2-12.
- Patient Education groups not limited to 2-12 rule.
- Identify Clinical or Non-Clinical (residential only).

Providers shall complete all progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0).

Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e., bundled services), such as Residential Treatment. If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.

Progress Notes

Intake- Assessments, Biopsychosocial, and Admission Include:

- The date of service.
- Start and end time.
- Duration of the service.
- Identification if service was in-person, by telephone, or telehealth.
- Location of the member at the time of receiving the service.
- Documentation of how confidentiality is ensured if service is conducted in the community.
- Overview of assessment and intake information including personal, medical and substance use history.
- Next steps include, but are not limited to, planned action steps by provider or member.
- A typed or legibly printed name, signature of the service provider, and date of signature.

Medical Necessity

- Review assessment and intake information including personal, medical and substance use history.
- Identify level of care based on ASAM criteria.
- Evaluate the member and diagnose using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).
- Document basis for diagnosis within 10 days of admission for Residential & 30 days of admission for Outpatient.
- If a member's assessment and intake information are completed by a counselor through a face-to-face review, telephone, or telehealth, the Medical Director or LPHA shall evaluate each member's assessment and intake information with the counselor to establish whether the member meets medical necessity criteria.
- Medical Director or **LPHA shall** determine whether SUD services are medically necessary within ten (10) days of admission to treatment for Residential or thirty (30) days for Outpatient based on a review of the client's personal, medical and substance use history.

Problem List/Care Plan

- Diagnoses identified by a provider acting within their scope of practice.
- Current International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.
- Problems or illnesses identified by the member and/or significant support person (SDOH).
- The name and title of the provider that identified, added, or resolved the problem.
- The date the problem was identified, added, resolved.
- The problem list shall be updated on an ongoing basis to reflect the current presentation and / or needs of the member.
- Problems must be added or resolved when there is a relevant change in the member's condition.

- Frequency of services and type of services per modality (e.g., Drug Court, Residential, Recovery services).
- Reasonable amount of time and generally accepted standards of practice include:
    - Developed within ten (**10) days** for **Residential** & thirty (**30) days** for **Outpatient.**
    - A minimum of every thirty (30) days must be reviewed and documented in the progress note.
    - The provider shall document the required elements of the care plan (type and frequency) within the member record.

Progress Notes (ODF individual) shall include:

- Type of Service.
- The date of service.
- Start and end time.
- Duration of the service that was provided to the member.
- Identification if service was in-person, by telephone, or telehealth.
- Location of the member at the time of receiving the service.
- A narrative describing the service, including how the service addressed the member's behavioral health need (i.e., an accurate picture of the member's condition, treatment provided, and response to the service provided).
- Documentation of how confidentiality is ensured if service was conducted in the community.
- Next steps include but are not limited to planned action steps by provider or member.
- Every individual or group counseling session must be written by the therapist or counselor who conducted the counseling session.
- LPHA or counselor shall type or legibly print name, signature of service provider, date of signature.
- Progress note must be written within 3 business days of counseling session and within 24 hours for crisis services.

Progress Notes (ODF group) shall include:

- Member Name
- Date of Group
- Group Time
- Duration of Group
- Service Code (must appear in the claim)
- Location of Member
- Topic of Group
- Problem Addressed from Problem list
- Service Provided in person, telephone or telehealth
- Narrative of Service
- Typed name of Counselor
- Signature of Counselor
- Date Counselor Signed

Progress Notes (IOT and Residential individual) shall include:

- (County requirement options are per day or per service note only)

Individual narrative summaries shall include:

- Type of Service.
- The date, start and end time, and duration of the service.
- Identification if service was in-person, by telephone, or telehealth.
- Location of member at the time of receiving the service.
- A narrative describing the service including how the service addressed the member's behavioral health need (i.e., an accurate picture of the member's condition, treatment provided, and response to the service provided).
- Documentation of how confidentiality is ensured if service is conducted in the community.
- Identify Clinical or Non-Clinical ** (Residential only)
- The daily note will require a record of the member's attendance at each counseling session conducted, including start and end times and topic of each counseling session.
- Written for each member participating in structured activities including counseling sessions.
- Next steps that include, but are not limited to, planned action steps by provider or member. LPHA or counselor shall type or legibly print name, signature of service provider, date of signature within 3 business days of counseling session and within 24 hours for crisis services.

Progress Notes (Group (IOT/RESI) Daily Note) shall include:

- Member Name
- Date of Group
- Group Times
- Duration of Groups
- Clinical or Non-Clinical Groups
- Location of Member
- Topic of Groups
- Problem Addressed from Problem list
- Service provided in person, telephone or telehealth
- Narrative of Services Per Group
- Typed Name of Counselor
- Professional Discipline/Credential
- Signature of Counselor
- Date Counselor Signed

Progress Note (IOT/RESI) Per Service shall include:

- Member Name
- Date of Group
- Group Time
- Duration of Group
- Location of Member
- Topic of Group
- Problem Addressed from Problem list
- Service provided in person, telephone or telehealth
- Narrative of Service
- Typed Name of Counselor
- Professional Discipline/Credential
- Signature of Counselor
- Date Counselor Signed

Progress notes for all non-group services Individual Progress Notes, Early Intervention, Care Coordination, and Peer Support Services shall include:

- The type of service rendered.
- The date that the service was provided to the member.
- Duration of direct member care for the service.
- Location/place of service.
- A typed or legibly printed name, professional discipline/credential, signature of the service provider, and date of signature.
- A brief description of how the service addressed the member's behavioral health needs (e.g., symptoms, condition, diagnosis, and/or risk 13 factors).
- A brief summary of the next steps.

Crisis is an actual relapse, or unforeseen event or circumstance causing an imminent threat of relapse. Services note shall include:

- Focus on alleviating crisis problems.
- Limited to stabilization of the emergency.
- In-person, by phone, by telehealth or in the community.
- Crisis intervention counseling progress notes shall be completed within 24 hours of service.

Discharge

Discharge Plan Note:

- The type of service rendered.
- The date that the service was provided.
- Duration of direct member care for the service.
- Location/place of service.
- A typed or legibly printed name, professional discipline/credential, signature of the service provider, and date of signature.

- A brief description of how the service addressed the member's behavioral health needs (e.g., symptoms, condition, diagnosis, and/or risk 13 factors).
- A brief summary (including reason for discharge).

Discharge Plan

The discharge plan shall be prepared within thirty (30) calendar days prior to the date of the last face-to-face treatment with the member.

The discharge Plan shall include the following:

- A description of each of the member's relapse triggers and a plan to assist the member to avoid relapses when confronted with each trigger.
- During the last face-to-face session, the plan must be completed and signed by both the therapist or counselor and the member.
- A copy of the discharge plan must be provided to the member.

NOTE: Transition ASAM must be completed within fourteen (14) days of discharge.

Discharge Summary

Once a provider has lost contact with a member, the provider shall develop a discharge summary for each member within seven (7) days of the member's discharge (last billable service).

The discharge summary completed by an AOD counselor or Healthcare Professional (HCP) shall include the following:

- Summary of the services provided.
- Date of termination of services.
- Reason for termination of services.
- Referral(s), if any.
- Description of treatment episodes.
- Description of recovery services completed.
- Current alcohol and/or other drug usage.
- Vocational and educational achievements.
- Member's plan for continued recovery including support systems and plans for relapse prevention.
- Member's prognosis.

Administrative Member Discharge:

If the Member Discharge is Involuntary the Provider must mail out a Notice of Adverse Benefit Determination (NOABD) within 24 hours of making the decision.

The provider shall inform the member of the right to a fair hearing:

- NOABD Your Rights
- Language Assistance Taglines
- Member Non- Discrimination Notice

NOABD must be provided **in writing at least 10 days prior** to an effective date of intended action to terminate or reduce services. (See NOABD Section)

During this time the member will have the right to appeal the notice.

If member returns to treatment, treatment will resume as normal.

If member does not respond or return to treatment, then provider should prepare a Discharge Summary.

Billing Services Prior to Assessment: DMC-ODS

DMC-ODS/SUDRS covered and clinically appropriate services, except residential services, are Medi-Cal reimbursable for up to thirty (30) days following the first visit with a LPHA or registered/certified Alcohol and Drug Counselor. These services are reimbursable for up to sixty (60) days if the person in care is under the age of 21, or experiencing homelessness, and therefore required additional time to complete an assessment.

Residential Billing Codes Day Service Codes and Room and Board

Room and Board service Code for Residential. 3.1, 3.3, 3.5 Remain 533 for Client only.
Room and Board service Code for Residential. 3.1, 3.3, 3.5 Remain 535 for Client with Child.
Room and Board service Code for 3.2 WM 961.

Drug Medi-Cal Day Service Code H0019 (See example below for each Residential LOC)

3.1 Residential	H0019U1
3.3 Residential	H0019U2
3.5 Residential	H0019U3
3.2 Withdrawal Management	H0012U9

Ensure to utilize the correct Level of Care Modifier when entering the service code and "Add-On" Codes

Level of Care Modifiers	
U1	Res 3.1
U2	Res 3.3
U3	Res 3.5
U7	ODF
U8	IOT
U9	3.2 WM
UA/HG	NTP/OTP

***90785 (Interactive Complexity) must be selected WITH the appropriate Level of Care Modifier when being selected as "Add-On" services to prevent denials.**
***All NON-BILLABLE local codes remain the same.**

Code	Allowable Disciplines	Billing Time Requirements	Allowable Level of Care (LOC) Modifiers	Allowable Modifiers	Place of Service Codes
90791 **Psychiatric Diagnostic Evaluation, 60 Mins** ***Psychiatric Diagnostic Eval**	LCSW ACSW CSW Candidate LCSW-CT LMFT AMFT MFT Candidate LMFT-CT LPCC APCC PCC Candidate LPCC-CT MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	31 – 1,440 minutes Claims greater than 68 minutes must use T2024 (Assessment substitute) – configured in *myAvatar*	U1, U2, U3, U7, U8, U9, UA/HG	59, 93, 95, AH, AJ, GC, HD, HL, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
90792 **Psychiatric Diagnostic Evaluation with Medical Services, 60 minutes** ***Psych Diag Eval w/med Servs**	MD/DO NP NP-CT PA	31 – 1,440 minutes Claims greater than 68 minutes must use T2024 (Assessment substitute) – configured in *myAvatar*	U1, U2, U3, U7, U8, U9, UA/HG	59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
90846 **Family Psychotherapy (Without the Patient Present)**	LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate	26 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	59, 93, 95, AH, AJ, GC, HD, HL, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27,33, 55, 57, 58, 99

***SUD Family Only Therapy 26-50 Min**	AMFT LMFT LPCC-CT PCC Candidate APCC LPCC MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD				
90847 **Family Psychotherapy (Conjoint Psychotherapy with Patient Present), 50 minutes** ***Family Psychotherapy w/pt present 50 min**	LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LPCC-CT PCC Candidate APCC LPCC MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	26 – 1,440 minutes Claims greater than 58 minutes must use T2021 (Therapy substitute) – configured in *myAvatar*	U1, U2, U3, U7, U8, U9, UA/HG	59, 93, 95, AH, AJ, GC, HD, HL, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
90849 **Multiple-family group psychotherapy, 84 minutes**	LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate	43 – 1,440 minutes Claims greater than 93 minutes must use T2021 (Therapy substitute) –	U1, U2, U3, U7, U8, U9, UA/HG	59, 95, AH, AJ, GC, HD, HL, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

***Multi-Fam Group Psychotherapy**	AMFT LMFT LPCC-CT PCC Candidate APCC LPCC MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	configured in *myAvatar*			
90882 **Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions, 15 minutes** ***SUD Medical Care Coordination**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LOT LPCC-CT PCC Candidate APCC LPCC LPT LVN MA MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9	59, AH, AJ, GC, HD, HL, HP, TD, UB	04, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

	Other (Uncertified Peer, PP, CT Trainee)				
90885 **Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes, 60 minutes** ***Psychiatric Eval of Hospital Record**	LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LPCC-CT PCC Candidate APCC LPCC MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD	31 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	59, AH, AJ, GC, HD, HL, HP, TD, TE, UB	04, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
90887 **Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, 50 minutes**	LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LOT LPCC-CT PCC Candidate APCC LPCC MD/DO NP NP-CT PA	26 – 50 minutes	U1, U2, U3, U7, U8, U9, UA/HG	59, 93, 95, AH, AJ, GC, HD, HL, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

***Explain Results to Family/Other**	PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT				
90889 **Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers, 15 minutes** ***SUD Admin Care Coordination**	LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LOT LPCC-CT PCC Candidate APCC LPCC LPT LVN MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	8 – 15 minutes	U1, U2, U3, U7, U8, U9, UA/HG	59, AH, AJ, GC, HD, HL, HP, TD, UB	04, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99202 **Office or other outpatient visit for the evaluation and management of a new patient** ***Off or Othr Outpt Vst of New Pt 15-29 Min**	MD/DO NP NP-CT PA	15 – 29 minutes	U1, U2, U3, U7, U8, UA/HG	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

99203 **Office or other outpatient visit for the evaluation and management of a new patient** ***Off or Othr Outpt Vst of New Pt 30-44 Min**	MD/DO NP NP-CT PA	30 – 44 minutes	U1, U2, U3, U7, U8, UA/HG	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99204 **Office or other outpatient visit for the evaluation and management of a new patient** ***Off or Othr Outpt Vst of New Pt 45-59 Min**	MD/DO NP NP-CT PA	45 – 59 minutes	U1, U2, U3, U7, U8	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99205 **Office or other outpatient visit for the evaluation and management of a new patient** ***Off or Othr Outpt Vst of New Pt 60 + Min**	MD/DO NP NP-CT PA	60 – 1,440 minutes Prolonged codes 99415 and 99416 are configured in myAvatar, as appropriate	U1, U2, U3, U7, U8	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99212 **Office or other outpatient visit for the evaluation and management of an established patient** ***Off/Othr Outpt Vst Est Pt (10-19 Min)**	MD/DO NP NP-CT PA	10 – 19 minutes	U1, U2, U3, U7, U8	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

99214 **Office or other outpatient visit for the evaluation and management of an established patient** ***Off/Othr Outpt Vst Est Pt (30-39 Min)**	MD/DO NP NP-CT PA	20 – 29 minutes	U1, U2, U3, U7, U8	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99215 **Office or other outpatient visit for the evaluation and management of an established patient** ***Off/Othr Outpt Vst Est Pt**	MD/DO NP NP-CT PA	40 – 1,440 minutes	U1, U2, U3, U7, U8	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99341 **Home or residence visit for the evaluation and management of a new patient, 15-29 minutes total time on the date of the encounter** ***SUD Home Visit of a New PT 15-29 Mins**	MD/DO NP NP-CT PA	15 – 29 minutes	U7, U8	27, 59, GC, HD, HP, UB	04, 12, 14, 15, 16, 33, 55, 99
99342 **Home or residence visit for the evaluation and management of a new patient, 30-59 minutes total time on**	MD/DO NP NP-CT PA	30 – 59 minutes	U7, U8	27, 59, GC, HD, HP, UB	04, 12, 14, 15, 16, 33, 55, 99

the date of the encounter ***SUD Home Visit of a New PT 30-59 Mins**					
99344 **Home or residence visit for the evaluation and management of a new patient, 60-74 minutes total time on the date of the encounter** ***SUD Home Visit of a New PT 60-74 Mins**	MD/DO NP NP-CT PA	60 – 74 minutes	U7, U8	27, 59, GC, HD, HP, UB	04, 12, 14, 15, 16, 33, 55, 99
99345 **Home or residence visit for the evaluation and management of a new patient, 75-89 minutes total time on the date of the encounter** ***SUD Home Visit of a New PT 75-89 Mins**	MD/DO NP NP-CT PA	75 – 103 minutes Prolonged code 99417 is configured in myAvatar, as appropriate	U7, U8	27, 59, GC, HD, HP, UB	04, 12, 14, 15, 16, 33, 55, 99
99347 **Home or residence visit for the evaluation and management of an established patient, 20-29 minutes total time on the**	MD/DO NP NP-CT PA	20 – 29 minutes	U7, U8	27, 59, GC, HD, HP, UB	04, 12, 14, 15, 16, 33, 55, 99

date of the encounter ***SUD Home Visit of Est Pt 20-29 Mins**					
99348 **Home or residence visit for the evaluation and management of an established patient, 30-39 minutes total time on the date of the encounter** ***SUD Home Visit of Est. Pt 30-39 Mins**	MD/DO NP NP-CT PA	30 – 39 minutes	U7, U8	27, 59, GC, HD, HP, UB	04, 12, 14, 15, 16, 33, 55, 99
99349 **Home or residence visit for the evaluation and management of an established patient, 40-59 minutes total time on the date of the encounter** ***SUD Home Visit of Est. Pt 40-59 Mins**	MD/DO NP NP-CT PA	40 – 59 minutes	U7, U8	27, 59, GC, HD, HP, UB	04, 12, 14, 15, 16, 33, 55, 99
99350 **Home or residence visit for the evaluation and management of an established patient, 60-74**	MD/DO NP NP-CT PA	60 – 88 minutes Prolonged code 99417 is configured in myAvatar, as appropriate	U7, U8	27, 59, GC, HD, HP, UB	04, 12, 14, 15, 16, 33, 55, 99

minutes total time on the date of the encounter ***SUD Home Visit of Est. Pt 60-74 Mins**					
99367 **Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30-1440 minutes; participation by physician** ***MD Consultation (30 Min)**	MD/DO	30 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	27, 59, 93, 95, GC, HD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99368 **Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30-1440 minutes; participation by nonphysician qualified health care professional** ***Clinical Consult (30 Min)**	LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LPCC-CT PCC Candidate APCC LPCC MA NP NP-CT PA	30 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	27, 59, 93, 95, AH, AJ, HD, HL, HP, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

	PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT				
99408 **Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minute** ***SUD Screen/Brief Intervention 15-30 Min**	MD/DO NP NP-CT PA	15 – 30 minutes	U1, U2, U3, U7, U8, UA/HG	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99409 **Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 31-1440 minutes** ***SUD Screen/Brief Intervention 30+ Mins**	MD/DO NP NP-CT PA	31 – 1,440 minutes	U1, U2, U3, U7, U8, UA/HG	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

99495 **Transitional Care Management Services, face-to-face visit within 14 calendar days of discharge, 54 minutes** ***SUD TC Within 14 Days**	MD/DO NP NP-CT PA	28 – 54 minutes	U1, U2, U3, U7, U8, U9, UA/HG	27, 59, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 33, 99
99496 **Transitional Care Management Services, face-to-face visit within 7 calendar days of discharge, 75 minutes** ***SUD TC Within 7 Days**	MD/DO NP NP-CT PA	38 – 75 minutes	U1, U2, U3, U7, U8, U9, UA/HG	27, 59, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 33, 99
G0396 **Alcohol and/or substance (other than tobacco) abuse structured assessment, 15-30 Minutes** ***SUD Assessment 15-30 Min ASAM Criteria**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LPCC-CT PCC Candidate APCC LPCC LPT	15 – 30 minutes	U1, U2, U3, U7, U8, U9, UA/HG	59, AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 16, 27, 33, 55, 57, 58, 99

	LVN MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)				
G0397 **Alcohol and/or substance (other than tobacco) abuse structured assessment, 31-1440 Minutes** ***SUD Assessment 30+Mins ASAM Criteria**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LPCC-CT PCC Candidate APCC LPCC LPT LVN MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT Other (Uncertified	31 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	59, AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 16, 27, 33, 55, 57, 58, 99

	Peer, PP, CT Trainee)				
G2011 **Alcohol and/or substance (other than tobacco) abuse structured assessment, 5-14 Minutes** ***SUD Assessment 5-14 Min**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LPCC-CT PCC Candidate APCC LPCC LPT LVN MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)	5 – 14 minutes	U1, U2, U3, U7, U8, U9, UA/HG	59, AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 16, 27, 33, 55, 57, 58, 99
H0001 **Alcohol and/or drug assessment, 15 minutes** ***SUD ASAM Screening**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 16, 27, 33, 55, 57, 58, 99

	LOT LPCC-CT PCC Candidate APCC LPCC LPT LVN MA MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)				
H0003 **Alcohol and/or drug screening. Laboratory analysis of specimens for presence of alcohol and/or drugs, 15 minutes** ***SUD Drug Test Screen Lab Analysis**	LPT LVN MA MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, AU/HG	AH, GC, HD, HG, HL, HP, TD, UA, UB	04, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
H0004 **Behavioral health counseling and therapy, 15 minutes**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

***SUD 1:1 CSL**	MFT Candidate AMFT LMFT LOT LPCC-CT PCC Candidate APCC LPCC MD/DO NP NP-CT PA PhD- CT/PsyD-CT PhD/PsyD WPhD/WPsy D RN RN-CT				
H0005 **Alcohol and/or drug services; group counseling by a clinician, 15 minutes** ***SUD Group Counseling**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LOT LPCC-CT PCC Candidate APCC LPCC MD/DO NP NP-CT PA PhD- CT/PsyD-CT PhD/PsyD WPhD/WPsy D RN	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

	RN-CT				
H0007 **Alcohol and/or drug services; crisis intervention (outpatient), 15 minutes** ***SUD Crisis Intervention Service (Per 15 mins)**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LOT LPCC-CT PCC Candidate APCC LPCC LPT LVN MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, TD, UB	04, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
H0025 **Behavior health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior) [Peer**	Certified Peer	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	HD, SC, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

Support group session], 15 minutes ***Peer Services Group**					
H0033 **Medication administration, direct observation, 15 minutes** ***Med Admin Direct Obsrv (15 min)**	LOT LPT LVN MA MD/DO NP NP-CT PA RN RN-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	GC, HD, HP, TD	04, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
H0034 **Medication training and support, 15 minutes** ***Med Trng Suprt (15 min)**	LPT LVN MA MD/DO NP NP-CT PA RN RN-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	GC, HD, HP, HQ, TD	02, 04, 10, 11, 12, 14, 16, 27, 33, 55, 57, 58, 99
H0038 **Self-help/peer services (individual), 15 minutes** ***Self-help/Peer Services (15 min)**	Certified Peer	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	HD, SC, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
H0048 **Alcohol and/or other drug testing. Collection and handling only,**	LPT LVN MA MD/DO NP NP-CT PA RN	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	GC, HD, HP, TD, UB	04, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

specimens other than blood, 15 minutes ***SUD Point of Care Test**	RN-CT				
H0049 **Alcohol and/or drug screening, 15 minutes** ***SUD Alcohol and/or Drug Screening**	AOD LCSW-CT CSW Candidate ACSW LCSW LMFT-CT MFT Candidate AMFT LMFT LPCC-CT PCC Candidate APCC LPCC LPT LVN MA MD/DO NP NP-CT PA PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
H0050 **Alcohol and/or Drug Services, brief**	AOD LCSW-CT CSW Candidate ACSW LCSW	8 – 1,440 minutes	U7, U8, UA/HG	HD, HF, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

intervention, 15 minutes ***SUD Recovery Incentives Svcs**	LMFT-CT MFT Candidate AMFT LMFT LOT LPCC-CT PCC Candidate APCC LPCC LPT LVN MD/DO NP NP-CT Other (Uncertified Peer, PP, CT Trainee) PA Certified Peer PhD-CT/PsyD-CT PhD/PsyD WPhD/WPsyD RN RN-CT				
H1000 **Prenatal Care, at risk assessment, 15 minutes** ***SUD Prenatal Care at Risk Assessment**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LPCC LPCC-CT APCC PCC Candidate LPT LVN MD/DO NP NP-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

	PA PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)				
H2011 with Place of Service 15 **Mobile Crisis, per encounter** ***Crisis Intervention Service (15 min)**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LPCC LPCC-CT APCC PCC Candidate LOT LPT LVN MA MD/DO NP NP-CT PA PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)	8 – 360 minutes	U7, U8, UA/HG	GT, HD, HW, SC, UB	15
H2014 **Skills training and**	AOD LCSW LCSW-CT ACSW	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9	AJ, GC, HD, HP, HL, HP, HQ, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

development, 15 minutes ***SUD Patient Education Services (15 min)**	CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT LVN MA MD/DO NP NP-CT PA PhD/PsyD WPhD/WPsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)				
H2015 **Comprehensive community support services, 15 minutes** ***SUD Comprehensive Community Supp SVC**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT LVN MD/DO NP NP-CT PA	8 – 1,440 minutes	U6 + (LOC must also be included): U1, U2, U3, U7, U8, U9, UA/HG	AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

	RN RN-CT Other (Uncertified Peer, PP, CT Trainee)				
H2017 **Psychosocial rehabilitation services, 15 Minutes** ***Psychosocial Rehab (15 min)**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT LVN MA MD/DO NP NP-CT PA Other (Uncertified Peer, PP, CT Trainee)	8 – 1,440 minutes	U6 + (LOC must also be included): U1, U2, U3, U7, U8, U9, UA/HG	AJ, GC, HD, HL, HP, HQ, SC, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
H2021 **Community-based wrap-around services (coordination with other programs),15 minutes** ***Community-Bsd Wrap-around Servs (15 min)**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

	LVN MA MD/DO NP NP-CT PA RN-CT RN Other (Uncertified Peer, PP, CT Trainee)				
H2027 **Psychoeducational Service, 15 minutes** ***SUD Psychosocial Rehab (15 min)**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT LVN MA MD/DO NP NP-CT PA PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD Other (Uncertified Peer, PP, CT Trainee)	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
H2035 **Alcohol and/or other drug treatment program, per hour**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT	31 – 1,380 minutes	U6 + (LOC must also be included): U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

***SUD RS Individual Counseling**	LMFT-CT AMFT MFT Candidate LPCC LPCC-CT APCC PCC Candidate LPT LVN MD/DO NP NP-CT PA PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD Other (Uncertified Peer, PP, CT Trainee)				
T1006 **Alcohol and/or substance abuse services, family/couple counseling, 15 minutes** ***SUD Family/Couple Counseling**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LPCC LPCC-CT APCC PCC Candidate MD/DO NP NP-CT PA PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD RN RN-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

T1007 **Alcohol and/or substance abuse services, treatment plan development and/or modification, 15 minutes** ***SUD Discharge Planning**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT LVN MD/DO NP NP-CT PA PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD RN RN-CT	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
T1013 **Sign language or oral interpretive services, 15 minutes** ***Sign Language/Oral Interpretation Serv (8-15)**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT LVN MA MD/DO NP	**Must be the exact time as the primary service billed.**	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

	NP-CT PA PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)				
T1017 **Targeted case management, 15 minutes** ***Targeted Case Management (15 min)**	AOD LCSW LCSW-CT ACSW CSW Candidate LMFT LMFT-CT AMFT MFT Candidate LOT LPCC LPCC-CT APCC PCC Candidate LPT LVN MA MD/DO NP NP-CT PA PhD-CT/PsyD-CT WPhD/WPsyD PhD/PsyD RN RN-CT Other (Uncertified Peer, PP, CT Trainee)	8 – 1,440 minutes	U1, U2, U3, U7, U8, U9, UA/HG	AH, AJ, GC, HD, HL, HP, SC, TD, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99
99415 **Prolonged clinical staff**	MD/DO NP NP-CT PA	30 – 60 minutes	U1, U2, U3, U7, U8	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

service during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour ***Prolonged EM, First Hour**					
99416 **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes** ***Prolonged EM each +30 mins**	MD/DO NP NP-CT PA	75 – 1,440 minutes	U1, U2, U3, U7, U8	27, 59, 93, 95, GC, HD, HP, UB	02, 04, 10, 11, 12, 14, 15, 16, 27, 33, 55, 57, 58, 99

*myAvatar Service Code Description

Functionality of myAvatar's Service Codes

To simplify service data entry, minimize errors, and ensure accuracy within the electronic health record, myAvatar contains functionality to:

Automate Add-Ons to Prolong Services

myAvatar will automatically create Add-On code(s) to prolong duration for primary codes entered with a service duration that extends beyond the maximum allowed for the primary code.

This functionality is available **for manual data entry and file import uploads only**; it is not available for services submitted via CBO837 electronic file uploads.

Add-ons that do not prolong duration, such as 90785, 90887, and T1013, should be added manually in the appropriate section (of the form or the import file).

Automated Add-Ons functionality is available for the codes in the table below.

MH or SUD	Primary Code	Description - Primary Code	Add-On Code	Description - Add-On Code
MH	90839	PSYCHOTHERAPY FOR CRISIS FIRST 30-74	90840	PSYCHOTHERAPY FOR CRISIS (ADDL 30 MIN)
Both	99205**	OFFC OR OTHR OUTPT VST NEW PT 60 + MIN	99415/ 99416	PROLONGED EM FIRST HOUR/ PROLONGED EM +30 MINS
Both	99215**	OFFC/OTHR OUTPT VST EST PT	99415/ 99416	PROLONGED EM FIRST HOUR/ PROLONGED EM +30 MINS
MH	96130	PSYCHOLOGICAL TESTING EVAL 1ST HOUR	96131	PSYCHOLOGICAL TESTING EVAL Additional Hour
MH	96132	NEUROPSYCHOLOGICAL TEST EVAL 1ST HOUR	96133	NEUROPSYCHOLOGICAL TEST EVAL Additional Hour
MH	96136	PSYCH OR NEURO TEST EACH 30 Mins.	96137	PSYCH OR NEURO TEST EACH Additional 30 mins

** County Clinics: See related information in the *Time-based Series 'X' Codes* section ahead.

Data Entry Details

Manual Entry

Users entering services manually using clinical documentation (County only), or *Client Charge Input* will enter:

Primary CPT code only

Full face-to-face duration of the service in the appropriate field

File Import

Report the code in the *Service Code* field (column 2), and the full face to face duration of the service in the *Duration* field (column 9).

Important Note for CBO837 Users

CBO837 submitters must report both the Primary and Add-On codes as separate service lines within the same claim.

Automate Substitute Codes T2021 and T2024

myAvatar will automatically claim the appropriate substitute code (T2021 or T2024) for Therapy or Assessment services when the service duration extends beyond the maximum allowed duration for the code.

This functionality is available for all types of data entry.

Automated Substitute Codes are available for the codes in the table below.

MH or SUD	Code	Description	Substitute Code
Both	90847	FAMILY PSYCHOTHERAPY W/PT PRESENT 50 MIN	T2021
Both	90849	MULTI-FAM GROUP PSYCHOTHERAPY	T2021
Both	90792	PSYCH DIAG EVAL W/MED SERVS	T2024
Both	90791	PSYCHIATRIC DIAGNOSTIC EVAL	T2024
Both	90885	PSYCHIATRIC EVAL OF HOSPITAL RECORD	T2024
MH	96105	MH ASSESSMENT OF APHASIA (60 MIN)	T2024
MH	96127	MH BRIEF EMOTIONAL/BEHAV. ASSESS (15 MIN)	T2024
MH	96110	MH DEVELOPMENTAL SCREENING (15 MIN)	T2024
MH	90853	MH GROUP PSYCHOTHERAPY	T2021
MH	90845	MH PSYCHOANALYSIS (15 MIN)	T2021
MH	90837*	MH PSYCHOTHERAPY WITH PATIENT (53-60)	T2021
MH	96125	MH STAND. COGNITIVE PERFORM TEST (PER HR)	T2024

* County Clinics: See related information in the *Time-based Series 'X' Codes* section ahead.

Data Entry Details

Manual Entry

Users entering therapy or assessment services in myAvatar via clinical documentation or *Client Charge Input*, will enter the Therapy or Assessment code in the *Service Code* field, and the full face to face duration of the service in the *Face to Face (Minutes)* field.

File Import

Records for Therapy or Assessment services should contain the Therapy or Assessment code in the *Service Code* field (column 2), and the full face to face duration of the service in the *Duration* field (column 9).

CBO837

Provide the Therapy or Assessment code and the full face-to-face duration (in minutes) of the service in the service line.
Only County Clinics have access to the codes described in the following section.

Time-based Series 'X' Codes

In myAvatar, codes 9083X, 9920X, and 9921X represent series of time-based consecutive codes. These 'X' codes are used instead of the individual codes within each series, normally selected according to the duration of face-to-face service. These codes eliminate the need for users to memorize the specific time thresholds for each code. Instead, users input the total face-to-face time in the *Face to Face (Minutes)* field, and myAvatar automatically assigns the correct CPT code for claim submission.

Code	Description	Code to use	Description
90832	MH PSYCHOTHERAPY WITH PATIENT (16-37)	9083X*	MH PSYCHOTHERAPY WITH PATIENT 16-60 MIN
90834	MH PSYCHOTHERAPY WITH PATIENT (38-52)	9083X	MH PSYCHOTHERAPY WITH PATIENT 16-60 MIN
90837*	MH PSYCHOTHERAPY WITH PATIENT (53-60)	9083X	MH PSYCHOTHERAPY WITH PATIENT 16-60 MIN
99202	OFFC OR OTHR OUTPT VST OF NEW PT 15-29 MIN	9920X	OFFC/OTHR OUTPT VST NEW PT 15+ MIN
99203	OFF/OTHR OUTPT VST NEW PT 30-44 MIN	9920X	OFFC/OTHR OUTPT VST NEW PT 15+ MIN
99204	OFFC OR OTHR OUTPT VST NEW PT 45-59 MIN	9920X	OFFC/OTHR OUTPT VST NEW PT 15+ MIN
99205**	OFFC OR OTHR OUTPT VST NEW PT 60 -74 MIN	9920X**	OFFC/OTHR OUTPT VST NEW PT 15+ MIN
99212	OFFC/OTHR OUTPT VST EST PT (10-19 MIN)	9921X	OFFC/OTHR OUTPT VST EST PT
99213	OFFC/OTHR OUTPT VST EST PT (20-29 MIN)	9921X	OFFC/OTHR OUTPT VST EST PT
99214	OFFC/OTHR OUTPT VST EST PT (30-39 MIN)	9921X	OFFC/OTHR OUTPT VST EST PT
99215*	OFFC/OTHR OUTPT VST EST PT (40-54 MIN)	9921X**	OFFC/OTHR OUTPT VST EST PT

Time-based Series 'X' Codes available in myAvatar:
If duration entered for 9083X is between 68-1440 minutes, myAvatar will automatically claim substitute code T2021.
If duration entered for 9920X or 9921X is higher than the maximum allowed for 99205 (74 minutes) or 99215 (54 minutes), myAvatar will automatically add the add-on code(s) 99415/99416 as needed.

Alternate Codes

County clinics have access to alternate versions of codes in myAvatar. These alternate codes are configured to include modifiers on the claims.
Some alternate versions of codes require specific Location Codes to receive cost of service and claim.

Examples of alternate codes:

MH or SUD	Code	Description	Modifier	Location
MH	90791HK	MH PSYCHIATRIC DIAGNOSTIC EVAL	HK	Any allowed
SUD	90791U7	ODF/EI PSYCHIATRIC DIAGNOSTIC EVAL	U7	Any allowed
MH	9079295	MH PSYCH DIAG EVAL W/MED SERVS	95	Must use 02 or 10
SUD	H2017U8HQ	IOT PSYCHOSOCIAL REHABILITATION, PER 15 MINUTES-GROUP	U8, HQ	Any allowed
MH	90837XHK	MH PSYCHOTHERAPY WITH PATIENT 16-60 MIN (9083XHK)	HK	Any allowed
SUD	9920XU8	SUD IOT OFFC/OTHR OUTPT VST NEW PT 15 + MIN	U8	Any allowed
SUD	H2017U8HQ	IOT PSYCHOSOCIAL REHABILITATION, PER 15 MINUTES-GROUP	U8, HQ	
SUD	H0001U8SC	SUD IOT ASAM SCREENING-PHONE ONLY	U8, SC	Must use 02 or 10
MH	9083XHK9359	MH PSYCHOTHERAPY WITH PATIENT 16-60 MIN	HK, 93, 59	Must use 02 or 10
MH	9921XQI5995	MH OFFC/OTHR OUTPT VST EST PT	HV, 59, 95	Must use 02 or 10

NOTE: Alternate codes for discipline-related modifiers (such as those for clinical trainees or disciplines not qualifying as Medicare providers) are unnecessary because myAvatar automatically applies these modifiers based on the individual delivering the service. Users should not manually enter discipline-related modifiers or include them in upload files.

Addendum I

DBH-System of Care Allowable Disciplines

MH/ SUD	Provider Disciplines	Provider Disciplines Abbreviated
MH/SUD	Alcohol and Other Drug Counselor	AOD
MH/SUD	Community Health Worker	CHW
MH/SUD	Licensed Clinical Social Worker Clinical Trainee	LCSW-CT
MH/SUD	Clinical Social Worker Candidate (Contractors)	CSW Candidate
MH/SUD	Registered Associate Clinical Social Worker	ACSW
MH/SUD	Licensed Clinical Social Worker	LCSW
MH/SUD	Licensed Marriage and Family Therapist Clinical Trainee	LMFT-CT
MH/SUD	Marriage and Family Therapist Candidate (Contractors)	MFT Candidate
MH/SUD	Registered Associate Marriage and Family Therapist	AMFT
MH/SUD	Licensed Marriage and Family Therapist	LMFT
MH/SUD	Licensed Occupational Therapist	LOT
MH/SUD	Licensed Professional Clinical Counselor Clinical Trainee	LPCC-CT
MH/SUD	Professional Clinical Counselor Candidate (Contractors)	PCC Candidate
MH/SUD	Registered Associate Professional Clinical Counselor	APCC
MH/SUD	Licensed Professional Clinical Counselor	LPCC
MH/SUD	Licensed Psychiatric Technician	LPT
MH/SUD	Licensed Vocational Nurse	LVN
MH/SUD	Medical Assistant	MA
MH	Medical Student in Clerkship	MD/DO-Clerks
MH/SUD	Medical Doctor/Doctor of Osteopathy (Physician)	MD/DO
MH	Medical Resident/Fellow	MD/DO
MH	Mental Health Rehabilitation Specialist:	MHRS
MH	Social Worker II	SWII
MH	BSW Student Intern	BSW

MH	Occupational Therapy Assistant	OTA
MH	Pre-licensed Clinical Therapist Trainee (DBH)	CT Trainee
MH/SUD	Nurse Practitioner Clinical Trainee	NP-CT
MH/SUD	Nurse Practitioner	NP
MH/SUD	Other Qualified Provider:	Other
MH/SUD	Uncertified Peer and Family Advocate/Peer Specialist	Uncertified Peer
MH/SUD	Parent Partner	PP
MH	Case Manager/Care Coordinator (Contractors & ECM)	CM
MH	Mental Health Specialist	MHS
SUD	Pre-licensed Clinical Therapist Trainee (DBH)	CT Trainee
MH/SUD	Peer Specialist	Certified Peer
SUD	Physician Assistant (Contractors)	PA
MH/SUD	Psychologist Clinical Trainee	PhD-CT/PsyD-CT
MH/SUD	Waivered Psychologist	WPhD/WPsyD
MH/SUD	Psychologist	PhD/PsyD
MH/SUD	Registered Nurse Clinical Trainee	RN-CT
MH/SUD	Registered Nurse	RN

Addendum II

Allowable Modifiers

MH/SUD	Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
MH	22	Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code.	Use this Modifier to specify that Parent Child Interaction Therapy (PCIT) services were performed.	90832, 90834, 90837

MH/SUD	27	**Multiple Outpatient Hospital Evaluation and Management (E/M) Encounters on the Same Date:** For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level of outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic).	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The lockout codes that can be overridden are listed in Column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have ** next to them in the Service Table. This modifier needs to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because SDMC compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	This modifier will only be used with CPT codes that are part of an over-ridable lockout combination.

MH/SUD	59	**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have * or ** next to them. This modifier is also to be used by any appropriate professional to override a 24-hour or day duplicate services lockout for S9484 (crisis stabilization).	This modifier will be used with: -CPT codes that are part of an over-ridable lockout combination -S9484

MH/SUD	93	**Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunication System:** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified professional. The totality of the communication of information exchanged between the physician or other qualified health care professional during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.	Use this modifier when a health care professional is providing services and benefits via telephone. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.	This modifier will be used with CPT codes that can be provided in a telehealth place of service and via telephone.

MH/SUD	95	**Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunication System.** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.	Use this modifier when a health care professional is providing services and benefits via telehealth. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.	This modifier will be used with CPT codes that can be provided in a telehealth place of service.
MH/SUD	AH	Clinical psychologist	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to become a psychologist.	This modifier only applies to taxonomy code 3902 if the service was performed by Clinical Trainees in the discipline of Psychology.

MH/SUD	AJ	Clinical social worker	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to become an LCSW, MFT, or LPCC.	This modifier only applies to taxonomy code 3902 if the service was performed by Clinical Trainees in the following disciplines: Social Work, Marriage and Family Therapy, Professional Counseling.
MH/SUD	GC	This service has been performed in part by a resident under the direction of a teaching physician.	For services that require Medicare COB and are performed by physician residents, use this modifier to bypass the Medicare COB requirement. Medicare does not reimburse for services rendered by residents. For claims that do not require Medicare COB and are performed by residents, use of the GC modifier is not required. When using this modifier, if the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising physician's NPI would be reported with modifier GC after the service to indicate that the service was performed by a resident. If the service was performed by a pre-licensed professional who is not a resident, use the HL modifier.	
SUD	GT	Via telehealth in 24-hour or day facilities or as part of mobile crisis.	Use this modifier on day, 24-hour or mobile crisis, transportation mileage or transportation staff time claims when the service was provided via telehealth.	This modifier only applies to HCPCS codes H2011 with POS 15, A0140, and T2007
MH	HA	Child/adolescent program	Use this modifier when billing for Children's Crisis Residential Program (CCRP) services or psychiatric inpatient: administrative day under 21.	

MH	HB	Adult program, non-geriatric	Use this modifier when billing for crisis residential treatment services provided to adults from 18 through 64 years of age.	
MH	HC	Adult program, geriatric	Use this modifier when billing for crisis residential treatment services provided to adults 65 years of age.	
MH	HE	Mental health program	Use this modifier when billing for 24-hour and day services. For additional information about when this modifier is required refer to service table 1. Do not use this modifier when claiming for outpatient services.	
MH	HK	Specialized mental health programs for high-risk populations	Use this modifier to indicate that an IHBS, ICC, and/or CFT service was provided.	

MH/SUD	HL	Intern/Registered Associates	For services that require Medicare COB and are performed by registrants/interns who are working in clinical settings under supervision to obtain licensure, use this modifier to bypass the Medicare COB requirement. Also use this modifier to indicate that the service was performed by a fully licensed MFT or LPCC who does not meet the requirements of Section 4121, Division F of the federal Consolidated Appropriations Act and are therefore not Medicare-recognized providers. Medicare does not reimburse for services rendered by registrants/interns or by non-Medicare recognized providers. For claims that do not require Medicare COB and are performed by registrant(s)/intern(s) or MFTs/LPCCs who are not Medicare-recognized, use of the HL modifier is not required. When using this modifier, if the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising clinician's NPI would be reported with modifier HL after the service to indicate that the service was performed by a pre-licensed professional. If the service was performed by a resident, use the GC modifier.	Services provided by individuals who are currently registered with the applicable Board or by MFTs/LPCCs who are licensed but do not meet Medicare's requirements to register as Medicare providers (ACSW, AMFT, APCC).

MH/SUD	HP	Doctoral level	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to become an advanced practice nurse (Nurse Practitioner or Clinical Nurse Specialist).	This modifier only applies to taxonomy code 3902 the service was performed by Clinical Trainees who are studying to be advanced practice nurses (NPs and CNS).
MH/SUD	HQ	Group setting	Use this modifier to indicate that a service was provided in a group setting.	For specific codes that take this modifier, refer to the Service Table.
MH	HV	This service is provided as a result of a federal mandate and the State covers 50 percent of the nonfederal share, as the service was determined to be covered under Proposition 30. Please note that this definition does not correspond to the national description reference; the definition reflects state policy.	Use this modifier to identify services that the county provided as a result of a **federal** mandate that is subject to Proposition 30.	To be used by Wraparound providers only.
MH/SUD	HW	This service is provided as a result of a State mandate and the State covers 100 percent of the nonfederal share, as the service was determined to be covered under Proposition 30.	Use this modifier to identify services that the county provided as a result of a **state** mandate that are subject to Proposition 30.	To be used by ChRIS providers only.

MH/SUD	SC	Valid for codes when the service was provided via telephone or audio-only systems.	Modifier SC is used only with HCPCs codes and to indicate that the service was provided via telephone or audio-only. If using the SC modifier, the place of service must be 02 or 10, unless the service is mobile crisis. With HCPCS codes, if the service is in POS 02 or 10 but does not have the SC modifier, the telehealth service is video/audio.	This modifier only applies to HCPCS codes when telephone services are being provided.
MH/SUD	TD	Registered Nurse	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to be a Registered Nurse.	This modifier only applies to taxonomy code 3902 if the service was performed by Clinical Trainees in the field of Registered Nursing.
MH/SUD	TG	Complex/high tech level of care	Use this modifier when billing for day treatment intensive and crisis stabilization. For additional information about when this modifier is required refer to the Service Table. Do not use this modifier when claiming for outpatient services.	
SUD	HD	Pregnant/Parenting women's program	All claims must have an HD modifier when service is provided to a woman who is pregnant/postpartum.	N/A
SUD	HF	Identifies when Contingency Management Services were provided as part of a Substance Use Disorder Program	Use this modifier to bill for Contingency Management Services, 15 minutes (H0050).	H0050 (contingency management)

SUD	HG	Opioid treatment program (OTP)	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. All claims must have HG (and UA) modifier when the service is provided in NTP Setting.	N/A
SUD	U1	ASAM 3.1 Residential (RES)	Clinically Managed Low - Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	N/A
SUD	U2	ASAM 3.3 Residential (RES)	Clinically Managed Population - Specific High Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	N/A
SUD	U3	ASAM 3.5 Residential (RES)	Clinically Managed High Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.	N/A

SUD	U4	Ambulatory withdrawal management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision. This modifier does not represent a “level of care”. It represents a certain service within one of the levels of care.	N/A
SUD	U5	Ambulatory withdrawal management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation. This modifier does not represent a “level of care”. It represents a certain service within one of the levels of care.	N/A
SUD	U6	Recovery Services	Recovery services that can be provided in all settings (ODF, IOT, PH, OTP/NTP, RES 3.1 & 3.3, 3.5, 3.2 WM). This modifier does not represent a “level of care”. It represents classification of service for within one of the levels of care.	N/A
SUD	U7	Outpatient Services (ODF)	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.	N/A
SUD	U8	Intensive Outpatient Services (IOT)	Nine or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.	N/A
SUD	U9	Residential Withdraw Management, ASAM 3.2	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	N/A

SUD	UA	ASAM OTP/NTP	All claims must include an UA (and an HG) modifier when service is provided in NTP setting.	N/A
SUD	UB	ASAM 2.5 Partial Hospitalization	Partial hospitalization services, 20 or more hours of service/week for multidimensional instability not requiring 24-hour care.	N/A

Addendum III

DBH System of Care Place Service Codes

MH/ SUD	Place of Service Code	Place of Service Name	Place of Service Description
MH/SUD	02	Telehealth provided other than in patient's home (Telehealth Not In Client's Home)	The location where service and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
MH	03	School	A facility whose primary purpose is education.
MH/SUD	04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
MH	09	Prison/Correctional Facility (Jail)	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
MH/SUD	10	Telehealth Provided in Patient's Home (Telehealth in Client's Home)	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
MH/SUD	11	Office (DBH/Contractor Site – Office)	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
MH/SUD	12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.

MH/SUD	14	Group Home	A residence with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial services, and minimal services (e.g., medication administration).
MH/SUD	15	Mobile Unit	A facility/unit that moves from place to place equipped to provide preventive screening, diagnostic, and/or treatment services.
MH/SUD	16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care and which is not identified by any other Place of Service code.
MH	20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
MH	23	Emergency Room — Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
MH/SUD	27	Outreach Site/Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.
MH	31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a hospital.
MH/SUD	33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
MH	51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
MH	52	Psychiatric Facility—Partial Hospitalization (Psych Facility—Partial Hospitalization)	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

MH/SUD	55	Residential Substance Abuse Treatment Facility (Residential Care/Comm Treatment Fac)	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
MH	56	Psychiatric Residential Treatment Center (Psych Res Tx Center)	A facility or a distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
MH/SUD	57	Non-residential Substance Abuse Treatment Facility (Non-Res SA Tx Facility)	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
MH/SUD	58	Non-residential Opioid Treatment Facility (Non-Res Opioid Tx Facility)	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).
MH/SUD	99	Other (Other Place of Service)	Other place of service not identified above.

Addendum IV

DBH Acronyms/Abbreviations

Acronym/Abbreviation	Description
0-5 CTS	0-5 Comprehensive Treatment Services
AAP	Adoption Assistance Program
ABGAR	Annual Beneficiary Grievance and Appeals Report
ACBO	Association of Community Based Organizations
AAHCPAD	American Academy of Health Care Providers in the Addictive Disorders
AAMFT	American Association of Marriage and Family Therapy
AB	Assembly Bill
ABC	Augmented Board and Care
ACA	Against Clinical Advice
ACA	Affordable Care Act
ACCP	Adult Community Services Program
ACE	Access, Coordination and Enhancement
ACE	Adverse Childhood Experience
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
AEVS	Automated Eligibility Verification System
AI/AN	American Indian/Alaskan Native
AIDS	Acquired Immune Deficiency Syndrome
AJMCC	Administrative Joint Management Coordination Committee
AMA	Against Medical Advice
AMA	American Medical Association
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
AOD	Alcohol and Other Drugs
AP	Accounts Payable
APA	American Psychological Association
APA	American Planning Association
APPIC	Association of Psychology Postdoctoral and Internship Centers
APR	Annual Progress Report
APR	Annual Program Review
APS	Association of Psychological Science
AR	Accounts Receivable
AR/UR	Authorization Review/Utilization Review Unit
ARC	American Red Cross
ARMC	Arrowhead Regional Medical Center
ARRA	American Recovery and Reinvestment Act
ACCP	Adult Continuing Care Program
ASAM	American Society of Addiction Medicine
ASC	Administrative Subcommittee of Wraparound
ASC	Accredited Standards Committee
ASG	Application Support Group
ASPE	Assistant Secretary for Planning and Education (Federal)

ASW	Associate of Social Worker (registered with Board)
ATC	Auditor Controller/Treasurer/Tax Collector
Attn	Attention
avg	Average
AWOL	Absent Without Leave
BA	Bachelor of Arts
BAC	Blood Alcohol Content
BAI	Board Agenda Item
BBS	Board of Behavioral Sciences
BC	Board Certified
Beh	Behavior
BG	Block Grant
BHC	Behavioral Health Commission
BHICCI	Behavioral Health Integration Initiative
BIC	Benefits Identification Card
BOC	Board of Corrections
BOS	Board of Supervisors
BPC	Business and Professions Code
BRN	Board of Registered Nursing
BSNLRP	Bachelor of Science Nursing Loan Repayment Program
Bx	Behavior
c/o	Care of
c/o	Complains of
CA	Cancer
CAADAC	California Association of Alcoholism and Drug Abuse Counselors
CAADE	California Association for Alcohol/Drug Educators
CAAHL	Child and Adult Abuse Hotline
CAARR	California Association of Addiction Recovery Resources
CAC	California Administrative Code
CAC	Children's Assessment Center
CADDTP	California Association of Drinking Driver Treatment Programs
CADPAAC	County Alcohol and Drug Program Administrators Association of California
CADTP	California Association of DUI Treatment Programs
CalHFA	California Housing Finance Agency
CalMHSA	California Mental Health Services Authority (Joint Powers Authority)
CalOMS	California Outcomes Measurements System
CalSWEC	California Social Work Education Commission
CAMFT	California Association of Marriage and Family Therapists
CANS	Child and Adolescent Needs and Strengths
CANS-SB	Child and Adolescent Needs and Strengths -San Bernardino
CAO	County Administrative Officer
CAPIC	California Psychology Internship Council
CAPTS	Child Abuse Prevention and Treatment Services
CARF	Commission on Accreditation of Rehabilitation Facilities
CASE	Coalition Against Sexual Exploitation
CASRA	California Association of Social Rehabilitation
CATC	Certified Addictions Treatment Counselor
CBHDA	County Behavioral Health Directors Association of California
CBMCS	California Brief Multicultural Scale Based Training

CBO	Community Based Organization
CBT	Cognitive Behavior Therapy
CC3	CCura3
CCAC	Cultural Competency Advisory Committee
CCAPP	California Consortium of Addiction Programs and Professionals
CCBCDC	California Certification Board of Chemical Dependency Counselors
CCD	Confidentiality of Care Document
CCICMS	Centralized Children's Intensive Case Management Services
CCL	Community Care Licensing
CCN	County Client Number
CCP	California Code of Civil Procedure
CCR	California Code of Regulations
CCR	Continuum of Care Reform
CCRT	Community Crisis Response Teams
CCS	California Children's Services
CCT	Care Coordination Team
CCTRO	Cultural Competency, Training, Retention & Outreach
CD	Chemical Dependency
CD	Conduct Disorder
CDBG	Community Development Block Grants
CDC	Centers for Disease Control
CDC	Central Detention Center
CDCI	Comprehensive Drug Court Implementation
CDCI	Corrected Data Charge Invoice
CDCR	California Department of Corrections and Rehabilitation
CDI	Charge Data Invoice
CDS	Client Data System
CE	Continuing Education
CEO	County Executive Officer
CEOP	County Emergency Operation Plan
CEU	Continuing Education Unit
CFR	Code of Federal Regulations
CFRA	California Family Rights Act
CFS	Children and Family Services (County)
CFT	Child Family Team
CFTM	Child & Family Team Meeting
CHAS	Centralized Hospital Aftercare Services
CHD	Community Housing and Development (County)
CHIP	Children's Health Insurance Program
CHOICE	Choosing Health Options to Instill Change and Empowerment
ChRIS	Children Residential Intensive Services
CIMH	California Institute for Mental Health
CIN	Client Index Number
CIS	Children’s Intensive Services
CIT	Crisis Intervention Training
CITA	Court for Individualized Treatment of Adolescents
CIU	Conservatorship Investigation Unit
CL	Club Live
CLAS	Culturally and Linguistically Appropriate Service

CLC	California Labor Code
clt	Client
CM	Case Management
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CNMHC	California Network of Mental Health Clients
CO	Certifying Organizations
COB	Close of Business
COB	Clerk of the Board (County)
CoC	Continuum of Care
COCE	Co-Occurring Center for Excellence
COD	Co-Occurring Disorders
CONS	Conservatorship
COP	Conditions of Participation
COS	Community Outreach Services
COTA	Certified Occupational Therapy Assistant
CPAC	Community Policy Advisory Committee
CPM	Core Practice Model
CPRP	Certified Psychosocial Rehabilitation Practitioner
CPS	Child Protective Services
CPSE	California Psychology Supplemental Exam
CPT	Current Procedural Terminology
CPU	Central Placement Unit (CFS)
CQI	Continuous Quality Improvement
CRM	Community Resiliency Model
CRP	Client Recovery Plan
CRS	California Relay Service
CRS	Community Reintegration Services
CRT	Crisis Residential Treatment
CS	Computer Services
CSAC	County Supervisors Association of California
CSAC	California State Association of Counties
CSAP	Center for Substance Abuse Prevention
CSBHS	County of San Bernardino Health Services (formerly BHRC)
CSEC	Commercial Sexual Exploitation of Children
CSI	Client and Service Information
CSOC	Children's System of Care
CSP	Coordination Service Plan
CSS	Community Services and Supports
CSTAR	Community Supervised Treatment After Release
CSU	Crisis Stabilization Unit
CSW	Clinical Social Worker
CT	Clinical Therapist
CTASC	Corrections to a Safer Community
CTF	Community Treatment Facility
CV	Central Valley
CWE	Community Wholeness and Enrichment
CWIC	Crisis Walk-in Centers
CY	Calendar Year

CYC	Child and Youth Connection
CYCS	Children and Youth Collaborative Services
D/MTN	Desert/Mountain Region
DAC	District Advisory Committee
DAAS	Department of Aging and Adult Services (County)
DATAR	Drug & Alcohol Treatment Access Report
DBH	Department of Behavioral Health (County)
DBT	Dialect Behavior Therapy
DCH	Day Care Habilitative
DCPP	Drug Court Partnership Program
DCR	Day Care Rehabilitative
DCR	Data Collection and Reporting
DD	Deputy Director
DDC	Dependency Drug Court
DEJ	Deferred Entry of Judgment
DEOP	Department Emergency Operation Plan
DGS	Department of General Services (State)
DHCS	Department of Health Care Services (State)
DHHS	Department of Health and Human Services (Federal)
DJJ	Division of Juvenile Justice (formerly California Youth Authority)
DLA	Daily Living Activity
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DOA	Date of Admission
DOB	Date of Birth
DOC	Department Operations Center (DBH)
DOC	Department of Corrections (State)
DOCD	Department Operations Center Director (DBH)
DOE	Date of Entry
DOJ	Department of Justice
DOR	Department of Rehabilitation (State)
DOS	Date of Services
DP	Direct Provider
DPH	Department of Public Health (County)
Dr.	Doctor
DRC	Day Reporting Center
DRS	Designated Record Set
DTO	Danger to Others
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSS	Department of Social Services (State)
DTS	Danger to Self
DTS	Day Treatment Services
DUI	Driving Under the Influence
DV	Domestic Violence
Dx	Diagnosis
EAP	Education Assistance Proposal
EBP	Evidence Based Practices
ECR	Error Correction Report
ECT	Electro Convulsive Therapy

ED	Emergency Department (general)
ED	Emotional Disturbance
EDBCR	Employee Database Cost Report
EDC	Eating Disorder Collaborative
EDI	Electronic Data Interchange
EDO	Eating Disorder
EDS	Employment Development Services
EEOC	Equal Employment Opportunity Commission (Federal)
EFC	Extended Foster Care
EHR	Electronic Health Record
EHT	Extended Hours Triage
EIIS	Early Identification and Intervention Services
EIN	Employer Identification Number
EIS	Early Intervention Service
ELDP	Executive Leadership Development Program (DBH)
EMACS	Employee Management and Compensation System
EOB	Explanation of Benefits
EOC	Emergency Operations Center
EP	Environmental Prevention
EPPP	Examination for the Professional Practice in Psychology
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
ERMHS	Educationally Related Mental Health Services
ES	Emergency Services
ESG	Emergency Solutions Grant
ETA	Estimated Time of Arrival
EV	East Valley
EVC	Eligibility Verification Confirmation Number
EVRC	East Valley Resource Center (DBH - Phoenix)
f/u	Follow-up
FACES	Focus on Achieving Customer-oriented Excellent Services
FACT	Forensic Assertive Community Treatment
FAS	Financial Accounting System
FAST	Forensic Adolescent Services Team
FBT	Family-Based Treatment
FC	Foster Care
FEHA	Fair Employment & Housing Act
FFA	Foster Family Agency
FFP	Federal Financial Participation
FFS	Fee-For-Service
FFT	Functional Family Therapy
FFY	Federal Fiscal Year
FHRSA	Federal Health Resources and Services Administration
FI	Financial Interviewers
FICS	Family Intervention and Community Support Team
FID	Federal Identification Number
FIT	Families in Transition
FLSA	Fair Labor Standards Act

FMAB	Fiscal Management and Accountability Branch (State SUD-PPFD)
FMAP	Federal Medical Assistance Percentage
FMLA	Family Medical Leave Act
FNL	Friday Night Live
FOTP	Female Offender Treatment Program
FP	Foster Parent
FRC	Family Resource Center
Freq	Frequent
FS	Family Stabilization
FSP	Full Service Partnership
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FY	Fiscal Year
GAD	Generalized Anxiety Disorder
GAF	Global Assessment of Functioning
GF	General Funds (State)
GF	Grandfather
GG	Golden Guardian
GH	Group Home
GHRC	Glen Helen Rehabilitation Center
GM	Grandmother
GP	Grandparent
GP	General Practitioner
Group Tx	Group Treatment
GSD	General System Development
GSG	General Services Group
HACSB	Housing Authority of the County of San Bernardino
HBP	high blood pressure
HCD (State)	Housing and Community Development
HCPCS	Healthcare Common Procedure Coding System
HCV	Hepatitis C Virus
HDDC	Highest Desert Detention Center
HE	Housing and Employment (DBH)
HEA	Hispanic Employees Alliance
HH	Healthy Homes
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMIS	Homeless Management Information System
HMO	Health Maintenance Organization
HPEF	Health Professions Education Foundation
HPI	Housing Partners I
HPN	Homeless Provider Network
HPSA	Health Plan Shortage Area
HR	Human Resources
HRD	Human Resources Department
HRO	Human Resource Officer
HRSA	Health Resources and Services Administration
HS	County of San Bernardino Human Services

HSC	Health and Safety Code (State)
HT	Housing Trust
HUD	Housing and Urban Development (Federal)
Hx	History
IA	Interagency Agreement
IAP	Interactive Accommodation Process
IC	Incident Commander
ICC	Intensive Care Coordination
ICCC	Intensive Case Coordination Coordinator
ICCD	International Center for Clubhouse Development
ICD 9 CM	International Classification of Diseases, Ninth Revision – Clinical Modification
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Edition
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th Edition
ICF	Intermediate Care Facility
ICH	Interagency Council on Homelessness
ICL	Initial Contact Log
ICM	Intensive Case Management
ICP	Incident Command Post
ICPM	Integrated Core Practice Model
ICT	Interdisciplinary Care Team
ICWA	Indian Child Welfare Act
IDT	Intra-department Transfer
IDU	Injection User
IEHP	Inland Empire Health Plan
IEP	Individualized Education Plan
IHBS	Intensive Home-Based Services
IIPP	Injury and Illness Prevention Program
ILP	Independent Living Program (CFS and Probation youth 16+)
IMD	Institute for Mental Disease
Incedo	Fee For Service registration and referral system
INFO	Integrated New Family Opportunities
INN	Innovation
INPT or IP	Inpatient
IOM	Interoffice Memo
IOM	Institute of Medicine Categories
IOT	Intensive Outpatient Treatment
IP	Identified Patient
IPC	Interagency Placement Council
IRC	Inland Regional Center
ISD	Information Services Department
ISFC	Intensive Services Foster Care
IST	Incompetent to Stand Trial
IT	Information Technology
ITFC	Intensive Treatment Foster Care
ITWS	Information Technology Web Services
IVDU	Intravenous Drug User
IYRT	Inter-agency Youth Resiliency Team (DBH Innovation project)

JCAHO	Joint Commission on Accreditation of Hospital Organization
JCBHS	Juvenile Court Behavioral Health Services
JDAC	Juvenile Detention and Assessment Center
JESD	Jobs and Employment Services Department
JH	Juvenile Hall
JIC	Joint Information Center
JIS	Joint Information System
JJCR	Juvenile Justice Community Reintegration
JJP	Juvenile Justice Program (formerly Juvenile Justice Outpatient Program)
JPA	Joint Powers Authority
Kin-GAP	Kinship Guardian Assistance Payment Program
LCD	Licensing and Certification Division (State)
LCSW	Licensed Clinical Social Worker
LDP	Leadership Development Program
LEP	Limited English Proficiency
LEP	Licensed Educational Psychologist
LEPP	License Exam Prep Program
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
LIHP	Low Income Health Program (ArrowCare)
LLUMC	Loma Linda University Medical Center
LMFT	Licensed Marriage and Family Therapist
LMHSPEP	Licensed Mental Health Services Provider Education Program
LMS	Learning Management System
LOC	Level of Care
LOI	Letter of Intent
LPCC	Licensed Professional Clinical Counselor
LPHA	Licensed Practitioner of The Healing Arts
LPS	Lanterman-Petris-Short Act
LPT	Licensed Psychiatric Technician
LS	Life Skills
LVN	Licensed Vocational Nurse
M/CAL	Medi-Cal
M/CARE	Medicare
MA	Master of Arts
MAPS	Member Assisted Program Services
MAT	Medication Assisted Treatment
MAUA	MyAvatar User Account
Max	Maximum
MC	Managed Care
MCCA	Medicare Catastrophic Care Act
MCCU	Managed Care Coordination Unit (DBH)
MCP	Managed Care Plan
MD	Medical Doctor (most likely a Psychiatrist in DBH)
MDT	Multi-Disciplinary Team
MEDS	Medi-Cal Eligibility Data System (State DHCS)
METRO	Metropolitan State Hospital
MFT	Marriage and Family Therapist
MGF	Maternal Grandfather

MGM	Maternal Grandmother
MHALA	Mental Health America Los Angeles
MHLAP	Mental Health Loan Assumption Program
MHP	Mental Health Plan
MHPSA	Mental Health Professional Shortage Area
MHS	Mental Health Specialist
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
MIA	Medically Indigent Adult
MLA	Management Leadership Academy
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MQs	Minimum Qualifications
MRSA	Medically-Resistant
MSE	Mental Status Exam
MSM	(Non-gay) Men who have sex with men (generally transient population)
MSSA	Medical Service Study Area
MSW	Masters In Social Work
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NACBHDD	National Association of County Behavioral Health & Developmental Disability Directors
NACo	National Association of Counties
NAL	Naltrexone
NAMI	National Alliance on Mental Illness
NAPA	Napa State Hospital
NARC	Native American Resource Center
NASMHPD	National Association of State Mental Health Program Directors
NCAA	National Commission for Certifying Agencies
NCTI	National Curriculum and Training Institute (nationally recognized for Crossroads® cognitive curricula)
NEO	New Employee Orientation
NGI	Not Guilty by Reason Of Insanity
NHAS	National HIV/AIDS Strategy
NHSC	National Health Services Corps
NIMS	National Incident Management System
NMD	Non-Minor Dependent
NNA	Negotiated Net Amount
NOA	Notice of Action
NOGA	Notice of Grant Award
NON-SPMP	Non-Skilled Professional Medical Personnel
NOPP	Notice of Privacy Practices
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NREFM	Non-Related Extended Family Member
NTP	Narcotic Treatment Program
NVCI	Non-Violent Crisis Intervention
OA	Office Assistant

OAC	Oversight and Accountability Commission
OCFA	Office of Consumer and Family Affairs
OCM	Outpatient Chart Manual
OD	Doctor of Osteopathic Medicine (can also be a Psychiatrist)
OD	Overdose
ODF	Outpatient Drug Free
OED	Organizational & Employee Development
OEI	Office of Equity and Inclusion
OES	Office of Emergency Services
OHC	Other Health Coverage
OHS	Office of Homeless Services
OIG	Office of Inspector General
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OMB	Office of Management and Budget (Federal)
OMH	Office of Minority Health (Federal)
OP	Outpatient Services
OPG	Office of the Public Guardian
OPPD	Office of Program and Policy Development
OS	Outreach Services
OSHPD	Office of Statewide Health Planning and Development (State)
OT	Occupational Therapist
OTA	Occupational Therapist Assistant
OTP	Opioid Treatment Program
PATS	Perinatal Addiction and Treatment Services
PBM	Pharmacy Benefit Manager
PC	Personal Computer
PCCI	Professional Clinical Counselor Registered Intern
PCIT	Parent-Child Interaction Therapy
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PED	Provider Enrollment Division (DHCS)
PEI	Prevention and Early Intervention
PERC	Performance, Education and Resource Center (County)
PFA	Peer and Family Advocate
PFI	Patient Financial Information Data
PGF	Paternal Grandfather
PGM	Paternal Grandmother
PH	Partial Hospitalization
PHC	Partial Hospitalization Coordinator
PhD	Doctor of Philosophy
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHMB	Partnership for Health Mothers and Babies
PHN	Public Health Nurse
PHP	Partial Hospitalization Program
PHP	Pre-Paid Health Plan
PIN	Provider Information Number
PIP	Performance Improvement Plan
PIO	Public Information Officer

PLWHA	People Living with HIV and AIDS
PM	Program Manager
PO	Probation Officer
PO	Purchase Order
POC	Plan of Correction
POE	Proof of Eligibility
POQI	Performance Outcomes & Quality Improvement
POR	Problem Oriented Record
POS	Point of Service
PRO	Professional Review Organization
PRO	Patients' Rights Office
Prob	Probation
Prob	Problem
PRR	Public Records Request
PS	Program Specialist
PSATS	Perinatal Substance Abuse Treatment Services
PSE	Public Service Employee
PSH	Patton State Hospital
PSH	Permanent Supportive Housing
PSI or PSII	Program Specialist
PSN	Parolee Services Network
PSPP	Post Service Post Payment
PSYC A	Psychology Assistant
PsyD	Doctor of Psychology (Psychologist)
Pv	Prevention
QA	Quality Assurance
QAR	Quality Assurance Review
QFFMR	Quarterly Federal Financial Management Report
QI	Quality Improvement
QIPP	Quality Improvement Performance Plan
QM	Quality Management
QMAC	Quality Management Action Committee
R2R	Ready to Rent
R&E	Research and Evaluation
RA	Remittance Advice
RAS	Registered Addiction Specialist
RBATS	Rialto Behavioral Addiction & Treatment Services
RBEST	Recovery Based Engagement Support Teams
RCL	Residential Care Licensing
RES	Real Estate Services
RESSL	Request for Extended Sick and Special Leave
RESTAT	Resource Status Unit
RFA	Request for Action
RFP	Request for Proposal
RFQ	Request for Qualifications
RGH	Riverside General Hospital
RH	Recovery Happens
RN	Registered Nurse
ROP	Regional Occupational Program

ROPCB	Residential and Outpatient Programs Compliance Branch (State SUD-PPFD)
RP	Resource Parent
RSAT	Referral, Screening, Assessment and Treatment
Rx	Prescription
S&R	Seclusion and Restraint
S/D	Short-Doyle
SA	Substance Abuse
SAEVS	Supplemental Automated Eligibility Verification
SAM	State Administrative Manual
SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	Student Assistance Program
SAPT	Substance Abuse Prevention & Treatment
SAR	Service Authorization Request
SARB	School Attendance Review Board
SARC	Screening, Assessment and Referral Center
SART	Screening, Assessment, Referral and Treatment
SAS	Supervisor of Administrative Services
SATS	School Aged Treatment Services
SB	Senate Bill (State)
SB 785	Senate Bill 785 provides for specialty mental health for out-of-county youth
SBCAAAE	San Bernardino County Association of African American Employees
SBCSS	San Bernardino County Superintendent of Schools
SBIRT	Screening, Brief Intervention and Referral to Treatment
SCHIP	State Children's Health Insurance Program
SCO	State Controller's Office
SCRP	Southern Counties Regional Partnership
SD/MC	Short-Doyle/Medi-Cal
SDI	State Disability Insurance
SED	Severely Emotionally Disturbed
SELPA	Special Education Local Plan Area
SEMS	Standardized Emergency Management Systems
SEP	Syringe Exchange Programs
SF/EW	Success First/Early Wrap
SGF	State General Fund
SIMON	San Bernardino Information Management On-Line Network
SIP	System Improvement Plan
SHOC	Shelter Operations Compound
SITSTAT	Situational Status
SLRP	State Loan Repayment Program
SLT	Speech and Language Therapist
SMA	Statewide Maximum Allowance
SMHI	Student Mental Health Initiative
SNF	Skilled Nursing Facility
SOA	Supervising Office Assistant
SOAR	Seeking Others Attaining Recovery
SOGI	Sexual Orientation and Gender Identity
SOC	Share of Cost
SOP	Standard Operating Procedure

SOP	Safety Organized Practice
SOS	Supervising Office Specialist
SOW	Scope of Work
SP	Service Plan
SPAN	San Bernardino Partners Aftercare Network
SPC	Shelter Plus Care
SPF	Strategic Prevention Framework
SPF SIG	Strategic Prevention Framework State Incentive Grant
SPM	Standard Practice Manual
SPMP	Skilled Professional Medical Personnel
SPOC	System-wide Performance Outcomes Committee
SPROUT	Special Programs Report for Outcomes, Utilization and Treatment
SSA	Social Security Administration
SSA	Support Services Account (State)
SSDI	Social Security Disability Insurance
SSI	Social Security Supplemental Income
SSN	Social Security Number
SSP	State Supplemental Program
SSP	Social Service Practitioner
SSSP	Supervising Social Service Practitioner
STAR	Supervised Treatment After Release
STAY	Serving Transitional Age Youth
STC	Standard Terms and Conditions
STD	Sexually Transmitted Disease
STEP-UP	Systematic Transformation for Engaging Partners & Uplifting People
STOP	Specialized Treatment Offender Program
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
SUD-PPFD	Substance Use Disorder-Program, Policy and Fiscal Division (State DHCS)
SUDRS	Substance Use Disorder and Recovery Services
SW	Social Worker
Sx	Symptoms
TA	Technical Assistance
TAD	Transitional Assistance Department
TANF	Temporary Aid for Needy Families
TAP	Therapeutic Alliance Program
TAPS	Tracking and Payment System (State SUD-PPFD)
TAR	Treatment Authorization Request
TAY	Transitional Age Youth
TB	Tuberculosis
TBS	Therapeutic Behavioral Services
TC	Team Captain (DBH Disaster Response Team)
TCON	Temporary Conservatorship
TCM	Targeted Case Management
TCOM	Transformational Collaborative Outcome Management
TCON	Temporary Conservatorship
TDD	Telecommunication Device for the Deaf
TDM	Team Decision Making
TEST	Triage Engagement and Support Teams

TFC	Therapeutic Foster Care
TFCBT	Trauma Focused Cognitive Behavioral Therapy
THP	Transitional Housing Program (CFS & Probation youth 16 - 18)
THPP	Transitional Housing Program Plus (18 -21)
TI	Training Institute
TIN	Tax Identification Number
TRM	Trauma Resiliency Model
TSC	Telephone Service Center
TTM	Treatment Team Meeting
TUT	TAR Update Transmittal Form
TX	Treatment
UACF	United Advocates for Children and Families
UMDAP	Uniform Method to Determine Ability to Pay
UOS	Unit of Service
UR	Utilization Review
USC	United States Code
USDR	Uniform Statewide Daily Reimbursement
VAHOSP	Veteran's Administration Hospital
VID	Volunteer Inpatient Detox
VSC	Volunteer Services Coordinator
VSP	Volunteer Services Program
VV	Victor Valley
VVBHC	Victor Valley Behavioral Health Center
WDD	Workforce Development Department
WET	Workforce Education and Training (DBH)
WIC	Welfare and Institutions Code (State)
WIC	Women, Infants and Children
WM	Withdrawal Management
WNL	Within normal limits
WPE	Work Performance Evaluation
WPIP	Work Performance Improvement Plan
WRMHP	Waived/Registered Mental Health Professional
WRAP	Wellness Recovery Action Plan
WRAP	Wraparound
WV	West Valley
WVDC	West Valley Detention Center
ZC	Zone Coordinator (DBH Disaster Response Team)