SUD Medical Record Review Standards

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	A. AOD 12020, "A separate, complete, and current record shall be maintained at the program for each client. Programs shall develop any necessary forms. All client files shall contain demographic information sufficient to identify the client and to satisfy data collection needs of the program and funding agencies."
B. Chart contents are securely fastened and consistently organized.	B. Printed chart contents are securely fastened, attached or bound to prevent record loss. Electronic record information is readily available. Charts are consistently organized. This is per PHC requirements.

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Criteria	II. Intake Services Reviewer Guidelines
A. Medical record contains a signed Consent to Release Information document.	A. There is evidence of a Consent to Release Information document signed and in the client file for review. This is per 42 CFR. A signed release of information (ROI) is present and includes Partnership HealthPlan, the County, and entities that assist in the coordination of care indicated in the treatment plan.
B. Medical record contains signed HIPAA notification.	B. There is evidence of a HIPAA (Health Information Portability and Accountability Act) notification signed and in the client file for review.
C. Medical record contains signed Client Rights document.	C. There is evidence of a Client's Rights document available in the client file for review.
D. Medical record contains signed Consent to Treatment document.	D. The beneficiary shall sign a consent for treatment form.
E. Medical record contains signed Program Rules document.	E. There is evidence of a Program Rules document signed and in the client file for review.
F. Medical record contains signed Admission Agreement.	F. There is evidence of an Admission Agreement and in the client file for review.
G. Medical record contains evidence of Medi-Cal/Partnership eligibility verification.	G. There is evidence of Partnership or Medi-Cal eligibility in the client file for review.
H. Medical record contains a documented physical exam within 30 days of admission.	H. A physical exam must be in documented in the patient's chart within 30 days of admission into program. The SUDS Clinician Must either: a. Obtain a copy of the most recent physical exam (if one was completed in the last 12 months). The exam can only be reviewed by a Physician, PA, or Nurse Practitioner (N.P.). b. OR c. Perform a new exam. The exam must be performed by a Physician, PA, or Nurse Practitioner (N.P.). d. Contact Partnerships Care Coordination (CC) team to assist the member with establishing a PCP provider that will be able to perform the necessary physical exam. • Perinatal Patients o Physician shall review the most recent physical examination within 30 days of admission to treatment. The physical examination should be within a 12 month period prior to the admission date. • Alternatively, a physician or non-physician medical practitioner may perform a physical examination within 30 calendar days of admission. 22 CCR § 51303, 42 CFR § 438.210(a)(4) PHC contract states if client has not been seen in longer than 6 months, client will be referred to Partnerhsip Care Coordination department to aid in receiving medical care.

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I. Medical Record indicates MAT services were offered or member was referred	I. Medical Record indicates MAT services were offered or member was referred
J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.	J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.
K. Appropriate documentation of admission and readmission criteria.	K. Each provider shall include in its policies, procedures and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at minimum: • DSM diagnosis • Use of alcohol/drugs abuse • Physical health status • Documentation of social and psychological problems
L. Medical Necessity is determined appropriately.	L. Medical necessity must be performed in a face-to-face or telehealth (video-conference) review by either a medical director or a LPHA. Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i. *This is part of a DHCS decision to make this a mandatory step in Medical Necessity Determination for waiver beneficiaries (see waiver). The intake information is compared to the DSM-IV criteria. A diagnosis is made if enough criteria are met to support the diagnosis. The ASAM criteria is compared to the DSM diagnosing criteria, and the level of care is then determined. For beneficiaries 21 and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain. For beneficiaries under 21 years of age, a service is deemed medically necessary if the service can improve or correct a screened health condition, such as SUD. The service does not have to correct the issue. It can sustain, support, improve or make the condition more tolerable to be necessary. These services are covered under Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. The diagnosis and medical necessity determination shall be completed within 30 calendar days of the first face-to-face interaction. Medical necessity determination for homeless patients shall be completed within 60 days.
M. Missed appointments and outreach efforts are consistently documented in the client's chart.	M. There must be documentation from the facility to the client for engagement in treatment. Medical record contains documentation of missed/excused group sessions and/or individual counseling sessions.

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N. Medical record contains evidence the provider accepts proof of eligibility as payment.	N. Per Title 22, providers must accept proof of Medi-Cal/Partnership eligibility as payment in full for treatment services rendered upon intake and monthly. NOTE: This is except when there is a share of cost (SOC).
O. Medical record contains evidence of ASAM criteria used to determine medical necessity.	O. • American Society of Addiction Medicine (ASAM) Criteria shall be documented by the diagnosing individual (Medical Director or LPHA) and used to determine placement and level of services needed. Adults must meet the ASAM criteria definition of medical necessity for services. • Providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. • The assessment shall include a typed or legibly printed name of the service provider, provider signature , provider title (or credentials), and date of signature • Assessments shall be updated as clinically appropriate, or as needed if the member's condition changes • For adolescent clients, a developmentally appropriate ASAM tool shall be used • RESIDENTIAL ASAM Criteria Assessment is required before a DMC-ODS plan authorizes a residential treatment level of care. **AUTOMATIC CAP IF ASAM IS NOT COMPLETED
P. Medical record contains evidence of appropriate documentation during intake.	P. The provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment. The history shall be completed during the first face-to-face interaction. Assessment for all beneficiaries shall include at a minimum: Drug/alcohol use history; Medical history; Family history; Psychiatric/psychological history; Social/recreational history; Financial status/history; Educational history; Employment history; Criminal history, legal status, and previous SUD treatment history.

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Criteria	III. Care Planning Criteria – Treatment Plans – NTP ONLY Guidelines
A. Medical record contains the most recent Treatment Plan.	A. The most recent treatment plan must be in the file.
B. Medical record contains a legibly signed treatment plan during appropriate timeframe.	B. Signature: If the MD or LPHA deem the services in the initial treatment plan medically necessary, they must print their name, sign, and date the treatment plan within 15 calendar days of being signed by the counselor. Withdrawal Management within one business day of admission. • It must be signed by the beneficiary (client) and the counselor within 30 days of admission to treatment. • IF the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment. Note: If ALL signatures are not within the total 30 day timeframe, Services rendered in that time will be ineligible for payment. Legibility: means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.
C. Treatment plan is client specific and AOD 7110 compliant.	C. Per Title 22, the statement of problems should match the assessment. Goals to be reached need to address each problem the patient presents with. Action steps refer to activities and interventions which will be taken to accomplish the goal(s). Target dates are dates set in place for when the action steps are scheduled to be accomplished. • Statement of problems • Goals including goal of obtaining a physical exam if needed, and goal of obtaining treatment for an identified significant medical illness if needed • Action steps should include: Target dates • Type and frequency of counseling/services • Diagnosis as documented by the Medical Director or LPHA • Assignment of primary therapist or counselor • Documentation of physical exam requirements • Documentation demonstrates the client played an active role in creating the treatment plan. • Recovery/discharge plan is part of ongoing treatment plan goals. • Timeframe: Within 30 calendar days from beneficiary's admission to treatment

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D. Medical record contains evidence that the ongoing treatment plan meets Title 22 requirements.	D. The Ongoing Treatment Plan must be: • Completed with 90 days after the signing of the initial Treatment Plan. • Signed by the counselor within 90 days after the initial Treatment plan. • Signed by the client within 30 days of being signed by the counselor. The ongoing Treatment plan must have a signature from the LPHA/MD within 15 days of being signed by the client. Per Title 22, It is mandatory for the ongoing treatment plan to be completed no later than 90 days after the initial treatment plan and must be signed by the counselor within 90 days after the initial treatment plan, signed by the client within 30 days of the counselor's or LPHA's signature, and signed by the MD/LPHA within 15 days of being signed by the client. • If beneficiary refuses to sign updated treatment plan, then document reason for refusal and document strategies to engage beneficiary to participate in treatment. Note: All Signatures must be present and within the appropriate timeframe in order to get the point for this criteria.
Criteria	**III. Care Planning Guidelines – Problem Lists – All LOC (except NTP)**
A. A problem list is established for each client	A. The problem list supports the medical necessity of each service provided.
B. Problem list includes all the required elements	B. The problem list includes a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through the assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list shall include all of the following, but is not limited to: A diagnosis given by a LPHA. Should include specifiers from the DSM, if applicable. Problems identified by provider acting within their scope of practice, if any. Problems or illness provided by client or significant support person, if any. Name and title of provider who identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.
C. Problem list is updated in a reasonable time frame	C. Any problems identified during a subsequent intervention may be added to the problem list. Problems should be updated on an ongoing basis when there is a relevant change. Provider is required to update when problems change and in a reasonable time.

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Criteria	IV. Treatment Services Reviewer Guidelines
A. Counseling session attendance is appropriately documented in the chart.	A. According to AOD 8000 c. 1-4, "The following documentation of attendance at each individual counseling session and group counseling session shall be placed in the client's file: 1. Date of each session attended; 2. Type of session (i.e., individual or group); 3. Signature of counselor who conducted the session; and 4. Notes describing progress toward achieving the client's treatment plan or recovery plan goals". This is also illustrated in § 51341.1. Drug Medi-Cal Substance Use Disorder Services.22 CA ADC § 51341.1
B. Progress notes contain the minimum required documentation according to Title 22 and AOD 7100b.BHIN 23-068	B.For Outpatient, Intensive Outpatient, Naltrexone Treatment, and Recovery Services, the Progress Note consists of all of the minimum components spelled out in the AOD 7100 b. Per Title 22 and AOD 7100 b, LPHA or Counselor must have these elements in their progress notes for all patients enrolled in outpatient services:
1) Topic of the session	1) Topic of the session
2) Description of beneficiary's progress toward treatment plan goals.	2) Description of beneficiary's progress toward treatment plan goals.
3) Date of each treatment service.	3) Date of each treatment service.
4) Start and end time of each treatment service.	4) Start and end time of each treatment service.
5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) within 3 days of the session	5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) within 3 days of the session
6) Identifies if the service was in-person, telephone or telehealth	6) Identifies if the service was in-person, telephone or telehealth
7) Location of the service and how confidentiality was maintained (if provided in the community) is clearly documented	7) Location of the service and how confidentiality was maintained (if provided in the community) is clearly documented

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8) If care coordination services are provided, additional criteria of: a description of how the services relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referral.	8) If care coordination services are provided, additional criteria of: a description of how the services relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referral.
9) For Crisis services, documentation must be completed within 24-hours of incidence.	9) For Crisis services, documentation must be completed within 24-hours of incidence.
C. There is evidence of at least two Evidence Based Practices (EBPs) being used.	C. Intergovernmental Agreement Exhibit A, Attachment I Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatment. They are as follows: • Motivational Interviewing: this approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. • 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. • Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivor's safety, choice, and control. • 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. • 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 disorder treatment.

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D. Medical record contains evidence of the required number of monthly counseling sessions.	D. Per Title 22 and AOD standards: Outpatient - two individual or group counseling sessions each month Intensive Outpatient – progress note for each session Residential –daily When applicable, the progress notes must contain dates and duration of group counseling sessions and have to be signed within 3 days There is evidence of the required number of counseling hours for each LOC. (OP 9 hours or less a week, IOP more than 9 hours a week, Residential: WM: NTP
E. Progress notes contain an individual narrative summary describing client's progress on the treatment plan/problem list goals and action steps.	E. Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps. The progress note must contain this documentation in order to receive points on this criteria. This is crucial to insuring that the care and action steps taken are individualized to the client identified needs and consistent with the treatment plan goals.
F. The program provides individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.	F. According to AOD 8000 a., "The program shall provide individual and group counseling sessions for clients. Family members and other persons who are significant in the client's treatment and recovery may also be included in sessions. Individual and group counseling sessions shall be directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources. Emphasis shall be placed on the recovery continuum appropriate to clients' needs."
G. Medical record contains evidence of provider coordination of care to ensure smooth transitions between LOCs	G. Both the discharging and admitting PROVIDER agencies shall ensure the transition to appropriate LOC. This may include a step-up or step-down in DMC-ODS services. Care coordinators shall provide warm hand-offs and transportation to the new LOC when medically necessary. Provider Agencies shall ensure transitions to other LOCs occur no later than 10 days from the time of assessment or reassessment with no interruption of current treatment services A warm hand off is an interaction that happens in person between members of the transferring and receiving provider in front of the client and family (if present).

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Criteria	V. Discharge Services Reviewer Guidelines
A. Discharge plan or Discharge Summary is documented in the chart	A. Per Title 22: "A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact." If the medical director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to go to an appropriate level of treatment services. Discharge plan should include the following: • A description of each of the beneficiary's relapse triggers. • A plan to assist the beneficiary to avoid relapse when confronted with a trigger • A support plan The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary. The discharge plan shall be completed by the time of transfer if moving to a different level of care.
B. The discharge plan is signed by both the patient and the counselor	B. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the patient and shall be documented in the patient's record. This is N/A if the provider loses contact with the client.
C. Discharge plan or summary shall include the following elements:	**C. A discharge summary shall include the following elements:** (This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client. 3 documented attempts of outreach to client within 30 days of last visit. According to AOD 7120 b)
1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;	1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;
2) Description of treatment episodes;	2) Description of treatment episodes;
3) Description of recovery services completed	3) Description of recovery services completed
4) Current alcohol and/or other drug usage	4) Current alcohol and/or other drug usage
5) Vocational and educational achievement	5) Vocational and educational achievement
6) Client's discharge summary signed by counselor and client	6) Client's discharge summary signed by counselor and client

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7) Transfers and referrals	7) Transfers and referrals
8) Client's comments	8) Client's comments
9) Beneficiary's prognosis	9) Beneficiary's prognosis
10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.	10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.
11) Medication needs were addressed in the discharge planning	11) Medication needs were addressed in the discharge planning
12) Housing needs and/or a safe discharge plan were addressed in the discharge planning	12) Addressing where the beneficiary will be residing after discharge. Are they unhoused? They should be referred to Community Supports. Returning to a home where substances are used? Alternative housing such as a sober living environment should be addressed. Reference ASAM Dimension 6
D. If client was unavailable to complete a Discharge Plan, the Discharge Summary was completed within 30 days of the last face-to-face contact with the client.	D. This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client. 3 documented attempts of outreach to client within 30 days of last visit.
1) 3 documented attempts of outreach to client within 30 days of last visit	1) 3 documented attempts of outreach to client within 30 days of last visit

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Criteria	VI. Care Coordination Reviewer Guidelines
A. Care coordination shall be provided in conjunction with all levels of treatment deemed necessary	A. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.
B. Care coordination services shall include one or more of the component listed (Medical, Mental Health, Ancillary services, Housing, Children's Services, Social Services)	B. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups. Case managers (e.g., care coordinators) provide continuous support for the adolescents, ensuring there are linkages to services including those provided by other systems (CSAT, TIP 27, 2008). a) Each adolescent and his or her family should receive case management and/or care coordination services from the SUD treatment provider. b) Case managers and/or care coordinators should be familiar with adolescentserving agencies/systems and other community resources, both formal and informal, to effectively facilitate access to other systems. Providers should help ensure the adolescent and his or her family are educated on health care options in the community. This may include assisting with the coordination of transportation and scheduling medical appointments.
C. Clinical Peer to Peer Consultation must be documented with a progress note	C. Clinician Consultation Services consist of LPHAs, such as addiction medicine physicians, licensed clinicians, addiction Psychiatrists, or clinical pharmacists, to support the provision of care. Clinician Consultation is not a direct service provided to beneficiaries. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries.

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Criteria	VII. Residential Reviewer Guidelines-Only if Applicable
A. Medical record contains evidence of prior authorization for services.	A. Residential Treatment requires a Prior Authorization for services.
B. Evidence of multidimensional LOC assessment within 72 hours of admission is present	B. Evidence of multidimensional LOC assessment is completed within 72 hours of admission is present
C. There is oversight of self-administered medications.	C. There is documentation present in the chart that illustrates oversight of patient's taking their medication.
D. Medical record contains documentation of a TB test performed, results, and services offered with a diagnosis of TB	D. A positive test and/or chest x-ray confirming Tuberculosis will be used to confirm the level of care that must be provided to the client. There has been Tuberculosis (TB) testing done and care received based on results. It is mandatory for Tuberculosis services to be offered with a diagnosis of Tuberculosis (TB).
E. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 15 days	E. Adult beneficiaries in Residential treatment shall be re-assessed at a minimum every 30 days (since they will be assessed on day one). Youth beneficiaries in residential treatment shall be re-assessed at a minimum of every 15 days, unless there are significant changes warranting more frequent reassessments.

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Criteria	VIII. Perinatal/Family Guidelines – Only if Applicable
A. Relevant services offered to perinatal patients or clients with families.	A. 1) Mother/child/ family rehabilitative services. 2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant. 3) Educational/vocational training and life skills resources 4) TB and HIV education and counseling 5) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding 6) Parenting skills-building and child development information 7)Child care is offered for women to receive primary medical care services and any gender-specific treatment services.
B. Daycare facilities are available to Outpatient Perinatal Patients.	B. In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment Program provides/arranges for therapeutic interventions for the children of the women receiving SUD treatment services to address the child's: i. Developmental needs; ii. Sexual abuse; iii. Physical abuse; and Neglect
C. Perinatal/Pediatric Patient Care	C. Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.
D. Interim services have been offered	D. If client waited more than 48 hours for treatment, indication of the offering of interim services and the outcome of that offering is included in the patients chart
E. IVDU Interim services have been offered	E. If the patient uses needles, documentation that the patient received expedited admission within 14 days after the request or within 120 days if interim services were provided.
F. Transportation have been offered/provided	F. Evidence of transportation provided to perinatal, postnatal, or well child appointments indicated within chart
G. Medical record contains proof of pregnancy and/or delivery for perinatal patients.	G.Positive pregnancy test or proof of delivery is documented in the medical records.

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	Telehealth Services Guidelines
Criteria	**DHCS requires that every provider offering covered services to a beneficiary via telehealth must also meet the requirements of Business and Professions Code Section 2290.5(a)(3), or otherwise be designated by DHCS as able to render Medi-Cal services via telehealth. All providers that are listed in the California Medicaid State Plan as qualified providers of SMHS, DMC, or DMC-ODS services are designated by DHCS as able to render covered services, within their scopes of practice, via telehealth.** **The California Medicaid State Plan includes qualified provider lists in Supplement 3 to Attachment 3.1-B, Limitation on Services 13.d.5, Substance Use Disorder Services, Provider Qualifications (Drug MediCal); Supplement 3 to Attachment 3.1-B, Limitation on Services 13.d.6, Expanded Substance Use Disorder Treatment Services, Practitioner Qualifications (Drug Medi-Cal Organized Delivery System); and Supplement 1 to Attachment 3.1-A, Qualification of Providers; Supplement 2 to Attachment 3.1-B, Provider Qualifications; and Supplement 3 to Attachment 3.1-A, Provider Qualifications (Specialty Mental Health).**
Member consent was received and documented prior to providing telehealth services.	Providers must document the beneficiary's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The beneficiary's consent must be documented in their medical record and made available to DHCS upon request. A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement: 1) specifically mentions the use of telehealth delivery of covered services; 2) includes the information described above; 3) is completed prior to initial delivery of services; and 4) is included in the beneficiary record. DHCS has created model verbal and written consent language, which can be found on the DHCS website. The Model Telehealth Patient Consent Language is available at: https://www.dhcs.ca.gov/provgovpart/Pages/Patient-Consent.aspx.

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Telehealth services are documented and clearly notes the mode of use; telephone or video.	Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to beneficiaries: •The beneficiary has a right to access covered services in person. •Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access MediCal covered services in the future, •Non-medical transportation benefits are available for in-person visits. •Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable
If the assessment was completed via telehealth services, it was performed via synchronous video interaction unless documented that the member does not have video capability.	Services provided by telehealth may be provided and reimbursed by each of the following programs as described below: **Drug Medi-Cal Organized Delivery System:** •The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care may be delivered through synchronous video interaction. •The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care shall only be delivered through synchronous audio-only interaction in the situations identified above in this BHIN. •Licensed providers and non-licensed staff may deliver services through telehealth, as long as the service is within their scope of practice. •Covered DMC-ODS services may be delivered through telehealth when those services meet the standard of care. The group size limit still applies for group counseling provided via telehealth. •Certain services, such as residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California's State Plan does not require that all components of these services be provided in-person. (For example, services can be provided via telehealth for a patient quarantined in their room in a residential facility due to illness.) **Drug Medi-Cal:** •DMC services, as defined in W&I section 14124.24, provided by a licensed practitioner of the healing arts, or a registered or certified alcohol or other drug counselor or another individual authorized by DHCS to provide DMC

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Criteria	Peer Support Services Guidelines
Where services are rendered by Peer Support Specialists they are limited to Education Skill Building Groups, Engagement, or Therapeutic Activity	Medi-Cal Peer Support Services may be delivered as a standalone service or provided in conjunction with other Specialty Mental Health Services (SMHS), DMC, or DMC-ODS services, including inpatient and residential services. Medi-Cal Peer Support Specialist Services are not subject to prior authorization by Medi-Cal behavioral health delivery systems. In accordance with the SMHS, DMC, and DMC-ODS billing manuals, there are no lockouts for Medi-Cal Peer Support Services. Medi-Cal Peer Support Services may be delivered by any Medi-Cal Peer Support Specialist affiliated with an organizational provider that is contracted with a Medi-Cal behavioral health delivery system to provide Medi-Cal Peer Support Services. Medi-Cal Peer Support Services must be coordinated to avoid duplicative services. Medi-Cal Peer Support Services must be based on an approved plan of care. Please refer to BHIN 23-068, or superseding guidance, for documentation requirements for SMH, DMC, and DMC-ODS services. Medi-Cal Peer Support Services are limited to the following three service components as outlined in California's Medicaid State Plan. Services provided shall fit within at least one of those service components: (1) Educational Skill Building Groups means providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, selfsufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

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Documentation indicates supervision was rendered and who the supervising staff was.	Medi-Cal Peer Support Specialists shall provide services under the direction of a Behavioral Health Professional. Behavioral Health Professionals must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and be listed in the California Medicaid State Plan as a qualified provider of SMHS, DMC, or DMC-ODS. All SUD and Expanded SUD services, including MediCal Peer Support Services, must be medically necessary and recommended by physicians or other Licensed Practitioner of the Healing Arts (LPHAs) acting within their scope of practice. All SMHS, including Medi-Cal Peer Support Services, must be medically necessary and recommended by physicians or other Licensed Mental Health Professionals (LMHPs) acting within their scope of practice. (1) For Medi-Cal Peer Support Services provided as SMHS, the following Behavioral Health Professionals listed in the state plan as LMHPs may direct services: Licensed Physicians; Licensed or Waivered Psychologists, Licensed, Waivered, or Registered Clinical Social Workers; Licensed, Waivered, or Registered Professional Clinical Counselors; Licensed, Waivered, or Registered Marriage and FamilyTherapists;16 Registered Nurses (including Certified Nurse Specialists or Nurse Practitioners); and Licensed Occupational Therapists. (2) For Medi-Cal Peer Support Services provided as a DMC/DMC-ODS service, the following Behavioral Health Professionals listed in the state plan as LPHAs may direct services: Physicians; Nurse Practitioners; Registered Nurses; Licensed Clinical Psychologists; Licensed or Registered Clinical Social Workers; Licensed or Registered Professional Clinical Counselors; Licensed or Registered Marriage and Family Therapists; and Licensed Occupational Therapists.

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Criteria	Adolescent Services Guidelines
Provider addresses co-occurring mental health disorders through direct services or documents outcome of referrals and connections to treatment. The provider documents services provided to individuals with cooccurring mental and/or physical health conditions (e.g., medication noncompliance or abuse, interactions of drug use and other medications).	SUDs often co-occur with physical health conditions which is why it is important to provide access to appropriate medical care for adolescents entering treatment. . It is recommended part of the adolescent's assessment include identification of physical health issues and subsequent referral to relevant providers, services, and supports. Physical interventions may lessen the likelihood of depression and support abstinence and recovery. Additionally, adolescents being treated for SUDs have a significantly higher prevalence of several medical conditions (e.g., asthma, pain conditions, and sleep disorders) that could be ameliorated by physical interventions (SAMHSA, 2013). With this in mind, all SUD treatment providers should screen for health conditions, be familiar with the process for making health care referrals and make appropriate referrals to health care providers as needed (SAMHSA, 2013). a) Comprehensive assessments should include a screening of the adolescent’s medical status, including medical history. b) Appropriately trained and educated providers should screen or refer adolescents for screening of existing physical health conditions and assess for behaviors that may place the adolescent’s physical health at risk. The screening should pay particular attention to the identification of conditions that co-occur more commonly in individuals with SUDs (e.g., fetal alcohol spectrum disorders, HIV, hepatitis, liver/kidney disease, chronic pain, sexually transmitted infections [STIs], and tuberculosis). c) Providers should establish partnerships with medical organizations or practitioners equipped to address the physical health needs of adolescents (e.g., primary care physicians, dentists, optometrists, gynecologists, obstetricians) to facilitate any necessary referrals. d) Providers should ensure that health education will be used to provide

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The adolescent's developmental and cognitive levels; social, emotional, and communication abilities and strengths; and independent living skills are assessed and documented in the member's chart.	Effective assessments identify the adolescent's strengths and resilience factors (Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2011). a) Providers should use a comprehensive and multidimensional assessment to determine the adolescent's level of care, needs, and treatment approach. The adolescent's geographic location, school, cultural identity, family, developmental level, priorities, and gender and sexual identity may also be taken into account as they relate to engagement, retention, and recovery supports. b) Assessment is an ongoing process that should be trauma informed, comprehensive, multifaceted, and culturally and developmentally appropriate for each adolescent admitted to treatment. c) The assessment should include questions that identify the strengths, resiliencies, natural supports, and interests of the adolescent to accurately assess the adolescent's unique abilities that will assist in his or her recovery. d) The adolescent's developmental and cognitive levels; social, emotional, and communication abilities and strengths; and independent living skills should be assessed. e) The goals of assessment should include the identification of natural supports, strengths, and resilience along with motivation and readiness for treatment, cultural/linguistic barriers to treatment and recovery, and areas of functional impairment or skills deficit. f) The provider should assess for substance use (including tobacco/nicotine use); co-occurring mental health disorders; physical health; cognitive, social, and affective development; family, peer, and romantic relationships; trauma; current or past emotional, physical, or sexual abuse; suicidality;

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Provider documents use of EBPs that are age, gender, developmentally, and culturally appropriate.	EBPs include screening tools, assessment tools, counseling, family counseling, group counseling practices, and use of medications in treatment. In acknowledgement of the ever-evolving field of SUD treatment, specific EBPs are not listed in this document, but providers are encouraged to seek out and use developmentally appropriate EBPs. a) Providers should have an understanding of models and theories of SUDs and behavioral, psychological, physical, and social effects of psychoactive substances. They should also remain up to date on current research and evidence-based and best practices for adolescent treatment and recovery. b) To use EBPs effectively, providers should ensure staff members are adequately trained and qualified to implement the practices with fidelity and have the appropriate supervision. c) Provider personnel files should document training(s) and/or certification(s) in the evidence-based model(s) the staff member is using in the provision of adolescent services. d) Providers should be able to demonstrate which EBP is implemented, how trainings and supervision are conducted, and how fidelity is assured. e) Providers should use EBPs that are age, gender, developmentally, and culturally appropriate as identified by national or state-level EBP clearinghouses (e.g., EBPs listed in SAMHSA's National Registry of Evidence-Based Programs and Practices).

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Treatment and recovery plans reflect the adolescent's educational goals and objectives. Providers work with adolescents to help them discover their interests (e.g., hobbies, games, sports, creative ventures) and strengths through the treatment and recovery plan.	The treatment and recovery plans are assessed and modified continuously and reflects changes in needs and preferences of the adolescent. a) The treatment and recovery plan should be developed in collaboration with the adolescent and his or her family or other supportive adults based on his or her unique strengths, assets, and needs. b) The plan should reflect the adolescent's developmental stage; gender identity; culture; sexuality; and chronological, emotional, and psychological age. c) During the treatment and recovery planning process, the adolescent and his or her family should identify recovery goals (desired outcomes) that reflect how they define progress and support needs (e.g., the adolescent developing positive relationships, reduced substance use and abuse symptoms, school retention, and improvement of family relationships). d) The adolescent's individual treatment and recovery plan should be assessed and reviewed by the adolescent and provider on a scheduled basis, and, additionally, as requested by the adolescent or family. The plan should be open to changes by either the provider or adolescent based on the adolescent's preference, or if the desired outcomes are not being achieved. e)Treatment and recovery plans should include goals for family functioning, or the program should develop a family services plan that identifies the ongoing family support and improvement goals. f) Family members should be involved and/or updated about changes in the treatment and recovery plan as appropriate, including being provided information on recovery support services and continuing care options. g) The strategies and services specified in the plan should include identification of the individuals providing treatment, an expected timetable
For adolescents in residential treatment, a transition plan is developed prior to their return to the community that includes linkages to community-based agencies.	Recovery support services are ideally incorporated at the inception of services (e.g., during engagement, assessment, treatment, and recovery planning) and continue after the adolescent's discharge from or completion of a primary treatment episode. Recovery support services should be developmentally appropriate and tailored to each adolescent and his or her family. Support services should also be provided in a variety of settings and formats, using new technologies to communicate and engage with adolescents in innovative ways (SAMHSA, 2013).

Group counseling sessions are provided when deemed clinically appropriate and in accordance with the adolescent's treatment and recovery plan	Adolescent identity formation is influenced by interactions with peers. Positive interaction with peers in facilitated, supportive group sessions can help the adolescent build meaningful interactions and/or relationships with his or her peers. Group therapies can be psychoeducational, cognitivebehavioral, therapeutic, or focused on relapse prevention. All group therapies should reflect the adolescent's treatment and recovery goals and objectives (CSAT, TIP 41, 2009). a) Group counseling sessions should be provided when deemed clinically appropriate and in accordance with the adolescent's treatment and recovery plan. b) Group counseling sessions should meet the client-to-staff ratio as designated by State regulation or requirement and the recommendations of the developer or purveyor of the group counseling type (e.g., group size). c) When possible and appropriate, providers should offer separate groups for girls, boys, and LGBTQI adolescents. All groups should be trauma-informed and sensitive to issues of gender, cultural norms, and sexual orientation. d) Providers should ensure proper training and supervision of staff members leading group therapy sessions. Training will include practicing group therapy techniques under the supervision of an experienced clinician and obtaining proper licensure or certification as required by thestate. e) Prior to placing adolescents in specific group therapy sessions (e.g., prevention based or educational), the provider (e.g., case manager or counselor) should properly screen participants for SUDs and match the participants to appropriate group(s) (CSAT, TIP 41, 2009). f) Group therapists/facilitators should have an understanding of group