Substance Use Disorder Services

DMC-ODS Practice Guidelines

County of El Dorado

1/24/2019

The El Dorado County Practice Guidelines represent a combination of local, State and Federal regulations, standards and guidelines, as well as best practices for effectively treating substance use disorders. Contracted and County-operated providers are expected to adhere to all applicable regulations, standards, guidelines, policies and practices.

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Substance Use Disorder Services DMC-ODS

Practice Guidelines

Introduction

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

The El Dorado County Health and Human Services Agency (HSAA) is authorized by the El Dorado County Board of Supervisors to administer the plan under an intergovernmental agreement with DHCS. The plan is administered by HHSA's Behavioral Health Division. The purpose of the pilot program is to test a new, more organized and comprehensive approach to providing substance use disorder (SUD) treatment services to Medi-Cal eligible youth and adults. The goal is to demonstrate how this treatment concept improves individual health outcomes while decreasing system-wide health care costs.

Treatment Practice Guidelines

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

Overview of Regulations

Substance Use Services administered in El Dorado County are held to varying, and at times overlapping, regulations depending on, but not limited to, the service modality, activities being performed and funding source. The El Dorado County (EDC) DMC-ODS will operate according to the regulations set forth by the Federal Government, the State of California, as well as its own provisions outlined in specific provider contracts. It is common for providers in El Dorado County to offer a variety of services each of which with their own set or multiple sets of regulations to follow. No one set of regulations addresses

all components of the provision of Substance Use Services and at times differences in regulatory language may create multiple interpretations on how regulations may apply. Whenever questions regarding regulation interpretation arise, the more stringent regulation applicable shall apply as this is how El Dorado County QA/UR and the Department of Health Care Services will evaluate providers. The following links will direct providers on where to access specific requirements to their programs.

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

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

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

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

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

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

CCR Title 22 Drug Medi-Cal and the DMC-ODS Special Terms and Conditions
Title 22 specifies a framework for the expectations and requirements of services delivered through the Drug Medi-Cal (DMC) system. With implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, the Special Terms and Conditions (STCs) of the DMC-ODS specify the new requirements and expectations of the DMC system. Where there is conflict between Title 22 and the DMC-ODS, the DMC-ODS will

override Title 22. However, Title 22 remains as the regulatory requirements in all other areas that are not in conflict with and not addressed by the DMC-ODS STCs.

42 CFR PART 2

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

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

For a summary of 42 CFR Part 2, please see: https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

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

HIPAA – Health Insurance Portability and Accountability Act

HIPAA Provides data privacy and security provisions for safeguarding medical information. A summary of the HIPAA privacy rule can be found here: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html.

For more general information on HIPAA, please see: http://www.hhs.gov/ocr/privacy/index.html.
For more specific information concerning covered entities, beneficiary information and health information technology, please see http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

Note: These laws and regulations should not be used as barriers to providing coordinated and integrated care. Provided that the appropriate patient releases and/or consents for treatment are obtained, every effort should be made to share clinical information with

relevant providers across the continuum of care (including mental and physical health). Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the SUD system must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

Required Standards and Guidelines

Alcohol and/or Other Drug Program Certification Standards

In May 2017 DHCS released updated AOD certification standards. El Dorado County expects providers and programs to meet compliance of all standards in section. For more information click on the following link: DHCS Certification Standards.

Drug/Medi-Cal Certification Standards

Substance use treatment programs participating in the Drug/Medi-Cal program are required to comply with the applicable Drug/Medi-Cal Certification Standards.

Facility Licensing Standards

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

The Department of Health Care Services offers voluntary facility certification to programs providing outpatient, intensive outpatient, and nonresidential detoxification treatment. This voluntary certification is granted to programs that exceed minimum levels of service quality and are in substantial compliance with State program standards, specifically the Alcohol and/or Other Drug

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

51490.1 – Claim Submissions Requirements; and 3) Section 51561.1 – Reimbursement Rates and Requirements. Title 22 refers and ties to Title 9 of the CCR which governs

requirements for Narcotic Treatment Programs. Providers are encouraged to learn more about state licensing and certification requirements by visiting the DHCS website.

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

Minimum Quality Drug Treatment Standards for SABG
All substance use treatment providers that have any SABG funding are required to comply with the Minimum Quality Treatment Standards.

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

Culturally and Linguistically Appropriate Services (CLAS) Standards
The national Culturally and Linguistically Appropriate Services (CLAS) Standards which are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. It is intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services to ensure access to quality care by diverse populations, each service provider receiving funds from the State-County Contract shall adopt CLAS national standards.

Perinatal Guidelines
Perinatal programs shall comply with the Perinatal Practice Guidelines FY 2018-19.

Adolescent Guidelines
Contractor shall follow the guidelines in The State of California Youth Treatment Guidelines in developing and implementing adolescent treatment programs until such a time a new Youth Treatment Guidelines are established and adopted.

Residential Guidelines
Residential programs shall comply with all requirements under DMC-ODS. [Exhibit A – Scope of Services]

Beneficiary Eligibility and Enrolment

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

Evidence Based Practices (EBP) Compliance

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

1. Motivational Interviewing: A beneficiary -centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries ' past successes.
2. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
3. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
4. Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
5. Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries ' lives; to instill self- awareness, suggest options for growth and change identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Tips for Ensuring Fidelity of EBPs

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

- A method for ensuring that treatment "dose" (intensity, frequency, length of contact) is consistent among beneficiaries with similar diagnoses.
- A protocol for the delivery of EBP that outlines accurate and consistent delivery.

- A method for determining that the clinicians are adhering to the protocol.
- A method for identifying areas for course correction (drift) and provide an outline for implementation of course correction.
- A training schedule and description of the training for clinicians (through documentation). Required elements to ensure they have been satisfactorily trained to deliver the intervention are:
  - ❖ Standardization of training upon hire: ensuring all clinicians are trained in the same manner.
  - ❖ Skill acquisition: should include didactic sessions, modeling, use of video materials, training manuals, role plays.
  - ❖ Measurement of clinician skill: determining performance criteria that include a rating for a "demonstrated understanding of key concepts" and documentation of review.
  - ❖ Maintenance of skill over time: continued training and EBP documented with performance reviews.

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

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

Description of Services

The following are descriptions of various treatment services available to members served within the EDC DMC-ODS system of care. These services are available to beneficiaries receiving outpatient, intensive outpatient, residential, withdrawal management and opioid treatment services.

Individual Counseling

Individual counseling sessions between a LPHA or Registered/Certified Counselor and a beneficiary are to be conducted in a confidential setting where individuals not participating in the counseling session cannot see or hear the comments of the beneficiaries, LPHA, or counselor. Individual counseling sessions can be provided in person in an office, home, or

community setting or via telephone or telehealth as long as confidentiality and informed consent requirements are met.

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

Group Counseling

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

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

Crisis Intervention Counseling

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

- These sessions are immediate and short-term encounters that focus on (1) stabilization and immediate management of the crisis, often by strengthening

coping mechanisms and (2) alleviating a beneficiary's biopsychosocial functioning and well-being after a crisis.

- Crisis interventions are provided when there is a relapse or an unforeseen event or circumstance causing imminent threat of relapse.
- A component of this service includes linkages to ensure ongoing care following the alleviation of the crisis. Crisis Intervention sessions are available at all levels of care
- A progress note must be written for each session and documented in the beneficiary chart.
- Crisis intervention sessions are not scheduled events, but need to be available to beneficiaries as needed during the agency's normal operating hours or in alignment with afterhours crisis procedures.

Case Management

Case management services are defined as a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The focus of Case management services includes: coordination of SUD care, integration around primary care especially for Beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed. The treatment provider is responsible for determining which entity monitors the case management activities. Case management services may be provided by a LPHA or a certified counselor. A treatment provider is responsible for ensuring a system of case management services with physical and/or mental health services are in place to ensure appropriate level of care. Case management services may be provided face-to-face, by telephone, or by telehealth with the Beneficiary and may be provided anywhere in the community. DHCS Case Management FAQ

- Case management is available at all levels of care.
- Beneficiaries will be guided through the system of care, linkages will be made to ancillary services, and beneficiary s will be assisted in connecting the next needed ASAM level of care.
- Case management will be utilized as a method to provide thorough discharge planning through implementation of aftercare plans that include access to ongoing Recovery Support Services, vocational rehabilitation, sober living housing, and access to childcare and parenting services to enhance the capacity of each beneficiary to achieve long-term recovery.
- A progress note must be written for each case management interaction and documented in the beneficiary's chart.

Recovery Services

A recovery service can be utilized when the Beneficiary is triggered, relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, the treatment program can provide Beneficiaries with recovery services, as medically necessary. Beneficiaries can access recovery services after completing their course of treatment through the following modalities: face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary.

Components of Recovery Services:

- Outpatient Counseling: In the form of individual or group counseling to stabilize the beneficiary, then reassess if further care is needed.
- Recovery Monitoring: Including recovery coaching and monitoring via telephone/telehealth.
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
- Support for Education and Job Skills: Including linkages to life skills, employment services, job training, and education services.
- Family Support: Including linkages to childcare, parent education, child development support services, and family/marriage education.
- Support Groups: Including linkages to self-help and faith-based support.
- Ancillary Services: Including linkages to housing assistance, transportation, case management, and individual services coordination.

Access to Recovery Services:

- **Post-Treatment.** Recovery Services are made available to eligible beneficiaries after they complete their course of treatment.
- Relapse Prevention and / or Early Intervention. Services are available to beneficiaries whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.
- Beneficiary treatment plan. Services should be provided in the context of an individualized consumer treatment plan that includes specific goals. This may include the plan for ongoing recovery and relapse prevention that was developed during discharge planning when treatment was completed.

Collateral Services

For all SUD treatment providers, regardless of DMC certification status, collateral services must be provided by an LPHA or Registered/Certified Counselors. Collateral services are defined as face-to-face contact with significant persons in the life of the beneficiary.

Significant persons are defined as individuals that a personal, not official or professional, relationship with the beneficiary. For example, a beneficiary's social worker would not meet the "significant persons" criteria. Each collateral service must focus on the treatment needs of the beneficiary to supports the achievement of treatment plan goals. A beneficiary does not need to be present at the collateral service for the service to be billable to DMC.

- Collateral services sessions are available at all levels of care.
- The focus of collateral services is on better addressing the treatment needs of the beneficiary.
- A progress note must be written for each session and documented in the beneficiary's chart.
- The frequency of collateral services sessions, in combination with other treatment services shall be based on medical necessity and individualized beneficiary needs rather than a prescribed program required for all beneficiaries.

Treatment Planning

El Dorado County DMC-ODS is adopting the DMC initial treatment plan requirements for all SUD treatment providers regardless of their DMC certification status. Each treatment plan must be documented, individualized, and based on information obtained during the intake and assessment. There also must be clear and documented links between beneficiary needs, treatment goals, and provided services. In addition, the rationale and justification for the content of each of the beneficiary treatment plan components must be well documented. The initial treatment plan must be completed within 30 calendar days (28 for NTPs) of a Beneficiary's admission to treatment and signed by an LPHA and Registered/Certified Counselor and the beneficiary. Treatment plans are to be updated a minimum of every 90 days or soon if significant changes in the Beneficiaries treatment occur prior to the renewal days.

A central element of El Dorado County's philosophy of care is to provide a whole person approach that meets an individual's behavioral health and primary care needs where a beneficiary accesses services. All SUD treatment providers, regardless of DMC certification status, must consider beneficiary physical health information when developing SUD treatment plan goals. Documentation must be provided by the beneficiary indicating the completion of a physical exam within the prior 12 months. If documentation cannot be provided or beneficiary reports not having primary care, physical health must be addressed on the initial and subsequent treatment plans until proof of beneficiary's physical health is provided by the beneficiary.

Physician Consultation Services

Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice when developing treatment plans for specific DMC-ODS beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. A treatment provider may contract with one or more physicians or pharmacists in order to provide consultation services

- For physician consultation services, additional MAT, and withdrawal management, the Medical Director or LPHA working within their scope of practice which provided the treatment service shall ensure documentation is present in a progress note in the beneficiary's file.

Special Issues

Suicide Protocol

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

Threats of Violence

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

Child Abuse and Elder Abuse

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

Incident reports

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

Other

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

American Society of Addiction Medicine Criteria (ASAM)

To ensure that beneficiaries have access to the full continuum of care for substance use disorder treatment, the array of benefits offered through the DMC-ODS Waiver are modeled after the ASAM criteria, which is the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. [Reference: DHCS ASAM Fact Sheet, 10/2015).

ASAM Assessment

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

Regular review of the beneficiary's treatment needs is important to gauge progress in treatment and to identify any new problem areas, goals, and action steps ASAM guides us to ensure the beneficiary is placed in the "least restrictive environment" for treatment; however, the criteria also directs the counselor to ensure the beneficiary is receiving the appropriate LOC for their needs.

The ASAM must be completed whenever there is a change in the Level of Care needed for the beneficiary , whether to more intensive or less intensive services or to transfer to another clinic. It is required at Intake, Transfers, and Authorization requests for Residential Treatment, requests for Recovery Residences and at Discharge. It will not be the only assessment used at your specific agency. Each agency should determine what format is used to complete the full biopsychosocial assessment.

The ASAM delineates a continuum of services with five levels of care, numbered Level 0.5 (early intervention) through Level 4 (medically managed intensive inpatient services).

ASAM Levels of Care

Withdrawal Management

Through the EDC DMC-ODS, beneficiaries will have access to a minimum one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or LPHA as medically necessary, and in accordance with the beneficiary's individualized treatment plan. All beneficiaries who are eligible and recommended to receive both residential services and WM services are monitored during the detoxification process. The treatment program is responsible for providing medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.

Early Intervention (ASAM Level 0.5)

Early Intervention services identify beneficiaries at risk of developing a substance use disorder or those with a possible substance use disorder which is unable to be diagnosed due to lack of information. This level of service also encompasses services offered to persons in a non-specialty setting such as hospital emergency departments, or primary medical clinics. Early intervention services include: screening for adults and youth, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage.

Outpatient Services (ASAM Level 1.0)

Outpatient services consist of up to nine hours per week of medically necessary services for adults. The services follow a defined set of policies and procedures or clinical protocols. Treatment Services are defined as the following activities: assessment, treatment planning, individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

Intensive Outpatient Services (ASAM Level 2.1)

Intensive outpatient services involve structured programming provided to beneficiaries, as medically necessary, for a minimum of nine hours and a maximum of 19 hours per week for adult beneficiaries. Services include: assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

Residential Treatment Services (ASAM Level 3.1 & 3.5)

Residential services are provided in DHCS or DSS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care

consistent with ASAM treatment criteria. Residential services can be provided in facilities with no bed capacity limit. The length of residential services range from 1 to 90 days twice in a 365-day period; unless medical necessity authorizes a one-time extension of up to 30 days per 365-day period. Only two non-continuous 90-day regimens may be authorized in a one-year period (365 days). The average length of stay for residential services is 30 days.

Opioid (Narcotic) Treatment Program Services (NTP)

EDC SUDS shall subcontract with licensed NTPs to offer services to beneficiaries who meet medical necessity criteria requirements. Services will be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber. Offer and prescribe medications to members covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram. Services provided as part of an NTP shall include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge services.

Medical Necessity

All SUD treatment providers must ensure that treatment services are medically necessary. Medical necessity for services must be determined as part of the intake assessment process and will be performed by a Licensed Practitioner of the Healing Arts (LPHA) or Medical Director directly or with an SUDS registered/certified counselor and validated by a face to face review by an LPHA or the Medical Director. Should the need arise, telehealth services may be used to assist with the determination of medical necessity.

Medical necessity refers to the applicable evidence based standards applied to justify the level of services provided to a beneficiary so the services can be deemed reasonable, necessary and/or appropriate. It is imperative that medical necessity standards be consistently and universally applied to all beneficiaries. The Medical Director or LPHA shall:

- Review personal, medical, and substance use history.
- Evaluate each beneficiary and diagnose using DSM-5.
- Document basis for diagnosis within seven (7) days of admission via face- to-face session with the beneficiary or counselor.
- Exceptions: Withdrawal Management and OTP/NTP must be documented on day 1.

The Medical Director or LPHA shall document, in narrative format, separately from the treatment plan, the basis for the diagnosis in the beneficiary ’s record within 30 calendar days of each beneficiary ’s admission to treatment date.

The Medical Director or LPHA shall type or legibly print their name, sign and date the diagnosis documentation. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM criteria shall be applied by the diagnosing LPHA to determine or confirm placement into the appropriate modality or level of assessed services.

The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), currently in its 5th edition, will be utilized by Providers for all beneficiaries accessing SUD services. In order for a beneficiary to meet criteria for substance use services, the following criteria must be met and documented by a LPHA or Medical Director.

- Youth (ages 12 – 17) and Young Adults (ages 18 – 20)
    - Either meet criteria for the DSM-5 specification for adults OR Be determined to be at-risk for developing a SUD
    - Youth and Young Adults are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Eligibility for EPDST broadens the definition of medical necessity for youth to include individuals who are deemed "at-risk" for SUDs, and also makes the full SUD benefit package available to all individuals up to age 21 without any caps or limitations, assuming medical necessity is established*. Importantly, these federal EPSDT requirements supersede state Medi-Cal requirements, and the Drug Medi- Cal Organized Delivery System (DMC-ODS) Waiver does not override EPSDT*.
- Adults (ages 21+)
    - Meet criteria for at least one diagnosis from the current DSM-5 for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

Medical necessity encompasses all six ASAM dimensions and takes into consideration the extent and biopsychosocial severity of the various dimensions within the full ASAM assessment. Medical necessity must not be restricted to acute care and narrow medical concerns. The six dimensions are:

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and Complications
- Emotional, Behavioral, or Cognitive Conditions and Complications
- Readiness to Change
- Relapse, Continued Use, or Continued Problem Potential
- Recovery/Living Environment.

DMC-ODS Provider Requirements:

- ASAM Designation: DMC-ODS residential treatment providers must receive a DHCS issued ASAM designation prior to providing services to beneficiaries.

- ASAM Training: At minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”.
- ASAM Tool: All providers shall use the County-approved ASAM Assessment Tools for Adults and Adolescents.
- ASAM Level of Care Determinations: The initial medical necessity determination, for an individual to receive a DMC-ODS benefit, shall be performed through a face-to face review or telehealth by a Medical Director or a LPHA. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM Criteria shall be applied by the diagnosing individual to determine placement into the level of assessed services. If the facility does not provide the indicated level of care, then the DMC-ODS provider shall link the beneficiary to another agency that offers that level of care.
- ASAM Re-Assessments: Re-assessments are required to be completed at a minimum of every 30 days for Adolescent Residential and Adult Residential, annually for NTP & MAT, every 90 days for Outpatient, 60 days for Intensive Outpatient, unless there are significant changes warranting more frequent re-assessments (ex: achieving treatment plan goals, lack of progress on treatment plan goals, identification or intensification of new problems that cannot be addressed at current level of care, and at the request of the beneficiary).
- ASAM Data: All ASAM data shall be sent to EDC SUDS QA Supervisor within 7 days of assessment.

Performance Standards:

- 100% of beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care.
- At least 100% of beneficiaries (excluding NTP and MAT) are re-assessed within 90 days of the initial assessment.

Documentation Timelines Based on ASAM LOC

Outpatient (OS) & Intensive Outpatient services (IOS) (ASAM Levels 1, 2.1)

Encounter Type	Timelines	Process
Intake	First face-to-face contact must be within 10 days of receipt of referral	• Review all acknowledgments, advisements and consents. • HSQ must be reviewed with beneficiary and obtain beneficiary signature • Complete a LOC to determine/confirm LOC • Document Intake summary with description of symptomology, nature of impairment or distress and

		specific criteria indication LOC. • Document Intake Summary.
Admission	Due within first 30 days	• HSQ must be reviewed & signed by MD within 30 days and prior to completion of Tx plan. • Proof of physical examination within past 12 months obtained or referral to PCP made and documented. • Determination of medical necessity must be made by MD or LPHA within 30 days of admit. • DSM 5 Diagnoses made and documented by LPHA or MD. • Complete full biopsychosocial assessment. • CalOMS admission form completed by 3rd session.
Treatment Engagement	4 clinical contacts within 30 days of admit.	• All outpatient beneficiaries should receive a minimum of 4 counseling sessions within first 30 days and as determined by individual need.
ASAM Review	Admission, Discharge, Transfers, Authorizations	• The ASAM must be completed at Admit and at Discharge, for transfers and for residential authorization. • The ASAM 6 Dimensions should be regularly reviewed with the beneficiary, documented within progress notes and be reflected in the TX Plan.
Initial Treatment Plan	Within 30 days of admission	• Must be completed, signed and dated by primary counselor and beneficiary • Must be reviewed by LPHA, if primary counselor is not a LPHA, and signed and dated within 15 days of the initial signature of the counselor. • If clinician is unable to obtain beneficiary's signature within 30 days then this must be documented within the progress notes including reason for not obtaining the signature and the plan to obtain it. • Frequency, duration, and type of treatment (i.e. Individual, Group, and Targeted Case Management) must be documented on the TX Plan.
Updated Treatment Plans	90 days after last Treatment Plan	• Subsequent Treatment Plans are completed no later than 90 days calendar days after last Treatment Plan or when a change in problem or focus of treatment. • Must be reviewed, approved, signed, and dated by the counselor and beneficiary no later than 90 calendar days after signing the initial Treatment Plan. • Must be reviewed by LPHA if the primary counselor is not a LPHA, and signed and dated within 15 days of the initial signature of the counselor.
Clinical Justification	Between 5th and 6th month	• This must be reviewed by the LPHA and signed by date CJS is due if the primary counselor is

for Services 6 month	of Treatment	credentialed or certified.
Clinical Justification for Services Annual	Between 11th and 12th month of Treatment	• This must be reviewed by the LPHA and signed by date CJS is due if the primary counselor is credentialed or certified.
Discharge Plan	Developed during treatment & completed by discharge date	• The Discharge Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources. • Must be signed and dated by the counselor and the beneficiary with a copy offered to the beneficiary and placed in the beneficiary record.
Discharge Summary	Within 30 days of last face-to-face or clinical telephone contact with beneficiary. *See Note	• Written summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary and discharge prognosis. • Complete CalOMS Discharge Questionnaire. • Use the CalOMS Administrative Discharge if beneficiary has left treatment and cannot be interviewed. • A LOC should be completed at Discharge ***Note: All documentation is required within 48 hours of date of service, thus when a beneficiary successfully completes treatment, the completion of DC should also be done at that time. The 30-day timeline is appropriately used for beneficiaries who stop attending treatment and it is unclear whether they are returning. DHCS allows for 30 days.**

Residential Specific Requirements (ASAM Levels 3.1 & 3.5)

Encounter Type	Timelines	Process
Intake First Face to Face contact with the beneficiary & starts clock for all Timelines requirements	First face to face contact by clinician within 24 hours of admission	• Review all acknowledgements, advisements and consents. • HSQ must be reviewed with beneficiary and obtain beneficiary signature at admission. • Complete ASAM to determine/confirm LOC • Document Intake summary with description of symptomology, nature of impairment or distress and specific criteria indicating LOC. • Document Intake summary.
Other Admission Procedures	Due within 10 calendar days	• HSQ must be reviewed & signed by MD within 10 days and prior to completion of TX plan. • Determination of medical eligibility by the M.D. must

		be signed and completed within 10 days of admit • Determine whether beneficiary had physical examination within last 12 months and obtain documentation of exam or document no exam and referral made. • Complete full Biopsychosocial Assessment. • Diagnoses based on medical necessity criteria from DSM 5 and ASAM must be confirmed within 10 days by LPHA with written documentation of face to face w non LPHA counselor. • Complete CalOMS admission form by 10th day.
ASAM Review	Admission, Discharge, Transfers, Authorizations	• The ASAM should be completed at Admission and Discharge for Transfers and Authorizations. • The ASAM 6 Dimensions should be regularly reviewed with the beneficiary, are documented within progress notes, and be reflected in the Treatment Plan.
Initial Treatment Plan	Due within 10 calendar days	• Must be completed, signed, and dated within 10 days of beneficiary's admission to treatment. • Must be reviewed and signed by LPHA within 10 days of admission if primary counselor is not a LPHA
Updated Treatment Plans	As needed	• Subsequent Treatment Plans are completed when a change in problem identification or focus of treatment occurs. • Must be reviewed and signed by LPHA by due date of updated TX plan if primary counselor is not a LPHA.
Discharge Plan	Completed by discharge date with beneficiary	• The Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources. • Must be signed and dated by the counselor and the beneficiary with a copy offered to the beneficiary & placed in the beneficiary record.
Discharge Summary	Completed within 48 hours of last face to face or last clinical telephone contact with beneficiary.	• Written summary of the treatment episode including duration of treatment, reason for discharge and discharge prognosis. • Complete CalOMS Discharge Questionnaire • Use the CalOMS Administrative Discharge if beneficiary has left treatment and cannot be interviewed • Updated ASAM

Withdrawal Management Requirements (WM) (ASAM Level 3.2)

Encounter Type	Timelines	Process

Intake First Face to Face contact with the beneficiary & starts clock for all Timelines requirements	First face to face contact by clinician within 24 hours of entry	• Review all acknowledgements, advisements and consents. • HSQ must be reviewed with beneficiary and obtain beneficiary signature at admission. • Complete ASAM to determine/confirm LOC • Document Intake summary with description of symptomology, nature of impairment or distress and specific criteria indicating LOC. • Document Intake summary.
WM Care Plan, Diagnosis and Medical Necessity	Within 48 hours of admit	• Diagnoses based on medical necessity criteria from DSM 5 and ASAM must be confirmed within 48 hours by LPHA with written documentation of face to face w non LPHA counselor. • LPHA must document the criteria met specific to the substance use disorder diagnosis.
Discharge Plan	Completed by discharge date with beneficiary	• The Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources. • Must be signed and dated by the counselor and the beneficiary with a copy offered to the beneficiary and placed in the beneficiary record.
Discharge Summary	Completed within 48 hours of last face to face with beneficiary	• Written summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary and discharge prognosis. • Complete CalOMS Discharge Questionnaire • Use the CalOMS Administrative Discharge if beneficiary has left treatment and cannot be interviewed • Updated ASAM

Medication-Assisted Treatment within All Levels of Care

Research has shown that a combination of FDA-approved medications and behavioral counseling is more effective for treating substance use disorders than either intervention alone. As such, Medication Assisted Treatments (MAT) need to be part of a comprehensive approach to treating substance use disorders and beneficiaries with opioid or alcohol use disorders should be provided options for access MAT, as appropriate.

As noted by SAMHSA, “a common misconception associated with MAT is that it substitutes one drug for another. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication.”

FDA-Approved MATs for Opioid Use Disorders include:

- Methadone – Methadone is a clinic-based opioid agonist that does not block other narcotics while preventing withdrawal while taking it; daily liquid dispensed only in specialty regulated clinics.
- Naltrexone – Naltrexone is an office-based non-addictive opioid antagonist that blocks the effects of other narcotics; daily pill or monthly injection.
- Buprenorphine – Buprenorphine is an office-based opioid agonist/ antagonist that blocks other narcotics while reducing withdrawal risk; daily dissolving tablet, cheek film, or 6-month implant under the skin.

FDA-Approved MATs for Alcohol Use Disorders include:

- Disulfiram - Disulfiram is a medication that treats chronic alcoholism. It is most effective in people who have already gone through detoxification or are in the initial stage of abstinence. This drug is offered in a tablet form and is taken once a day.
- Acamprosate - Acamprosate is a medication for people in recovery who have already stopped drinking alcohol and want to avoid drinking. It works to prevent people from drinking alcohol, but it does not prevent withdrawal symptoms after people drink alcohol. It has not been shown to work in people who continue drinking alcohol, consume illicit drugs, and/or engage in prescription drug misuse and abuse. The use of Acamprosate typically begins on the fifth day of abstinence, reaching full effectiveness in five to eight days. It is offered in tablet form and taken three times a day, preferably at the same time every day.
- Naltrexone - When used as a treatment for alcohol dependency, naltrexone blocks the euphoric effects and feelings of intoxication. This allows people with alcohol addiction to reduce their drinking behaviors enough to remain motivated to stay in treatment, avoid relapses, and take medications (SAMSHA).

Performance Standard

- At least 80% of beneficiary records for individuals receiving Medication Assisted Treatment for substance use disorders will have 42 CFR compliant releases in place to coordinate care.
- At least 80% of beneficiaries with a primary opioid or alcohol use disorder will be linked to an MAT assessment and/or MAT services.

Care Coordination Practices

EDC Practice Guidelines mandate that Drug Medi-Cal ODS plan beneficiaries must have an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating services. The individual shall be provided information on how to contact their designated person or entity. EDC Drug Medi-

Cal ODS coordinates the services between settings of care including appropriate discharge planning for short term and long-term hospital and institutional stays. Care shall be coordinated with services plan beneficiaries receive from:

- Other managed care organizations
- FFS Medicaid.
- Community and social support providers.

EDC DMC ODS designates case managers and SUD counselors as primarily responsible for coordinating DMC services. They are responsible for coordinating beneficiary care:

- Between settings and levels of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;
- With the services that the beneficiary receives from any other managed care organization and/or through fee-for-service providers; and
- With the services that the beneficiary receives from community and social support providers.

Care coordination activities, including referrals, are documented in the beneficiary's treatment record.

EDC DMC ODS case managers shall obtain signed Releases of Information (ROI) from plan beneficiaries prior to coordinating services with other providers. Signed ROIs are maintained in the beneficiary's treatment record.

Coordination with Mental Health

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

- California Health and Wellness
- Anthem
- Kaiser Permanente

EDC DMC ODS clinical care coordinators and contracted network providers shall ensure coordination of care for beneficiaries with co-occurring mental health and SUD conditions using:

- Identified screening and assessment procedures/tools (such as LOCUS) to accurately determine when an individual is presenting with co-occurring SUD and MH condition(s).
- Written procedures for linking/coordinating plan beneficiaries with needed MH services. Care for beneficiaries with severe MH conditions is to be coordinated to MH.

- Designated El Dorado County Drug Medi-Cal ODS staff responsible for ensuring linkage/care coordination.
- Integrated SUD/MH care must be documented in the beneficiary's treatment plan

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

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

Coordination with Physical Health

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

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

Continuity of Care Expectations

Case Manager Point of Contact:

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

The coordination of services shall be furnished to the beneficiaries:

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

Access to Care

Beneficiaries shall access care through the following access points:

- EDC DMC-ODS 24-hour Toll Free Access Phone Line
- EDC Behavioral Health SUDS Office Phone Line
- Walk-In to EDC Behavioral Health SUDS Locations
- Referrals received by EDC Behavioral Health SUDS
- Walk-In to Contract Provider Outpatient Clinic Locations

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

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

- Outpatient, Intensive Outpatient
- Narcotic Treatment Program Services
- Outpatient or Residential Withdrawal Management Services
- Residential Treatment Services
- Recovery Services
- Case Management Services

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

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

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

Special Health Care Needs

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

Providers shall produce a treatment plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment plan or service plan shall be:

- Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary;
- Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR §441.301(c)(1);
- Approved by the Contractor in a timely manner, if this approval is required by the Contractor;
- In accordance with any applicable Department quality assurance and utilization review standards; and
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

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

Care Coordination Procedures

Plan beneficiaries will be assessed and have access to a full continuum of SUD services with an emphasis on engaging the beneficiary in the right care, at the right time, with the right provider, utilizing the principles of the American Society of Addition Medicine (ASAM) Placement Criteria. Beneficiaries shall be linked to care through known

treatment providers. Beneficiary's treatment services shall be coordinated across the Levels of Care (LOC) by following the continuity of care procedures.

Screening

Initial Screening

Screening via EDC DMC-ODS 24/7 access line

- Beneficiaries will be able to access SUD services through any contact within DMC-ODS, local managed care plans, community health clinics or other health/human services providers.
- The 24/7 toll-free access line will be provided to any beneficiary seeking or identified as needing any level of SUD services. Using this “no wrong door” approach will ensure that beneficiaries will be directed to the point of access for SUD services immediately upon identification of need.
- Community based SUD treatment providers will be another point of access where screening and referral can occur. Initial screenings of each beneficiary's needs shall be conducted upon first contact.

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

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

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

Screening via SUD Network Provider

- Beneficiaries will be able to access SUD services by calling or by walk-in request for services at the Plan contract outpatient provider program during business hours.
- The 24/7 toll-free access line will be available on the contract provider voicemail and posted on the front door of the provider facility for times provider is closed.

Procedures for screening via SUDS Network Provider

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

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

Referral Process

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

- Beneficiaries will be provided a list of SUD network providers to contact for treatment. County DMC-ODS Access staff will contact the SUD network provider of the beneficiary's choice to schedule an intake appointment.
- Beneficiaries **must** receive an appointment **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing
- Access line staff will provide appointment information to the beneficiary.

- Access line staff will forward screening information to the chosen network provider.
- SUD network providers will schedule a full intake/assessment with ASAM **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing of receipt of referral.

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

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

Intake and Placement

Intake Assessment and ASAM Level of Care Determination Procedure

1. The selected agency from the initial contact and brief screening (either ODS Staff or a SUD Network Provider) will meet with the beneficiary and complete the full assessment to provide additional information for determining the diagnosis, medical necessity, and appropriate ASAM level of care.
2. In instances when the beneficiary requests services from the treatment SUD Network Provider without a scheduled appointment, a qualified staff will conduct the initial assessment, if available.
3. If no qualified staff person is available, the beneficiary will be given an appointment to return for a face-to-face appointment, at the earliest time available, for the beneficiary to complete a full assessment. An appointment must be made **within 10 business days** for outpatient treatment and **within 3 business days** for Opioid Treatment Program
4. The assessment will be conducted by a Licensed Practitioner of the Healing Arts (LPHA), or certified /registered Drug and Alcohol Counselor. Services are available in English and Spanish.
5. The assessment, diagnosis, and medical necessity will be clearly documented in the beneficiary's electronic health record (EHR) and/or medical record. For adults, the diagnosis will include at least one DSM Substance-Related and Addictive Disorder (excluding Tobacco Related and/or non-Substance-related disorders). For beneficiaries under the age of 21, the diagnosis may also include an assessed risk for developing a SUD. Assessments will be conducted by a Licensed Practitioner of the Healing Arts (LPHA) or a certified /registered Drug and Alcohol Counselor.
6. Medical necessity will be determined for all beneficiaries entering the DMC-ODS. The beneficiary must be diagnosed with a DSM/ICD 10 Substance Related Disorder by a licensed LPHA, licensed physician, or Medical Director. DMC Title 22 requires that all SUD Network Providers include documentation of medical necessity in the beneficiary's file.
7. Once the assessment process is complete, the diagnosis, placement recommendations, and information about treatment services will be authorized and discussed during a face-to-face meeting with the beneficiary by an LPHA.

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

ASAM Outpatient Level of Care Placement Procedure

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

ASAM Residential Level of Care Placement Procedure

1. When higher levels of care (such as withdrawal management, residential, or inpatient services) are identified by the county Access line screening beneficiary will be assigned to county ODS staff.
2. When higher levels of care are indicated by the SUD Network Provider full assessment, provider will initiate the request for authorization with ODS staff.
3. ODS Staff will complete the full assessment or review the provider treatment authorization request and determine/verify and document diagnosis and medical necessity for the appropriate level of care.
4. For provider submitted treatment authorizations requests ODS staff will provide one of the following response to the requesting provider within 24 hours.
    - Approved
    - Pending – Requesting additional information
    - Denied
5. SUD Network provider will have 24 hours to respond to county requests for additional information for requests in a Pending status.
6. Upon authorization for services, the beneficiary will be given a list of SUD Network Providers and ODS Staff will contact the selected SUD Network Provider to schedule an appointment for the beneficiary.

7. ODS Staff will **securely** send the selected SUD Network Provider information regarding the beneficiary, including the completed assessment and ASAM, the treatment authorization, and confirmation of the appointment time and date.
8. If an authorization request is denied, a written Notice of Action will be sent to the beneficiary notifying them of the authorization decision. ODS Staff will also refer the beneficiary to the appropriate ASAM Level of Care.
9. If the beneficiary's selected SUD Network Provider is not available within 10 business days, linkage with other SUD Network Providers will be offered.

Only two non-continuous 90-day treatment periods will be authorized in a one-year time period. If the beneficiary's medical necessity demonstrates additional services are needed, a one-time extension of up to 30 days on an annual basis may be authorized. Perinatal and criminal justice beneficiaries may receive a longer length of stay, based upon medical necessity.

Continuing Services

Re-assessments

Re-assessments are conducted in order to ensure that beneficiaries are served at the most appropriate level of care, and that beneficiary's response to treatment, current level of functioning and severity is evaluated. Beneficiary treatment plans will be completed within 30 days of admission to services and will be reviewed at 60 and 90 day intervals. Beneficiaries may be referred to higher or lower levels of care, depending upon medical necessity and response to treatment. Reassessments will be conducted according to the timeline shown below.

Level of Care (LOC)	Re-Assessment Maximum Timeframe
Outpatient Treatment	90 Days
Intensive Outpatient	60 Days
Case Management	90 Days
Narcotic Treatment Programs	1 year
Medication Assisted Treatment	1 year
Residential Detoxification, Level 3.2	5 Days

Residential Treatment, Levels 3.1, 3.3, 3.5	30 Days and follow ASAM Residential Level of Care Placement Procedure. Provider to submit request at least seven (7) business days before end date of current authorization.

Specific situations that necessitate re-assessment and potential placement in a different level of care may include:

- Completion of treatment and agreed upon goals
- Inability or incapacity of beneficiary to demonstrate progress toward achievement of treatment goals
- Inability to achieve treatment plan goal despite amendments to the treatment plan
- Change in service needs based upon clinical necessity, and
- Requests for a different level of care by the beneficiary

Medical Necessity

Beneficiaries will be re-assessed for reauthorization of medical necessity every 6 months (except for NTP services which require annual reauthorization).

Transition to Other Levels of Care

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

Case Management

Case management is defined as a service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Services include:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management services;
- Transition to a higher or lower level of substance use disorder (SUD) care;
- Development and periodic revision of a beneficiary plan that includes service activities;
- Communication, coordination, referral, and related activities;

- Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
- Monitoring the beneficiary's progress;
- Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services; and,
- Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

ODS Staff will both provide case management services directly, and when necessary, will authorize SUD Network Providers to provide case management services to beneficiaries. High utilizers of service, beneficiaries at risk of unsuccessful transitions to other levels of care will be assigned an ODS Staff case manager upon completion of full assessment.

Case managers will be responsible for assisting the beneficiary with initial placement, transitions to different levels of care, and collaborate with the provider to ensure effective discharge planning. Case managers will also provide support in scheduling intake appointments and linking beneficiaries to ancillary support services.

Coordination with Out of Network Providers

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

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

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

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

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

Out of Network Approval Procedure

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

Performance Standard

- There is documentation of physical health and mental health screening in 100% of beneficiary records;
- At least 80% of beneficiaries have 42 CFR compliant releases in place to coordinate care with physical health providers;
- At least 70% of beneficiary records have documentation of coordination with physical health;
- At least 80% of beneficiaries engaged for at least 30 days will have an assigned Primary Care Provider;
- At least 80% of beneficiaries who screen positive for mental health disorders have 42 CFR compliant releases in place to coordinate care with mental health providers; and
- At least 70% of beneficiary records for individuals who screen positive for mental health disorders have documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).
- Transitions between levels of care shall occur within five (5) and no later than 10 business days from the time of re-assessment indicating the need for a different level of care.

Staffing Regulations and Requirements

Training information and Procedure

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

Training Requirements

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

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

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

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

Training Plan

EDCBH-SUDS maintain a written plan, updated annually, that outlines the training requirements of staff and providers. The Training Plan lists the types of training that staff and providers are required to complete, and includes the topics, frequency, and target staff and providers. The Training Plan may also indicate when a specific training offers CEUs.

The EDCBH-SUDS Quality Improvement (QI) Supervisor, in conjunction with the SUDS Program Manager, is responsible for organizing and developing the training plan for EDCBH-SUDS staff.

Completion of or participation in mandatory training is monitored by the Quality Improvement (QI) Supervisor or designee. Staff or providers who are not up to date on their training requirements are notified by the Quality Improvement (QI) Supervisor or designee of the issue.

Training Log/Documentation

- EDCBH-SUDS staff receives a certificate of completion for participating in online and in-person training sessions through EDCBH-SUDS. Staff shall be responsible to maintain a record of their training completion in their own personal file and submit verification of training to the Quality Improvement (QI) Supervisor or designee. Personal training files are audited randomly by the Quality Improvement (QI) Supervisor or designee.
- Trainings provided through the contract providers are documented to include staff name, license/certification information, and a copy of the completed training certificates (if applicable). This documentation is maintained at the provider site and submitted upon request to the Quality Improvement (QI) Supervisor or designee.

Training Curricula

Training curricula address components that are specific to SUD treatment, as well as broader Behavioral Health issues and state and federal regulations.

Mandatory annual trainings include at least the following topics:

- ASI and ASAM
- Beneficiary confidentiality (42 CFR Part 2; HIPAA; HITECH; etc.)
- Compliance program (fraud, ethical conduct, etc.)
- Drug Medi-Cal Organized Delivery System (DMC-ODS) requirements
- DMC-ODS documentation standards
- Practice Guidelines
- Title 22 regulations

Additional training topics include:

- Communicable diseases

- Crisis management
- Cultural and linguistic competence
- Dual-diagnosis/co-occurring disorders
- Intake/authorization process and procedures
- CalOMS
- Recovery concepts
- Service provision to special populations (e.g., older adults; PTSD; diverse populations)
- Sexual harassment prevention
- Suicide prevention training

In addition, certain EDCBH-SUDS staff and contract providers in each modality of treatment are required to attend training on at least two (2) of the following Evidence-Based Practices (EBPs) each year:

- Motivational Interviewing
- Relapse Prevention
- Trauma-Focused Care
- Seeking Safety
- Cognitive Behavioral Therapy
- Matrix Recovery Model
- Other Evidence Based Practices or Models

EBP training may be chosen by the trainee, prescribed by the trainee's supervisor, and/or offered and mandated by EDCBH-SUDS. Please refer to the current EDCBH-SUDS Training Plan for specific training titles, target staff, and frequencies.

Continuing Education Requirements

EDCBH-SUDS supports the continuing education efforts of licensed and certified staff and providers through in-person and online training opportunities that offer CEUs.

A. Licensed Practitioners of the Healing Arts

Licensed Practitioners of the Healing Arts (LPHA) include Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), and Licensed Marriage and Family Therapists (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

- LPHAs are required to complete a number of continuing education hours at a level mandated by the California licensing board responsible for the individual's specific license.
- In addition, LPHAs providing counseling services in the SUD program are required to receive a minimum of five (5) hours of continuing education related to "addiction medicine" each year.

B. SUD Counselors

- In order to renew certification, each certified SUD Counselor must complete a minimum of forty (40) hours of continuing education, approved by a certifying organization, during each two-year period of certification.

PROCEDURE

1. EDCBH-SUDS staff and contract providers are invited to in-person, onsite trainings as they occur. Mandatory trainings are noted as such.
    - A sign-in sheet is provided at each training; completed sign-in sheets are maintained by the Quality Improvement (QI) Supervisor or designee.
    - Upon completion of the training, participants are provided with a certificate of completion
2. Required trainings conducted online are assigned to EDCBH-SUDS staff and may include select contract providers, with specific due dates.
    - Enrollment in online trainings is announced via email to each enrolled EDCBH-SUDS staff member.
    - The Quality Improvement (QI) Supervisor or designee monitors the online training completions.
        - Staff who are not up to date on their training requirements are notified by the Quality Improvement (QI) Supervisor or designee of the issue.
3. LPHAs providing counseling services in the SUD program are required to submit evidence of completion of at least five (5) hours of continuing education related to "addiction medicine" each year.
    - The initial five (5) hours of addiction medicine training must be completed within one (1) year of the date of hire or contract, and annually thereafter.
    - Evidence documenting the continuing education is maintained by the LPHA.

- EDCBH-SUDS staff shall maintain this information in their own personal training file and submit verification of completion to the Quality Improvement (QI) Supervisor or designee.

LPHAs under contract maintain this documentation at the provider site and submit it upon request to the Quality Improvement (QI) Supervisor or designee.

Training Schedule

Mandatory annual trainings will be held bimonthly and include at least the following topics:

- ASI and ASAM
- Beneficiary confidentiality (42 CFR Part 2; HIPAA; HITECH; etc.)
- Compliance program (fraud, ethical conduct, etc.)
- Drug Medi-Cal Organized Delivery System (DMC-ODS) requirements
- DMC documentation standards
- Practice Guidelines
- Title 22 regulations

Information regarding opportunities for training in additional topics may be available:

- Communicable diseases
- Crisis management
- Cultural and linguistic competence
- Dual-diagnosis/co-occurring disorders
- Intake/authorization process and procedures
- CalOMS
- Recovery concepts
- Service provision to special populations (e.g., older adults; PTSD; diverse populations)
- Sexual harassment prevention
- Suicide prevention training

In addition, certain EDCBH-SUDS staff and contract providers are required to attend training on at least two (2) of the following Evidence-Based Practices (EBPs) each year:

- Motivational Interviewing (required)
- Relapse Prevention (required)
- Trauma-Focused Care (required)
- Seeking Safety (required)

- Cognitive Behavioral Therapy (required)
- Matrix Recovery Model (required)

DMC-ODS Provider Credentialing

In addition to responsibilities outlined in the County/Provider Contract Exhibit I and DHCS Information Notice 18-019, which is based on 42 CFR, Part 438.214 DMC-ODS Providers are responsible for performing and documenting the following to ensure that staff are appropriately licensed, registered, waivered and/or certified as required by state and federal law. Contractor shall provide evidence of these completed verifications when requested by County, DHCS or the US Department of Health & Human Services.

Provider credentialing ensures that providers are licensed, registered, waivered, and/or certified as required by state and federal law. The uniform credentialing and re-credentialing requirements apply to all licensed, waivered, or registered mental health providers and licensed substance use disorder services providers. Applicable provider types include licensed, registered, or waivered mental health providers, licensed practitioners of healing arts, and registered or certified Alcohol or Other Drug counselors.

Counselor Certification

Effective April 1, 2005, any individual providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program are required to be certified. In accordance with HSC Section 11833(b)(1), any individual who provides counseling services in a licensed or certified AOD program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization. Licensed professionals (LCSW, MFT, Psychologist or interns) are not required to be certified.

If a Provider's license, certification, or registration has lapsed, then they cannot provide any of the treatment services listed above until such a time as their license, certification, or registration becomes active again.

- All EDC DMC ODS clinical staff and contract provider clinical staff must be appropriately licensed, registered, waivered, and/or certified.
- Contracted network providers must be in good standing with the Medicaid/Medi-Cal programs.
- Any provider excluded from participation in Federal health care programs, including Medicare or Medicaid/Medi-Cal, may not participate in any EDC DMC ODS.

DMC-ODS staff may delegate credentialing and re-credentialing to a professional credentialing verification organization under a formal and detailed agreement with the entity performing those activities. Before these functions are delegated, QA/UR staff shall:

- Evaluate the credentialing organization's ability to perform these activities including an initial review to assure it has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;
- Ensure credentialing organization meets EDC DMC ODS standards and all applicable state and federal law and regulations and other contract requirements.

Maintain a system for reporting serious quality deficiencies that result in suspension or termination of a contract provider to state regulatory authorities

For all licensed, waivered, registered and/or certified providers, EDC DMC ODS will either directly verify and document the required credentialing information, or delegate the process. When applicable to the provider type, the information must be verified by the EDC DMC ODS unless EDC DMC ODS can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

Initial Provider Credentialing

Providers must be licensed, registered, or waivered mental health providers, licensed practitioners of healing arts and registered or certified alcohol or other drug counselors. EDC DMC ODS program staff shall verify and document the following items in the provider's file through the appropriate state licensing entity:

- The appropriate license and/or board certification or registration, as required for the particular provider type;
- Evidence of graduation or completion of any required education, as required for the particular provider type;
- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
- Satisfaction of any applicable continuing education requirements, as required for the particular provider type.
- Signed and dated attestation from provider attesting to:
    - Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation
    - History of loss of license
    - History of felony convictions.
    - History of loss or limitation of privileges or disciplinary activity
    - Lack of present illegal drug use.
    - The accuracy and completeness of the attestations.

NOTE: A felony conviction does not automatically exclude a provider from participation in the Plan's network.

In addition, contracted network providers operating facilities must:

- Provide for appropriate supervision of staff;

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

Recredentialing

EDC DMC ODS shall verify and document at a least every three years that each provider that delivers clinical services continues to possess valid credentials.

Clinical professionals

The following categories of professionals are eligible to provide services through EDC DMC ODS:

- Registered and certified SUD counselors
- SUD Peer Counselors (delivering peer-to-peer substance abuse assistance services as a component of recovery services)
- Licensed Practitioners of the Healing Arts (LPHAs), which include:
    - Physicians;
    - Nurse Practitioners;
    - Physician Assistants;
    - Registered Nurses;
    - Registered Pharmacists;
    - Licensed Clinical Psychologists;
    - Licensed Clinical Social Workers;
    - Licensed Professional Clinical Counselors;
    - Licensed Marriage and Family Therapists; and
    - License Eligible Practitioners working under the supervision of Licensed Clinicians.

EDC DMC ODS shall verify and document the clinical staff following information from each network provider, as applicable:

- Work history
- Hospital and clinic privileges in good standing
- History of any suspension or curtailment of hospital and clinic privileges
- Current Drug Enforcement Administration identification number
- National Provider Identifier number
- Current malpractice insurance in an adequate amount, as required for the particular provider type
- History of liability claims against the provider
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List (may not participate in the network). This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp;
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

Required Duties and Documents for Licensed and Certified Providers

License Verification

Programs shall ensure that those providing services will have all necessary and valid professional certification(s) or license(s) to practice the contracted services. This includes implementing procedures of professional license checks, credentialing and re-credentialing, monitoring limitations and expiration of licenses, and ensuring that all providers have a current National Provider Identifier (NPI) through the National Plan and Provider.

Credentialing-Certification/License Verification/Exclusion Checks

Code of Federal Regulations requires States to establish, and subsequently provides under county Mental Health Plans and pilot DMC-ODS programs to adhere to, a uniform credentialing and re-credentialing policy. Individuals delivering services will need to have their eligibility to deliver services verified as either licensed, licensed-waived, registered, and/or certified prior to hire and monthly thereafter.

Organizational providers are required to verify that their own employees and applicants are not on the Exclusion Lists. Verification documentation is maintained by provider in its personnel files and may be requested by DMC-ODS SUDs QA/UR Supervisor as a contract monitoring activity.

It is expected that all individuals and entities that are involved in providing EDC DMC-ODS clinical services are properly licensed or certified, per their scope of practice. EDC DMC-

ODS verifies the credentials of new providers prior to contract execution; and retained providers are verified regularly to ensure compliance with licensing/certification standards.

DMC-ODS SUDs QA/UR is responsible for verifying individual and organizational/entity contract providers and EDC DMC-ODS staff. Verification documentation is maintained by DMC-ODS SUDs QA/UR. DMC-ODS SUDs QA/UR has developed a form to assist in documenting certification and recertification requirements. This form shall be completed and kept in the record for each DMC EDC ODS clinical staff and contract provider.

All individuals and entities that are involved in Drug Medi-Cal billing are verified on the following lists for the status indicated for each list:

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

- Prior to contract, verify the individual's social security number.

CA Medi-Cal List of Suspended and Ineligible Providers:
http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp

- Prior to contract, and then monthly, verify that the individual is NOT a suspended or ineligible provider.

Federal OIG List of Excluded Individuals and Entities:
https://oig.hhs.gov/exclusions/index.asp

- Prior to contract, and then monthly, verify that the individual/organization is NOT an excluded individual or entity.

California Licensing Boards
https://www.breeze.ca.gov

- Prior to contract, and then monthly, verify that provider's license has not expired and that there are no current limitations on the license.

Excluded Parties List System (EPLS) via the System Award Management (SAM) system
https://www.sam.gov/

- Prior to contract, and then monthly, verify that the individual/organization is NOT an excluded individual or entity.

National Plan and Provider Enumeration System (NPPES) – National Provider Identifier (NPI)
https://npiregistry.cms.hhs.gov/

- Prior to contract, and then annually, verify that the NPI number(s) and related information are accurate, for both individual and organizational/entity providers.

California Revoked and/or Suspended Substance Use Counselor List
http://www.dhcs.ca.gov/provgovpart/Pages/CounselorCertification.aspx

- Prior to contract, and then monthly, verify that the individual is NOT a suspended or ineligible provider.

California Association of DUI Treatment Programs (CADTP)
https://www.cadtp.org/counselors/

- Prior to contract, and then monthly, verify that the provider's certification has NOT expired and that there are no current limitations on the certification.

California Consortium of Addiction Programs and Professionals (CCAPP)
https://ccappcredentialing.org/index.php/verify-credential

- Prior to contract, and then monthly, verify that provider's certification has not expired and that there are no current limitations on the certification.

Eligible DMC-ODS Staff Categories and Definitions

Licensed Practitioner of the Healing Arts (LPHA) Non-Physician:
Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Non-Physician LPHAs include: Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

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

Counselors: "Certified AOD Counselor" means an individual certified by a certifying organization; as defined in Section 13005(a)(2) or 13005(a)(8) of Title 9 of the California Code of Regulations.