



**Placer County
Drug Medi-Cal Organized Delivery System
Practice Guidelines
2020 Update**

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I. Introduction

1. Practice Guidelines

Placer County services are recovery focused, client centered, and based on individual needs. Placer County has a “no wrong door” approach that focuses on connecting people to the appropriate services and level of care regardless of where they first show up.

The *Placer County Drug Medi-Cal Organized Delivery System Practice Guidelines* is a provider manual to offer guidance to all Placer County Substance Use Disorder providers in complying with State, Federal, and Placer County substance use disorder (SUD) treatment requirements and standards. These guidelines reflect the best possible quality client care standards and seeks to prevent program deficiencies that can lead to the assessment of recoupments. This document will also outline systematic changes with the DMC-ODS compared to the previous State Plan to illustrate new practices. It has been developed in partnership with SUD treatment providers in the spirit of collaboration and transparency.

2. DMC-ODS Waiver & Placer County SUD Requirements

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a State Pilot to test a new paradigm for the organized delivery of health care services for Medicaid (Medi-Cal) eligible individuals with substance use disorders. The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services, increased local control and accountability, greater administrative oversight, new utilization controls to improve care and efficient use of resources, evidence-based practices in substance abuse treatment, and increased coordination with other systems of care. The DMC-ODS Pilot approach is expected to provide Medi-Cal clients with improved access to care and to support the level of system interaction needed to achieve sustainable recovery.

Not only do DMC treatment standards and requirements reflect good clinical practice, but also, they offer Placer County the opportunity to improve access to high quality care under the DMC- ODS Pilot program. County specific implementation plans can be found at the Department of Health Care Services (DHCS) website located [here](#).

DHCS is responsible for administering SUD treatment in California. The Placer County Department of Health & Human Services contracts with DHCS to fund local SUD treatment services. As part of the contract with DHCS, the Placer County Adult System of Care (SOC) ensures that state SUD treatment requirements and standards are met by maintaining fiscal management systems, monitoring provider billing, conducting compliance site visits, processing claims for reimbursement, and offering training and technical assistance to SUD treatment providers.

3. SOC Modalities Covered

By opting-in to participate in the DMC-ODS, Placer County is required to provide a continuum of services to all eligible beneficiaries modeled after the ASAM criteria. Services required to participate in the DMC-ODS include:

- a. Early Intervention (overseen through the managed care system)
- b. Outpatient Services
- c. Intensive Outpatient Services
- d. Short-Term Residential Services
- e. Withdrawal Management
- f. Opioid/Narcotic Treatment Program Services
- g. Recovery Services
- h. Case Management
- i. Physician Consultation

The following *optional* services can be provided to beneficiaries:

- a. Partial Hospitalization
- b. Additional Medication Assisted Treatment
- c. Recovery Residences

The table below indicates the difference and similarities between the previous State Plan delivery system versus DMC-ODS.

<u>Old State Plan</u>	<u>New DMC-ODS</u>
Outpatient Drug Free Treatment	Outpatient Services
Intensive Outpatient Treatment	Intensive Outpatient Services
Naltrexone Treatment	Naltrexone Treatment
Narcotic Treatment Program (methadone)	Opioid (Narcotic) Treatment Program OTP/NTP (methadone + additional medications)
Perinatal Residential SUD Services (limited by bed capacity)	Residential Services (not restricted by bed capacity or limited to perinatal)
Detoxification in a Hospital (with a TAR)	Withdrawal Management (at least one level) Recovery Services Case Management Physician Consultation Partial Hospitalization (Optional) Additional Medication Assisted Treatment (Optional)

4. Regulatory Oversight

Substance Use Disorder Services administered in Placer 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 Placer County DMC-ODS will operate according to the regulations set forth by the Federal Government Special Terms and Conditions, the State of California Intergovernmental Agreement, as well as its own provisions outlined in specific provider contracts. It is common for providers in

Placer 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 Disorder 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 Placer County Quality Management and the Department of Health Care Services will evaluate providers. Should a question arise, Providers are encouraged to seek clarification by Placer County Quality Management at PlacerQM@placer.ca.gov.

II. Administration

1. Certification Requirements for Treatment Providers

Provider certification and enrollment in the federal Medicaid program is required to provide DMC services. This is submitted to DHCS. DHCS will certify each provider and designate each residential alcohol and/or other drug treatment facility with the appropriate ASAM level of care based on the services provided at the facility. All providers offering services under the pilot program must be certified by DHCS and provide their certification letter to the SOC upon request.

2. Certification Requirements for Recovery Residences

Recovery Residences are safe, stable, and supportive living environments that are essential to individuals recovering from SUD and require housing assistance to support their health wellness and recovery. Recovery Residences are not reimbursable through the DMC-ODS Waiver. Placer has adopted the standards set by the National Association of Recovery Residences (NARR) as a basis for determining the quality of a potential recovery residence program, however it is not required for individual programs to be certified by NARR at this time. Recovery Residences are established as part of the Placer SOC network by submitting the *Substance Use Services Recovery Residence Readiness Review* which attests to the safety and security of the residence. Upon review, a determination is made by the Placer QM department and can be submitted to placerm@placer.ca.gov.

3. Beneficiary Service and Financial Eligibility

Beneficiaries under the DMC-ODS are individuals who have been determined eligible for Placer County Medi-Cal; have a qualifying substance-related disorder (explained in section III), meet the admission criteria for DMC covered services (explained in section III) and are not institutionalized.

It is the responsibility of each SUDS provider to conduct a verification/determination of each client's Medi-Cal eligibility and county of residence as part of program acceptance. The program must inform the client that they may request a financial assessment to determine his/her ability to pay program fees. This shall be included in all client service contracts. Programs may not deny services to a client if, based on the results of financial assessment, the program determines the client is unable to pay the

program fee. In no case is a qualified Medi-Cal client who is pregnant or less than 60 days postpartum to be charged for any residential treatment. A sliding fee scale shall be utilized for non-Medi-Cal clients. Providers must assess the client program fee and set the payment schedule based on the client's documentation of income. Providers must maintain in the client records a copy of all financial assessments and documentation of income provided by the client. If the client is eligible for Medi-Cal services, it shall be documented that Medi-Cal is accepted as payment in full.

Providers of DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the *Department of Health Care Services DMC Provider Billing Manual*. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the *Department of Health Care Services DMC Provider Billing Manual*.

4. Beneficiary Rights

Beneficiaries are afforded the following rights:

- a. To receive medically necessary SUD treatment services from the County Plan;
- b. To Be treated with respect and with due consideration for his or her dignity and privacy;
- c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand;
- d. Participate in decisions regarding his or her health care, including the right to refuse treatment;
- e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- f. Request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 160 & 164 subparts.
- g. To be furnished health care services in accordance with 42 CFR §§438.206 through 438.210;
- h. Receive timely access to care, including services available 24 hours a day, 7 days a week, when medically necessary to treat an emergency condition or an urgent or crisis condition;
- i. Receive the Placer County Drug Medi-Cal Organized Delivery System Member Handbook;
- j. Have their confidential health information protected;
- k. Receive written materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested;
- l. Receive oral interpretation services for their preferred language;

- m. Receive SUD treatment services from a County Plan that follows the requirements of its contract with the State in the areas of availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services;
- n. Access Minor Consent Services, if applicable;
- o. Access medically necessary services out-of-network in a timely manner, if the plan does not have an employee or contract provider who can deliver the services;
- p. Request a second opinion from a qualified health care professional within the county network, or one outside the network, at no additional cost;
- q. File grievances, either verbally or in writing, about the organization or the care received;
- r. Request an appeal, either verbally or in writing, upon receipt of a notice of adverse benefit determination;
- s. Request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible; and
- t. Be free to exercise these rights without adversely affecting how they are treated by the County Plan, providers, or the State.

5. Informing Materials

Beneficiaries are to receive informing materials upon admission into a program including:

- a. How to access the *Placer County Drug Medi-Cal Organized Delivery System Member Handbook*, This can be found [here](#). If requested a paper copy must be printed;
- b. Beneficiary rights;
- c. Share of cost if applicable;
- d. Notification of DMC funding accepted as payment in full.
- e. Consent to treatment;
- f. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay;
- g. Complaint process and grievance procedures (found in the beneficiary handbook);
- h. Appeal process for involuntary discharge (found in the beneficiary handbook); and
- i. Program rules and expectations.

6. Non-Discrimination

Providers shall accept individuals eligible for enrollment in the order in which they apply without restriction and with regard to noted timely access standards, urgent status as outlined in Placer County Policy. Providers shall take affirmative action to ensure that beneficiaries are provided covered services and will not discriminate against individuals

eligible to enroll under the laws of the United States and the State of California. Providers shall not unlawfully discriminate against any person.

7. Special Populations

1. Perinatal

Placer County and its providers shall comply with federal and state mandates to provide SUD services as medically necessary for Medi-Cal eligible pregnant and post-partum women. Coverage for post-partum women begins the day after termination of pregnancy, plus 60 days. Providers who offer perinatal DMC services are required to be properly certified to provide these services and shall comply with the Perinatal Services Network Guidelines.

2. Adolescents and Youth

Youth under age 21 who are eligible under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. DMC-ODS does not overrule any EPSDT requirement. Medical necessity for youth under 21 is determined if the adolescent shall be assessed to be at risk for developing a substance use disorder, and if applicable, meets the ASAM adolescent treatment criteria. Early intervention for adolescents (ASAM Level 0.5) constitutes a service for individuals who are at risk of developing substance-related problem. Providers are required to follow the Youth Treatment Guidelines in developing and implementing adolescent treatment programs funded through the DMC-ODS waiver.

8. Provider Staff

The DMC-ODS' expansion of the SUD treatment continuum also brought on changes to provider staff roles and level of oversight. Below is a breakdown of service provider types as well as a brief breakdown of responsibilities by classification.

9. Licensed Practitioners of the Healing Arts

Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Please note: although classified as an LPHA, some professional service provider types cannot undertake all the responsibilities of an LPHA as they may be restricted by their scope as dictated by their governing board. For example, a registered nurse or pharmacist cannot diagnose. These will be expanded later in the SUD Treatment Process and Documentation sections.

LPHAs include:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Registered Nurses
- Registered Pharmacists
- Licensed Clinical Psychologists

- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Licensed Professional Clinical Counselors
- Licensed Eligible Practitioners working under the supervision of a licensed clinician

10. Counselors

All counselors 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 is required to be registered or certified as defined in Title 9, Division 4, Chapter 8 and shall adhere to all requirements. If at any moment there is a lapse in their certification renewal they are ineligible to provide DMC services to beneficiaries.

11. Counselor/LPHA Responsibilities:

- Intake – including assessment
- Individual & Group Sessions
- Crisis Intervention
- Progress Notes
- Continuing Services Justification
- Initial & Updated Treatment Plans
- Sign-In Sheets
- Collateral Services
- Case Management Services
- Discharge Plan / Discharge Summary

12. Medical Director Role and Responsibilities

While SUD treatment providers may have more than one physician on staff, the Medical Director has medical responsibility of all clients and must be available on a regularly scheduled basis. The SUD Medical Director is a physician who is licensed by the Medical Board of California and credentialed by Placer County Quality Management (QM). Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician, and provided to the county QM program. Placer County policy QM 315, DMC-ODS Medical Director Monitoring, provides such documents to be signed and returned to QM. Duties of the Medical Director may vary, but at a minimum, DMC-ODS Medical Directors must:

- a. Ensure medical care provided by physicians, registered nurse practitioners, and physician assistants meet the applicable standard of care.
- b. Ensure physicians do not delegate their duties to non-physician personnel.
- c. Establish, review, and maintain medical policies and standards.
- d. Ensure the medical decisions made by physicians are not influenced by fiscal considerations.

- e. Ensure physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for clients, determine the medical necessity of treatment for clients (includes 5 CEUs related to addiction medicine annually).
- f. Ensure physicians are adequately trained to perform other physician duties.
- g. Ensuring the quality of medical services provided to all clients.
- h. Ensuring at least one physician providing services for the provider has admitting privileges to a general acute hospital.

13. Peer Roles and Responsibilities

Peer support services are only available as part of Recovery Services. Qualified peer support staff can share their lived experience and assist beneficiaries with their recovery. The role of the Peer is to provide Substance Abuse Assistance services which includes peer-to-peer service and relapse prevention. Peer staff will also contribute to the treatment planning process as applicable. Prior to delivering services, peers must be trained and credentialed and complete the *Placer Peer Skills Training Modules*.

Each provider will develop procedures to ensure that peer support staff will receive regular supervision focused on Professional development and training, client interactions, documentation training and practices, and the provision of direct service. Additionally, they will ensure peer support staff remain in compliance with regulatory personnel requirements. Peer Support Specialist chart documentation will be reviewed and approved by the supervisor or designee, acting within their scope. Peer Support Specialists will have ongoing evaluation during the supervision process and a performance evaluation after one year of hire and annually thereafter.

III. SUD Treatment and Documentation

1. Overview

The SUD treatment process reflects a logical approach that can be applied to solving challenges in any area. Solving a challenge begins with the preliminary identification of the general nature of the challenge, followed by a more detailed determination of the specifics of the challenge. For substance use disorder treatment providers, this preliminary step is the intake process of admission (identifying the challenges faced by a client and establishing how a provider can help) and assessment (determining the various issues that make up the challenge). As a next step in the process, a treatment plan is developed in partnership with beneficiaries to address issues identified during the intake/assessment process, followed by the implementation of the treatment plan (clients receiving treatment and referrals). The treatment plan is continually updated and changed to reflect any changes in problems or a new treatment focus. When SUD treatment services are completed, and a program determines the client has made sufficient progress to be discharged, providers discharge a client, prepare a discharge plan, and close the client record. If any of the SUD treatment process steps are not

completed, the chances for positive client and program compliance outcomes are greatly reduced.

2. Beneficiary Record

All aforementioned steps in the treatment process require sound clinical documentation. Clinical documentation refers to anything in the client's record or chart that describes the care provided to the client and the reasoning for any services delivered. All progress notes are to be observational and narrative in content as they tell the story of the client that is being served. Clinical documentation is a critical component of quality care delivery and serves multiple purposes including but not limited to helping to ensure comprehensive and quality care, ensures an efficient way to organize and communicate with other providers, protects against risk and minimizes liability, complies with legal, regulatory and institutional requirements and helps to facilitate quality improvement and application of utilization management. The Provider shall establish, maintain, and update as necessary, an individual client record for each client admitted to treatment and receiving services. Each client's individual record shall include documentation of:

- a. Personal information;
- b. All activities, services, sessions, and assessments;
- c. Identification of the person rendering services;
- d. Billings;
- e. Treatment authorization requests;
- f. All medical records, service reports, and orders prescribing treatment plans;
- g. Records of medications, drugs, assistive devices, or appliances prescribed, ordered for, or furnished to beneficiaries;
- h. Copies of original purchase invoices for medication, appliances, assistive devices, written requests for laboratory testing and all reports of test results, and drugs ordered for or supplied to beneficiaries;
- i. Copies of all remittance advices which accompany reimbursement to providers for services or supplies provided to beneficiaries; and
- j. Any other information relating to the treatment services rendered to the beneficiary.

Records shall be retained for a minimum of 10 years from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

3. Access

As part of Placer's "no wrong door" approach, several access points have been established to ensure continuous and timely availability and access to covered services, facilities, service sites and personnel.

The Placer County Access Points are located at county operated screening clinics, designated provider sites, and by phone. These access points offer beneficiaries access to ASAM screening as part of “Same Day Assistance.” Beneficiaries can walk into the daily screening clinics and/or a designated access point and request a screening.

After-hours care is accessed through the 24-hour access lines. Beneficiaries who call the access line are screened and their condition is triaged for risk and referrals are made to the appropriate level of care. In addition, DMC-ODS subcontracted providers will maintain a 24-hour on-call service for beneficiaries in their programs and shall ensure beneficiaries are aware of how to contact the treating or covering provider after hours, including weekends and holidays.

Placer County standard is that each beneficiary will be offered a first appointment within 10 days of referral or request for service for non-urgent services. Urgent conditions are those that require immediate attention but do not require inpatient hospitalization (emergency). At the time of first contact, each beneficiary's needs will be triaged to identify the presence of an urgent condition. Once a DMC-ODS provider is made aware of an urgent condition, an appointment shall be offered within 48 hours.

Type of Care	Time Frame
Non-urgent/Routine	Appointment offered within 10 business days
Urgent	Appointment offered within 48 hours
Emergency	Immediately, 24 hours per day, 7 days per week

Any program not meeting timeliness or access requirements will be required to develop a Plan of Correction (POC) which will be monitored by QM. Fines or even loss of contract may occur if demonstrated efforts and progress are not accomplished by the agreements within the POC.

4. Screening

A level of care (LOC) brief screen and/ or assessment that utilizes the published ASAM criteria will be used to determine a beneficiary's most appropriate and least restrictive level of care.

A level of care brief screen is required for initial placement recommendation. ASAM brief screens will be conducted by county staff at a Screening Clinic or by an Access Point prior to admission and can be used to determine medical necessity. When used to determine medical necessity all six dimensions shall be considered as a holistic concept of clinical necessity. During intake/assessment and to establish medical necessity, a full LOC assessment will be completed. A LOC assessment is completed by a certified counselor or LPHA that has completed the two, required e-learning through Change Companies, or equivalent. All LOC assessments must be reviewed and approved by an LPHA.

When a residential placement is recommended, all risk rating scores and supporting rationale documentation must be submitted to the Placer County Substance Use

program for review and approval prior to residential authorization, via the Provider Connect Portal (outlined later in this section).

LOC assessments will be completed at intake, when re-establishing medical necessity with every treatment plan update, major change, when a different LOC need is identified and at discharge.

In instances where a recommended LOC is not available within the SOC comparable interim or alternative services will be offered and provided. Placer's SOC currently has the following LOC

- a. Outpatient Treatment
- b. Narcotic Treatment Provider
- c. 2.1 Intensive Outpatient
- d. 3.2 WM – clinically-managed residential withdrawal management
- e. 3.1 Clinically-managed, low intensity residential treatment
- f. 3.5 Clinically-managed, medium/high intensity residential treatment
- g. Recovery Services

5. Intake

Intake is the process of determining a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation. Each beneficiary to be admitted into treatment program will go through an intake procedure to determine medical necessity. Intake will consist of an ASAM Brief Screen, Full SUS assessment, DSM V diagnosis and medical examination requirement. Medical Necessity determination shall be performed by the Medical Director or LPHA. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets medical necessity criteria. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM Criteria shall be applied to determine placement into the level of assessed services.

6. OTP/NTP Admission Requirements

OTP/NTP services and regulatory requirements shall be provided in accordance with CCR, Title 9 Chapter 4, as well as those outlined by the DMC-ODS.

1. Naltrexone Treatment

Providers shall confirm and document that the beneficiary meets the following conditions:

- a. Has a documented history of opiate addiction;

- b. Is at least 18 years of age;
- c. Has been opiate free for a period to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary;
- d. Is not pregnant and is discharged from the treatment if she becomes pregnant;
- e. The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results; and
- f. The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.

2. Identification Card

Each Program shall create a protocol to supply identification cards compliant with CCR Title 9 §10240,10245 that accurately document the identification of the client. The ID card shall contain the following:

- a. The patient's name;
- b. The patient's record number;
- c. The patient's physical description;
- d. The patient's signature;
- e. A full-face photograph of the patient;
- f. The program's name, address, 24-hour phone number, and signature of the program director or designee; and
- g. The issuance and expiration dates of the card.

3. Multiple Registration Form

Before a program admits a beneficiary for treatment, the program shall Notify the beneficiary that it cannot provide replacement narcotic therapy to a patient who is simultaneously receiving this therapy from another program and require the beneficiary to sign a written statement documenting whether he/she is currently receiving replacement narcotic therapy from another program and retain the statement in the beneficiary record. If the beneficiary refuses to sign this statement, the program shall not admit the beneficiary for treatment. Programs shall refer to CCR Title 9 §10210 for additional requirements.

4. Detoxification & Maintenance Treatment

Before admitting an applicant to detoxification or maintenance treatment, the Medical Director shall either conduct a medical evaluation or document his or her review and concurrence of a medical evaluation conducted by the physician extender. The Medical Director shall document the evidence, or review and concur with the physician extender's documentation of evidence, used from the medical evaluation to determine physical dependence and addiction to opiates and document his or her final determination concerning physical dependence and addiction to opiates.

The Provider shall determine which applicants are accepted for detoxification treatment subject to the following minimum criteria:

- a. Certification of fitness for replacement narcotic therapy by a physician;
- b. Determination by a program physician that the patient is currently physically dependent on opiates. Evidence of current physical dependence shall include:
 - i. Observed signs of physical dependence, which shall be clearly and specifically noted in the patient's record; and
 - ii. Results of an initial test or analysis for illicit drug use shall be used to aid in determining current physical dependence and shall be noted in the patient's record. Results of the initial test or analysis may be obtained after commencement of detoxification treatment;
- c. Patients under the age of 18 years shall have the written consent of their parent(s) or guardian prior to the administration of the first medication dose;
- d. At least seven days shall have elapsed since termination of the immediately preceding episode of detoxification treatment;
- e. The beneficiary's signed statement that at least seven days have elapsed since termination of the immediately preceding episode of detoxification treatment;
- f. The applicant is not in the last trimester of pregnancy.
The Provider shall determine which applicants are accepted for Maintenance treatment subject to the following minimum criteria:
- g. Confirmed documented history of at least two years of addiction to opiates;
- h. Confirmed history of two or more unsuccessful attempts in withdrawal treatment with subsequent relapse to illicit opiate use;
- i. A minimum age of 18 years;
- j. Certification by a physician of fitness;
- k. Evidence of observed signs of physical dependence;
- l. Pregnant beneficiaries who are currently physically dependent on opiates and have had a documented history of addiction to opiates in the past may be admitted to maintenance treatment without documentation of a two-year addiction history or two prior treatment failures, provided the medical director or program physician, in his or her clinical judgment, finds treatment to be medically justified; and
- m. Pregnant beneficiaries shall be reevaluated by the program physician no later than 60 days following termination of the pregnancy to determine whether continued maintenance treatment is appropriate.

5. Courtesy Dosing

An OTP/NTP provider may provide replacement narcotic therapy to visiting beneficiaries approved to receive services on a temporary basis (less than 30

days) in accordance with CCR Title 9, §10295. Prior to providing replacement narcotic therapy to a visiting beneficiary, an OTP/NTP provider must comply with CCR Title 9, §10210(d).

7. Physical Exams

As part of the intake process, physical examinations are a required element to beneficiaries receiving services, to determine their fitness for treatment. If a beneficiary has a physical examination within 12 months prior to admission, the physician, registered nurse practitioner or physician's assistant will need to obtain and review a copy within 30 calendar days of admission.

Alternatively, in lieu of a previous physical not being available or within the 12-month timeframe, the physician, registered nurse practitioner or physician's assistant may perform a physical examination of the beneficiary within 30 calendar days of admission. In the event the physical examination has not been reviewed or performed within the required timeframe, the LPHA or counselor shall include in the consumer's initial and updated treatment plans the goals of obtaining a physical examination, until this goal is met.

Reviewing or conducting a physical exam shall be documented in the individual client record progress notes and will include the reviewer's name legibly printed, signature, and date.

8. 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. Medical necessity is determined in the assessment process. Below is an overview of how determining medically necessary services have been expanded with the implementation of the DMC-ODS.

Old State Plan

Intake Assessments
Based on DSM Criteria
CCR, Title 22, §51303
Determined by a Physician

New DMC-ODS

Intake Assessments
Based on DSM Criteria
CCR, Title 22, §51303
Determined by a Physician or LPHA (new)
42 CFR, §438.210(a)(4) (new)
ASAM – Six Dimensions (new)

Only a Medical Directors or LPHA can establish Medical necessity. To do so, the Medical Director or LPHA shall:

- a. Review personal, medical, and substance use history;
- b. Evaluate each consumer and diagnose using DSM 5;

- i. Youth (ages 12-17) and Young Adults (ages 18-20) will either meet criteria for the DSM 5 specification for adults or be determined to be at risk for developing a Substance Use Disorder.
 - ii. Adults (ages 21+) must meet criteria for at least one diagnosis from the current DSM 5 for Substance Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance Related Disorders.
- c. Evaluate each beneficiaries' assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish if medical necessity is met;
 - d. Document, in narrative format, separately from the treatment plan, the basis for the diagnosis in the consumer's record within 5 business days of each beneficiaries' admission to treatment date (must be type or legibly print their name, sign, and date the diagnosis); and
 - e. 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 assessed.

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.

*Youth ages 12-20 are eligible for EPSDT services, which expands the definition of medical necessity to include individuals who are deemed "at risk" for SUDs.

When the Medical Director or LPHA determine medical necessity is no longer being met, the beneficiary shall be discharged from treatment or moved to a different level of care and recorded in the documentation.

9. Assessment

Generally, the documentation of determining medical necessity will begin when you first begin the assessment and/or ASAM. The assessment contains many different areas required under DMC-ODS. A counselor or LPHA shall complete the personal, medical, and substance use history for each beneficiary upon admission to treatment.

Assessments for all beneficiaries shall include at a minimum:

- Drug/Alcohol use history
- Family history
- Social/recreational history
- Educational history
- Criminal history and legal status
- Medical history
- Psychiatric/psychological history
- Financial status history
- Employment history
- Previous SUD treatment history

1. Additional Requirements for Perinatal

Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as the following, which are to be recorded in the ASAM and assessments.

- a. Relationships
- b. Sexual and physical abuse
- c. Development of parenting skills.

Additionally, medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the record. For residential, lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends).

2. Additional Requirements for Adolescents

- a. *The State of California Youth Treatment Guidelines* Provide additional information requirements to be considered and documented in adolescent assessments., including:
 - b. Major life domains abilities and needs.
 - c. Development,
 - d. A health screening (including a medical health history, disease screening, dental, and mental health).
 - i. Developmental and cognitive levels;
 - ii. Social, emotional, communication and self-help/independent living skills.
 - iii. Safety issues, such as risk of suicide or danger to others;
 - iv. Current, or history of, physical and/or sexual abuse;
 - v. Perpetration of physical or sexual abuse on others.

Additionally, for residential, services may be authorized up to 30 days maximum per 365 days, unless medical necessity warrants a one-time extension of up to 30 days per 365-day period. Only two non-continuous 30-day stays may be authorized in a 365-day period.

The Medical Director or LPHA shall review each beneficiary's personal, medical and substance use history if completed by a counselor. The content of the assessment must be documented by an LPHA or counselor along with their printed name, signature and date within 30 calendar days of a beneficiary's admission to treatment.

3. Reassessment

Reassessments are to be completed as follows, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan, Case Management plan or Recovery Services Plan:

- a. Outpatient (LOC 1.0) at a minimum of every 90 days.

- b. Intensive outpatient (LOC 2.1) at a minimum of every 60 days.
- c. Residential treatment (LOC 3.1, 3.5) at a minimum of every 30 days.
- d. Recovery Services (RS) at a minimum 12 months from the date of the previous assessment.

10. Treatment Plans

For each beneficiary admitted to treatment services, the LPHA or counselor must prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process. The treatment plan is the beneficiary's prescription of treatment services. There must be an attempt to engage the beneficiary to meaningfully participate in the preparation of the initial and updated treatment plans. The beneficiary's participation must be documented in the record. For youth, having only the parent or legal guardian's signature on the treatment plan does not suffice. There must be clear documentation of attempts to engage the beneficiary, as well as efforts informing the beneficiary of their treatment plan goals. Treatment plans are required to include all the following:

- a. Problem statements identified by the ASAM, assessment, or intake documentation.
- b. Measurable goals addressing each problem.
- c. Action steps taken by the Provider and/or beneficiary to meet measurable goals.
- d. Target dates to accomplish action steps and goals.
- e. Assignment of a primary LPHA or counselor
- f. Description of services, including the type of counseling to be provided and frequency and duration (see tables below)
- g. Diagnosis documented by the Medical Director or LPHA
- h. Physical examination goal (if not conducted in prior 12-months period of admission date)
- i. Goal addressing a serious medical treatment, if identified in the physical exam
- j. All initial treatment plans, at the minimum must contain the following components and follow this workflow.
- k. Completed by an LPHA or counselor
- l. LPHA or counselor to type or legibly print name, sign (adjacent to print name), and date
- m. Completed within 30 calendar days of admission date***
- n. Beneficiary to review, approve, type or legibly print name, sign and date (within 30 calendar days).

- i. If refusal to sign, must document reason and strategy or plan to engage beneficiary.
- o. Medical Director or LPHA to review every plan for medically necessary services if completed by a counselor.
 - i. Must be reviewed within 15 calendar days of the counselor. Printed name, signature (adjacent) and dated.

For Perinatal Providers treatment plans must also include evidence of specific perinatal services offered including:

- a. Development of parenting skills
- b. Training in child development, which may include the provision of cooperative child care
- c. Service access i.e., provision of or arrangement for transportation to and from medically necessary treatment.

For NTP Providers, additional or more restrictive requirements under CCR Title 9 are to be included and upheld including timelines and perinatal requirements.

All updated treatment plans, at the minimum must contain the above listed components including:

- a. Be completed no later than 90 calendar days after the previous plan's date, or when there is a change in treatment modality or significant event, whichever comes first.

***Residential withdrawal management to be completed within 48 hours of admission. Other residential programs shall be developed within 10 calendar days from the date of admission (AOD certification standards, May 2017). NTP Plans will be due within 28 days of admission per CCR § 910305)

4. Types of Services to include in the treatment plan by modality

	Outpatient LOC 1.0/2.1	NTP	Residential LOC 3.1/3.5	Withdrawal Mgmt. LOC 3.2
Assessment	X	X		
Case Management	X	X	X	
Collateral Services	X	X	X	
Coordination				X
Crisis Intervention	X	X	X	
Discharge Services	X	X	X	X
Family Therapy	X	X	X	
Group Counseling	X	X	X	
Individual Counseling	X	X	X	
Intake		X		X
Medical Psychotherapy		X		

Medication Services	X	X		X
Observation				X
Patient Education	X	X	X	
Physician Consultation	X	X	X	
Safeguarding medications			X	
Transportation		X		
Treatment Planning	X	X	X	

5. Hours of service required and allowable by Modality

- a. Outpatient hours of service allowed per week
 - i. Adults aged 21+ maximum of 9 hours
 - ii. Adolescents up to the age of 21 maximum of 6 hours
- b. Intensive Outpatient hours of service allowed per week
 - i. Adults Aged 21+ minimum of 9 maximum of 18 hours
 - ii. Adolescents to the age of 21, minimum of 6 maximum of 19 hours
- c. NTP hours of service allowed per month:
 - i. A minimum of 50 minutes and a maximum of 200 minutes.
- d. Residential LOC 3.1
 - i. Adults: Maximum of two non-consecutive 90-day stays per 365 days
 - With medical necessity can have one 30-day extension per year
 - A Minimum of 5 hours of clinical service per week
 - ii. Adolescents: maximum of two non-continuous 30-day stays per 365 days
 - iii. With medical necessity can have one 30-day extension per year
 - iv. A Minimum of 5 hours of clinical service per week
- e. Residential LOC 3.5
 - i. Adults: Maximum of two non-consecutive 90 day stays
 - With medical necessity can have one 30-day extension per year
 - A Minimum of 20 hours of clinical service per week
 - ii. Adolescents: maximum of two non-continuous 30-day
 - With medical necessity can have one 30-day extension per year
 - A Minimum of 20 hours of clinical service per week

11. Progress Notes

Progress notes are individual narrative summaries of services provided. For outpatient and NTP providers including case management and recovery services, a progress note will be recorded for each individual and group session.

For group sessions, a progress note will be recorded for each beneficiary who participated in the counseling session or treatment service.

For residential and intensive outpatient providers, a progress note will be recorded, at a minimum, once per calendar week, for each beneficiary participating in program activities, including counseling sessions or other treatment services. The LPHA or counselor shall type or legibly print their name adjacent to their signature and date the progress note within seven calendar days of the counseling session.

Progress notes shall include the following:

- Beneficiary name.
- A description of the beneficiary's progress on the treatment plan
- For case management notes, document how the service relates to the treatment plan problems, goals, action steps, objectives, and/or referrals.
- Identify if services were provided in-person, by telephone, or by telehealth.
- The topic of the session or purpose of the service, The Type of counseling format (individual or group) or service provided
- problems, goals, action steps, objectives, and/or referrals.
- If services were provided in the community, identify the location and how the provider ensured confidentiality.
- Information on the beneficiary's attendance, including the date, start and end times of each individual and group session or treatment service.

12. Sign-In Sheets

Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries. There must be a group sign-in sheet for every group session, that is documented and conducted. The LPHA or counselor who conducted the group session shall type or legibly print their name, sign adjacent, and date the sign-in sheet on the same day of the session. By signing the sign-in sheet, the LPHA and counselor attest that the sign-in sheet is accurate and complete. The group sign in sheet must additionally include:

- a. The date of the group session;
- b. The topic of the group session;
- c. The start and end times of the group session; and
- d. A typed or legibly printed list of the beneficiaries' names and the signatures of each beneficiary in attendance.

13. Continuing Services Justification

Continuing services shall be justified for outpatient services, intensive outpatient services, case management, and Naltrexone treatment. The LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services and *recommend* whether services shall continue at the same level of care. Like the previous State Plan, DMC-ODS requires this justification to occur no sooner than five months and no later than six months after the beneficiary's admission to treatment or the date of completion of the most recent justification for continuing services.

The Medical Director or LPHA shall determine medical necessity for continuing services no sooner than five months and no later than six months after the beneficiary's admission to treatment or the date of completion of the most recent justification for continuing services. When determining medical necessity for continued services, the following documents shall be considered:

- a. The beneficiary's personal, medical and substance use history;
- b. Documentation of the beneficiary's most recent physical exam;
- c. The beneficiary's progress notes and treatment plan goals; and
- d. The LPHA's or counselor's recommendation as aforementioned.

If medical necessity is not justified, the beneficiary shall be discharged from their current level of care and transfer to the appropriate services.

For NTP providers the Medical Director or program physician shall discontinue a beneficiary's maintenance treatment within two continuous years after such treatment is begun unless the medical director or physician complete the following:

- e. Evaluates the patient's progress, or lack of progress in achieving treatment goals
- f. And determines, in his or her clinical judgment, that the patient's status indicates that such treatment should be continued for a longer period because discontinuance from treatment would lead to a return to opiate addiction.

Patient status relative to continued maintenance treatment shall be re-evaluated at least annually after two continuous years of maintenance treatment. The Medical Director or program physician shall document in the patient's record the facts justifying his or her decision to continue the patient's maintenance treatment.

14. Discharge

Discharging a beneficiary may occur on a voluntary or involuntary basis. Developing a discharge plan and discharge summary is a required element for all outpatient, intensive outpatient, and residential services. Providers should collaborate with other substance use disorders treatment providers, and with relevant County and community-based organizations to maximize discharge planning using the continuum of care model. Successful discharge from one level of care into another, or into recovery

services supports the client and provides next steps towards the overall goal of recovery, increasing the success of seamless transitions thru the continuum.

1. Discharge Plan

A discharge plan must be completed by a LPHA or counselor within 30 calendar days prior to the scheduled date of the last face-to-face treatment contact. A final exit conference with the client will be conducted, one-on-one, to review the plan that will, at a minimum, include a description of each of the beneficiary's relapse triggers, a plan for avoiding relapse when faced with each trigger, a support plan identifying people, organizations, and other support resources. The discharge plan must contain the name of the LPHA or counselor typed or legibly printed, with signature and date. A copy must be provided to the beneficiary and clearly documented in their record. If no documentation in the client's record indicates they have been offered or received the discharge plan, then there is no evidence this occurred. In the event a beneficiary is being transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, a discharge is not required unless there has been more than a 30-calendar day lapse in treatment services.

2. Discharge Summary

Separate from the discharge plan, the summary is completed by the LPHA or counselor within 30 calendar days of the date of the last face-to-face treatment contact. The discharge summary must contain the name of the LPHA or counselor typed or legibly printed, with signature and date. At the minimum, the summary will need to include:

- Duration of treatment based on dates of admission and discharge
- Narrative summary of the treatment episode and progress
- Description of completed services, current substance use, vocational/educational achievements, transfer/referrals, and client comments.
- Reason for discharge
- Client's prognosis
- Name
- Date of Discharge

For NTP providers: a discharge summary must additionally be developed for each client who is voluntarily or involuntarily discharged.

For all modalities, timely discharge is an important part of the documentation. For individuals in residential treatment their discharge is directly linked to the ability to admit another beneficiary into treatment via the Provider Connect Portal, more information can be found under section IV. Authorized Services.

15. Coordination of Care

Beneficiaries should successfully transition between levels of care within the SOC without disruptions to services. Case management services are to be provided and documented in accordance with a treatment plan.

Case Managers shall ensure the transition of the beneficiaries to appropriate LOC. This may include step-up or step-down in SUD treatment services.

Case Managers shall provide warm hand-offs and transportation to the new LOC when medically necessary and documented in the individualized treatment plan. Case Managers shall ensure transitions to other LOCs occur no later than 10 business days from the time of assessment or reassessment with no interruption of current treatment services.

Case Managers from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next LOC.

IV. Authorized Services and Provider Connect

For beneficiaries who have an indicated LOC as 3.1, 3.2, or 3.5 residential, or for services that by contract require prior or ongoing authorization, providers are to utilize the Provider Connect Portal (PCONN), unless specified by the contract monitor in which case an alternative arrangement can be made. PCONN is a bi-directional portal into Placer's electronic health record. This portal is user and site specific to ensure confidentiality.

Each individual provider staff will be registered with a PCONN log in and access as requested by their agency's designated user(s). All requests for PCONN access should be done completing most recently updated and required forms, include the *New Clinician Form* and *Provider Connect Access Request form*, and should be sent to placerm@placer.ca.gov. Once the individual's identified have been verified the log in information will be returned via encrypted email. Any additional user needs related to PCONN can also be submitted to the QM-inbox including password resets or need for technical assistance. Users may log in to the portal via the process below.

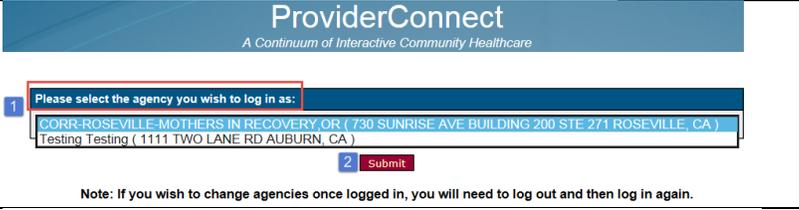
1. Website, Login, and Navigation

URL / Website Path	https://providerconnecttest.netsmartcloud.com/placeruat/login.asp
--------------------	---

Login and Password



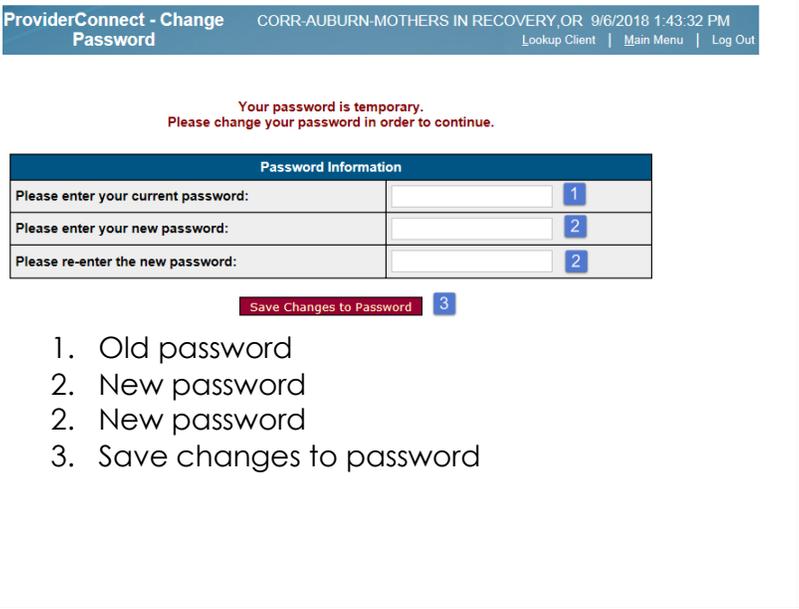
Pick the agency you are logging into



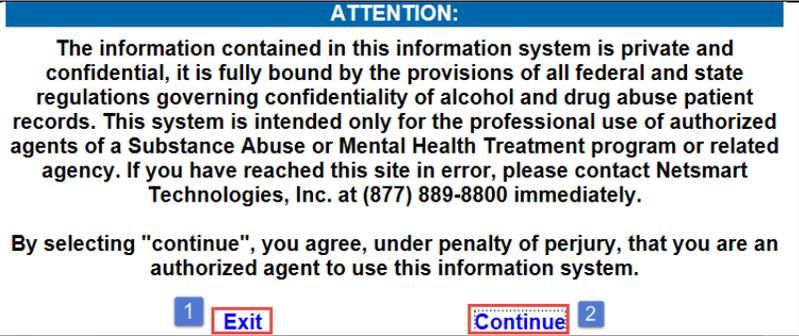
Password Tips:

- Cannot be "password"
- Must be between 6 and 30 characters
- Is case-sensitive
- Cannot be the same as your username, or your username backwards
- Cannot be common English words or commonly used (i.e., "guessable") passwords

Tip: Try substituting numbers or punctuation for letters. For example, instead of "provider", use "pr0v1d3r".

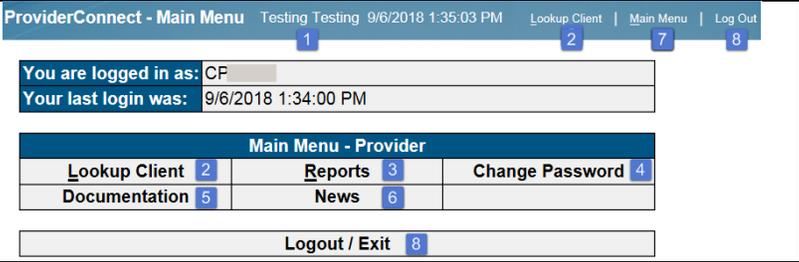


1. If you are not authorized to login, please **Exit**
2. If you are authorized to access this system, select **Continue**



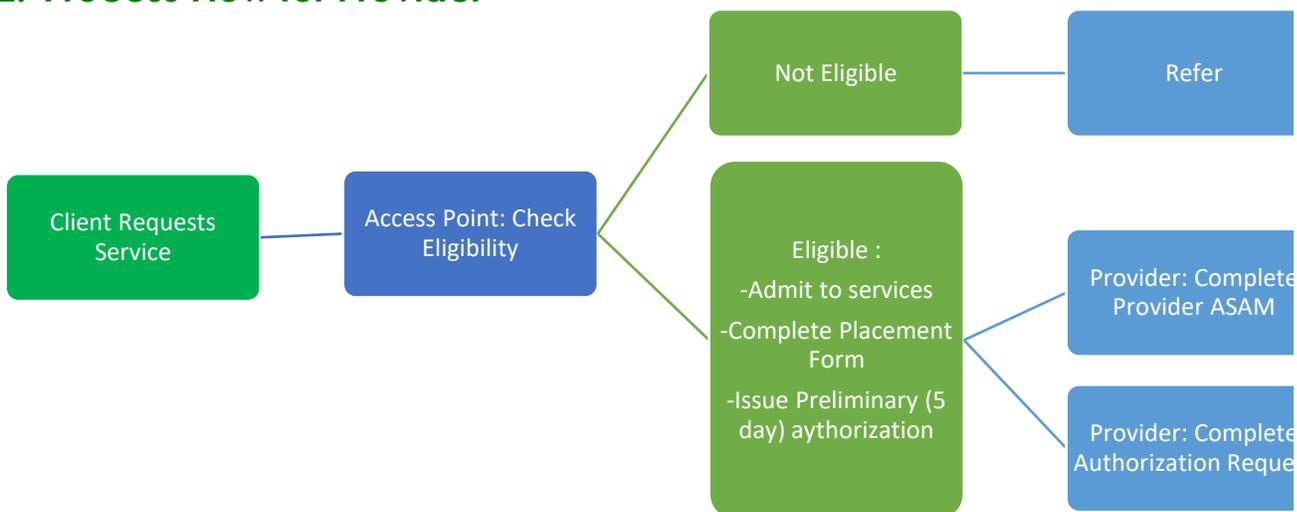
From the **Main Menu**, select an option:

1. Your agency name
2. Lookup Client
3. Reports
4. Change Password
5. Documentation

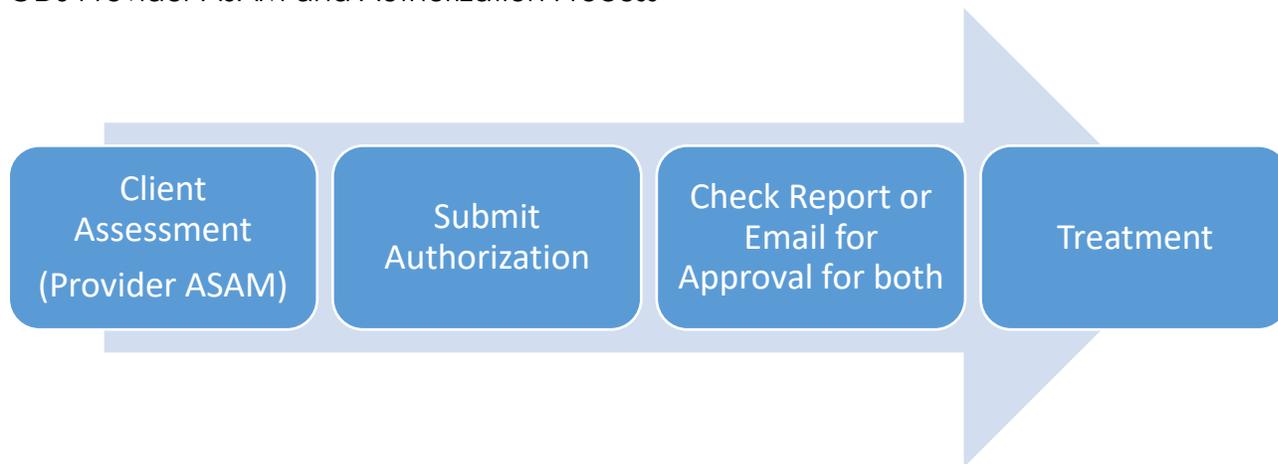


6. News 7. Back to Main Menu 8. Log Out	
The News page will display any information Placer County wants to share with Providers. 1. News 2. Lookup Client 3. Main Menu 4. Log Out	

2. Process Flow for Provider



ODS Provider ASAM and Authorization Process



3. Residential Access, Screening and Placement

All clients that will be referred to a residential setting will have come through a Placer County Screening Clinic or another access point where they would have had their eligibility verified and their brief screen completed.

1. Access Point Providers

Access Point providers that will be conducting screening, eligibility and admitting a client to the facility will be able to directly request admission into the client Portal by submitting the Provider Admission Form using the steps below:

- a. Before admitting a client, conduct a search to ensure that a duplicate entry is not made.

When completing the initial search criteria, assure to use all first initial in CAPS. The SSN is a required field

The screenshot shows a web browser window with the following elements:

- Browser tabs: County Claim Reports, Workday Resources - Home, ProviderConnect Login, Browse - California Code..., Caseload Explorer [Nanniz...], Drug Medi-Cal Organized..., MEDS Search, MHSUDS, Title 22 Drug Medi-Cal Fre...
- Page Header: **ProviderConnect - Add New Client/Client Search**, ODS-GWC Auburn Res 11/26/2019 1:07:53 PM, [Lookup Client](#), [Main Menu](#), [Log Out](#)
- Form Title: **Search Criteria**
- Form Fields:
 - Social Security Number:** [Text Input]
 - Last Name:** [Text Input]
 - First Name:** [Text Input]
 - Sex:** Female - F Male - M Other - O Transgender (F to M) - FTM Transgender (M to F) - MTF Unknown - U *
 - Date of Birth:** [Text Input]
- Buttons: **Search** (dark red), [Back](#) (blue)

- b. If client did not show up in Search Results, Select Reports under Main Menu and pull up the admission form for the specific location:

ProviderConnect - Main Menu ODS-GWC Auburn Res 11/26/2019 1:10:13 PM [Lookup Client](#) | [Main Menu](#) | [Log Out](#)

You are logged in as: PNannizzi
Your last login was: 11/26/2019 1:07:00 PM

Main Menu - Provider		
Lookup Client	Reports	Add New Client/Client Search
Change Password	Documentation	News
Logout / Exit		

[Back](#) **ProviderConnect - Authorization Status Report** ODS-GWC Auburn Res 11/26/2019 1:11:20 PM [Lookup Client](#) | [Main Menu](#) | [Log Out](#)

Export Data

Search:

No.	Request Date / Time	Member ID	Provider	Origin	Request Status	Last Name	First Name	Begin Date	End Date
				PCON-GWC Auburn Res (12183 Locksley Lane AUBURN, CA)					
				PCON-GWC Grass Valley Peri Res (159 Brentwood Dr GRASS VALLEY, CA)					
				PCON-GWC Grass Valley Res (159 Brentwood Dr GRASS VALLEY, CA)					
				PCON-GWC Lovett Residential (145 Bost Ave NEVADA CITY, CA)					
				PCON-Progress House Camino Peri Res (5494 Poney Express Trail CAMINO, CA)					
				PCON-Progress House Camino Res (5494 Poney Express Trail CAMINO, CA)					
				PCON-Progress House Coloma Residential (838 Beach Ct. COLOMA, CA)					
				PCON-Progress House Garden Valley Res (5607 Mount Murphy Road GARDEN VALLEY, CA)					
				PCON-Progress House PERI Gdn Vly Res (5607 Mount Murphy Road GARDEN VALLEY, CA)					

- c. Complete the Admission form
 - i. Complete as much Demographic Data that you can.
 - ii. Admitting Practitioner= LPHA
 - iii. Attending Practitioner = counselor
 - iv. When selecting the Program below, be sure to select the PCONN
 - v. Type of Admission should always be ODS-25.
 - vi. SOC clerical will verify this form in AVATAR to assure the Sex of the client matches MEDS for DMC billing.

Admission Information	
Sex <input type="radio"/> Female - F <input checked="" type="radio"/> Male - M <input type="radio"/> Other - O <input type="radio"/> Transgender (F to M) - FTM <input type="radio"/> Transgender (M to F) - MTF <input type="radio"/> Unknown - U	
Date of Birth []	Age []
Admission Date 10/08/2019	Admission Time 03:26 PM <small>HH:MM AM/PM</small>
Program --Please Choose One--*	Admitting Practitioner --Please Choose One--*
Attending Practitioner --Please Choose One--*	Treatment Setting --Please Choose One--
Treatment Service --Please Choose One--	Type of Admission --Please Choose One--*
Social Security Number 123-45-6789	
Demographics	
Client Last Name TEST	Client Home Phone Number []
Client First Name C	Client Work Number []
Client Address Line 1 []	Client Address Line 2 []
Client Address - City []	Client Address - State --Please Choose One--
Client Address - Zip Code []	Client Address - County --Please Choose One--
Marital Status --Please Choose One--	Are you heterosexual, lesbian, gay, bisexual, transgender or do you question your sexual orientation? --Please Choose One--*
Race --Please Choose One--	Education --Please Choose One--
Ethnic Origin --Please Choose One--	Religion --Please Choose One--
Other Ethnic Origin Field not yet supported	Place of Birth []
Country of Origin --Please Choose One--	Maiden Name []
Occupation --Please Choose One--	Client's Primary Language --Please Choose One--
Informed of Smoking Policy <input type="radio"/> No - N <input type="radio"/> Yes - Y	
Employment Status --Please Choose One--	
Alias []	Alias 2 []
Alias 3 []	Alias 4 []
Alias 5 []	Alias 6 []
Alias 7 []	Alias 8 []
Alias 9 []	Alias 10 []

d. Once a client has been admitted into the system a Placement Form

Placement Form	
Referral Date <input type="text"/> Today Yesterday	ASOC/CSOC <input type="radio"/> ASOC <input type="radio"/> CSOC
AKA <input type="text"/>	Marital Status <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Single <input type="radio"/> Widowed
Ethnicity <input type="radio"/> Cuban <input type="radio"/> Mexican/Mexican American <input type="radio"/> Not Hispanic <input type="radio"/> Other Hispanic/Latino <input type="radio"/> Puerto Rican <input type="radio"/> Unknown	Place of Birth - City/County/State/Country <input type="text"/>
Race <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Black/African American <input type="radio"/> Other <input type="radio"/> White/Caucasian	Other <input type="text"/>
Primary Language <input type="radio"/> ASL <input type="radio"/> English <input type="radio"/> Other <input type="radio"/> Russian <input type="radio"/> Spanish	Other <input type="text"/>
would like to receive services in my preferred language <input type="checkbox"/> Select	I would like to receive services from a provider who is competent in my culture. <input type="checkbox"/> Select
What is the culture or group identity <input type="text"/>	Do you need wheelchair access or other accommodation for disability? <input type="radio"/> No <input type="radio"/> Yes
If Yes, please select <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Hearing <input type="checkbox"/> Mental Health <input type="checkbox"/> Mobility <input type="checkbox"/> Other <input type="checkbox"/> Visual	Other <input type="text"/>
Are you a Placer County resident? <input type="radio"/> No <input type="radio"/> Yes	
Where do you live? <input type="radio"/> Friends/Family <input type="radio"/> Home/Apartment <input type="radio"/> Homeless <input type="radio"/> Transitional Living	
Why are you here today? <input type="text"/>	

Who referred you?	
<input type="radio"/> Court <input type="radio"/> CWS <input type="radio"/> Family <input type="radio"/> Friend <input type="radio"/> Other <input type="radio"/> Probation <input type="radio"/> Self	
Other <input type="text"/>	
Have you ever served in the US Military or Reserves?	(If Yes, consider linking to the local VA to access benefits)
<input type="radio"/> No <input type="radio"/> Yes	
Are you eligible for VA Benefits?	
<input type="radio"/> No <input type="radio"/> Unsure <input type="radio"/> Yes	
Are you pregnant?	(If Yes, qualifies for perinatal funding)
<input type="radio"/> No <input type="radio"/> Yes	
Do you have children under 18 years old?	(If Yes, may qualify for perinatal funding)
<input type="radio"/> No <input type="radio"/> Yes	
County of Eligibility <input type="text"/>	
Describe your financial resources (work, CalFresh, family support, etc.) <input type="text"/>	
Do you have children under 18 years old?	(If Yes, may qualify for perinatal funding)
<input type="radio"/> No <input type="radio"/> Yes	
Do you have custody?	
<input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Yes	
Do you have parental rights?	
<input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Yes	
What type of insurance do you have? (check all that apply)	
<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Private Insurance - Type <input type="checkbox"/> Private Pay	
Private Insurance Type <input type="text"/>	Policy Number <input type="text"/>
Medi-Cal Active	
<input type="radio"/> No <input type="radio"/> Yes	
CIN (ALL CAPS) <input type="text"/>	
SSN <input type="text"/>	<input type="text"/>

<p>Are you on probation/parole?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Unknown</p> <p><input type="radio"/> Yes</p>
<p>Type?</p> <p><input type="radio"/> Formal Probation</p> <p><input type="radio"/> Informal Probation</p> <p><input type="radio"/> Parole</p> <p><input type="radio"/> PRCS</p> <p><input type="radio"/> Probation Status Unknown</p> <p><input type="radio"/> Split Sentence</p> <p><input type="radio"/> Supervised OR</p>
<p>Parole or Probation officers name</p> <input type="text"/>
<p>Do you have outstanding warrants?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Unknown</p> <p><input type="radio"/> Yes</p>
<p>What are they for?</p> <input type="text"/>
<p>Do you have any upcoming court dates?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p>When and where?</p> <input type="text"/>
<p>Are you a Megan's Law 290 Registrant</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p>Have you ever been convicted of arson or a violent felony?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p>What charge?</p> <input type="text"/>
<p>Charge Date Range (years)</p> <p><input type="radio"/> (A) Less than 1</p> <p><input type="radio"/> (B) 1 - 3</p> <p><input type="radio"/> (C) 4 - 6</p> <p><input type="radio"/> (D) 7 - 9</p> <p><input type="radio"/> (E) 10 -12</p> <p><input type="radio"/> (F) Greater than 12</p>
<p>Have you ever had a Mental Health Diagnosis?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>

Date of ASAM	
<input type="text"/>	<input type="button" value="Today"/> <input type="button" value="Yesterday"/>
Case Manager	
Search for: <input type="text"/> <input type="button" value="Search"/>	
<input type="text"/>	<input type="text"/>
Program Name	Program Referred To
<input type="text"/>	<input type="text"/>
Potential Funding Sources	
<input type="checkbox"/> AB109 <input type="checkbox"/> CalWorks <input type="checkbox"/> CWS <input type="checkbox"/> Drug Medi-Cal <input type="checkbox"/> JDF <input type="checkbox"/> MHS <input type="checkbox"/> Perinatal <input type="checkbox"/> SAPTBG/NNA	
Recommended LOC	Actual LOC
<input type="text"/>	<input type="text"/>
Additional Recommended LOC	Additional Actual LOC
<input type="text"/>	<input type="text"/>

2. Submitting ASAM and Authorization for ALL Providers

Once the client has been admitted into the system by Placer County or an Access point provider using the instructions above, a preliminary authorization will be issued. A preliminary authorization will allow up to 5 days for the purposes of establishing medical necessity, and submitting an ASAM and authorization to via PCONN using the steps below:

First you must search and find your client:

When completing the initial search criteria, assure to use all first initial in CAPS. The SSN is a required field

Search Criteria	
Social Security Number:	<input type="text"/>
Last Name:	<input type="text"/>
First Name:	<input type="text"/>
Sex:	<input type="radio"/> Female - F <input type="radio"/> Male - M <input type="radio"/> Other - O <input type="radio"/> Transgender (F to M) - FTM <input type="radio"/> Transgender (M to F) - MTF <input type="radio"/> Unknown - U *
Date of Birth:	<input type="text"/>

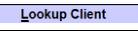
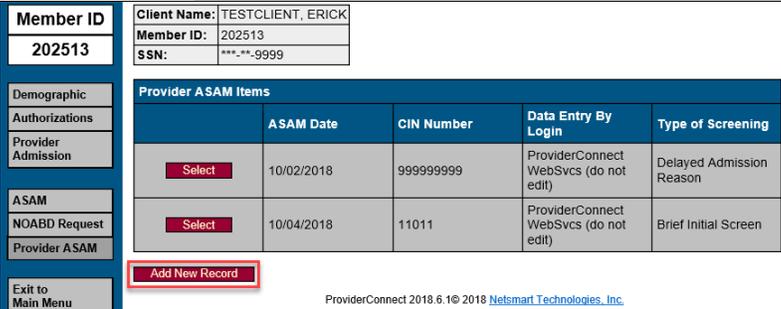
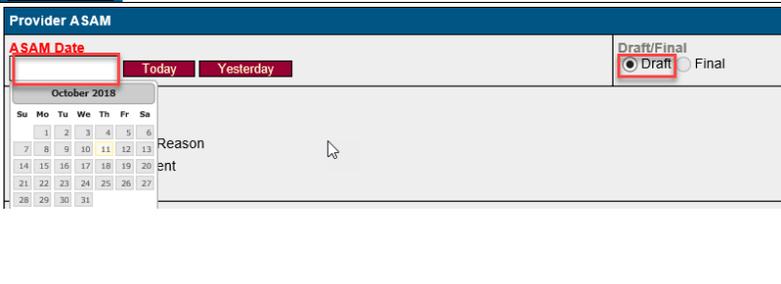
Provider ASAM. The turnaround process for the Provider ASAM submitted in PCONN is as follows:

- a. Response within 24 hours or less by county staff

- i. If the ASAM is accepted, it will be finalized by county staff.
 - ii. If it is rejected, correction notes will be entered into the form and a report (sent to BOX) will show that the ASAM remains in draft
 - iii. The counselor will have 24 hours to re-submit ASAM
 - iv. The county staff will have an additional 24 hours to respond to corrections and finalize ASAM.
- b. Communication will primarily be through use of reports
 - c. Whenever possible County staff will also email out information to counselors when corrections are needed
 - d. Reports will be sent to Box.com accounts at 10:00 a.m., 2:00 p.m., and 4:00 p.m.

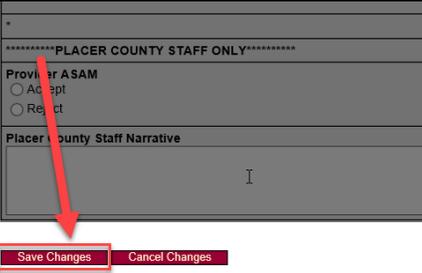
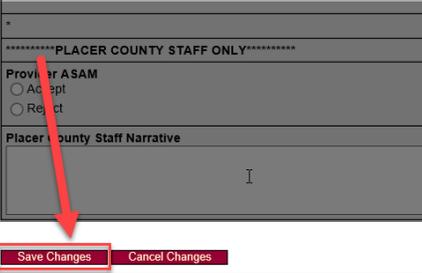
For urgent issues Providers can reach out to the Placer County Recovery Coach (530) 906-3724 or email SUDS at SUDS@placer.ca.gov

3. Creating the Provider ASAM

<p>Always Ensure that you are logged into Avatar in the correct Agency, ODS or Non-ODS. You can check which Agency you are logged in as by looking at the top-left corner of the page. If the Agency is incorrect, click "Log Out" and log back in.</p>	 <p>Note: If you wish to change agencies once logged in, you will need to log out and then log in again.</p> 															
<ul style="list-style-type: none"> • Lookup Client either in the Navigation bar or Main Menu 	 <p>OR</p> 															
<ul style="list-style-type: none"> • Select Provider ASAM 																
<ul style="list-style-type: none"> • View all ASAMs for this client • Select Add New Record button to create new ASAM 	 <table border="1"> <thead> <tr> <th></th> <th>ASAM Date</th> <th>CIN Number</th> <th>Data Entry By Login</th> <th>Type of Screening</th> </tr> </thead> <tbody> <tr> <td>Select</td> <td>10/02/2018</td> <td>999999999</td> <td>ProviderConnect WebSvcs (do not edit)</td> <td>Delayed Admission Reason</td> </tr> <tr> <td>Select</td> <td>10/04/2018</td> <td>11011</td> <td>ProviderConnect WebSvcs (do not edit)</td> <td>Brief Initial Screen</td> </tr> </tbody> </table>		ASAM Date	CIN Number	Data Entry By Login	Type of Screening	Select	10/02/2018	999999999	ProviderConnect WebSvcs (do not edit)	Delayed Admission Reason	Select	10/04/2018	11011	ProviderConnect WebSvcs (do not edit)	Brief Initial Screen
	ASAM Date	CIN Number	Data Entry By Login	Type of Screening												
Select	10/02/2018	999999999	ProviderConnect WebSvcs (do not edit)	Delayed Admission Reason												
Select	10/04/2018	11011	ProviderConnect WebSvcs (do not edit)	Brief Initial Screen												
<p>On the Provider ASAM page:</p> <ul style="list-style-type: none"> • Select the ASAM Date from the calendar that is displayed or click the Today button if the ASAM is for today. Date format is XX/XX/XXXX. (REQUIRED) • On the right, in the Draft/Final section, the selection will 																

<p>default to "Draft" and cannot be changed.</p>													
<p>Type of Screening</p>	<ul style="list-style-type: none"> ▪ Brief: Completed by all staff who are acting as an "Access Point" (including Screening clinics, AEGIS and CORR) for individuals entering treatment for the first time or who have no active open treatment episodes ▪ Initial: Completed by Providers as part of their initial assessment and to help establish medical necessity ▪ Follow up: completed by providers for all ASAM done after an initial assessment including for extension requests ▪ Delayed Admission: completed by any staff who completes an ASAM through ProviderConnect, for consumer's who were not able to get into treatment in accordance with timeliness measures 												
<ul style="list-style-type: none"> • For the Type of Screening, select the appropriate type (REQUIRED) 	<p>Type of Screening</p> <p><input type="radio"/> Brief Initial Screen</p> <p><input type="radio"/> Delayed Admission Reason</p> <p><input type="radio"/> Follow-Up Assessment</p> <p><input type="radio"/> Initial Assessment</p>												
<ul style="list-style-type: none"> • If the client has active Placer County Medi-Cal, select Yes, otherwise, select No. (REQUIRED) 	<p>Does the client have active Placer County Medi-Cal</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>												
<ul style="list-style-type: none"> • If No is selected above, the CIN Number field will become disabled. • If enabled, enter the CIN Number 	<p>CIN Number</p> <input type="text"/>												
<ul style="list-style-type: none"> • If "Delayed Admission Reason" is selected for "Type of Screening", skip the next section and scroll all the way down to "ASAM - Delayed Admission Reason" instructions section. 													
<ul style="list-style-type: none"> • Fill in Dimensions 1 -6 with the appropriate information. (REQUIRED) 	<table border="1"> <tr> <td data-bbox="704 1377 1096 1444"> <p>Dimension 1 - Acute Intoxication and/or Withdrawal Potential</p> <input type="text"/> </td> <td data-bbox="1096 1377 1487 1444"> <p>Rationale Dimension 1 - Acute Intoxication and/or Withdrawal Potential</p> <p>Type rational here for Dimension 1</p> <input type="text"/> </td> </tr> <tr> <td data-bbox="704 1444 1096 1509"> <p>Dimension 2 - Biomedical Conditions and Complications</p> <input type="text"/> </td> <td data-bbox="1096 1444 1487 1509"> <p>Rationale Dimension 2 - Biomedical Conditions and Complications</p> <p>Type rational here for Dimension 2</p> <input type="text"/> </td> </tr> <tr> <td data-bbox="704 1509 1096 1575"> <p>Dimension 3 - Emotional, Behavioral, or Cognitive Condition and Complications</p> <input type="text"/> </td> <td data-bbox="1096 1509 1487 1575"> <p>Rationale Dimension 3 - Emotional, Behavioral, or Cognitive and Complications</p> <p>Type rational here for Dimension 3</p> <input type="text"/> </td> </tr> <tr> <td data-bbox="704 1575 1096 1640"> <p>Dimension 4 - Readiness to Change</p> <input type="text"/> </td> <td data-bbox="1096 1575 1487 1640"> <p>Rationale Dimension 4 - Readiness to Change</p> <p>Type rational here for Dimension 4</p> <input type="text"/> </td> </tr> <tr> <td data-bbox="704 1640 1096 1705"> <p>Dimension 5 - Relapse, Continued Use, or Continued Problem Potential</p> <input type="text"/> </td> <td data-bbox="1096 1640 1487 1705"> <p>Rationale Dimension 5 - Relapse, Continued Use, or Continued Problem Potential</p> <p>Type rational here for Dimension 5</p> <input type="text"/> </td> </tr> <tr> <td data-bbox="704 1705 1096 1774"> <p>Dimension 6 - Recovery/Living Environment</p> <input type="text"/> </td> <td data-bbox="1096 1705 1487 1774"> <p>Rationale Dimension 6 - Recovery/Living Environment</p> <p>Type rational here for Dimension 6</p> <input type="text"/> </td> </tr> </table>	<p>Dimension 1 - Acute Intoxication and/or Withdrawal Potential</p> <input type="text"/>	<p>Rationale Dimension 1 - Acute Intoxication and/or Withdrawal Potential</p> <p>Type rational here for Dimension 1</p> <input type="text"/>	<p>Dimension 2 - Biomedical Conditions and Complications</p> <input type="text"/>	<p>Rationale Dimension 2 - Biomedical Conditions and Complications</p> <p>Type rational here for Dimension 2</p> <input type="text"/>	<p>Dimension 3 - Emotional, Behavioral, or Cognitive Condition and Complications</p> <input type="text"/>	<p>Rationale Dimension 3 - Emotional, Behavioral, or Cognitive and Complications</p> <p>Type rational here for Dimension 3</p> <input type="text"/>	<p>Dimension 4 - Readiness to Change</p> <input type="text"/>	<p>Rationale Dimension 4 - Readiness to Change</p> <p>Type rational here for Dimension 4</p> <input type="text"/>	<p>Dimension 5 - Relapse, Continued Use, or Continued Problem Potential</p> <input type="text"/>	<p>Rationale Dimension 5 - Relapse, Continued Use, or Continued Problem Potential</p> <p>Type rational here for Dimension 5</p> <input type="text"/>	<p>Dimension 6 - Recovery/Living Environment</p> <input type="text"/>	<p>Rationale Dimension 6 - Recovery/Living Environment</p> <p>Type rational here for Dimension 6</p> <input type="text"/>
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<ul style="list-style-type: none"> • Select an "Indicated Level of Care" from drop down (REQUIRED) • Select an "Actual Level of Care" from drop down (REQUIRED) 	<p>1. Indicated Level of Care</p> <ul style="list-style-type: none"> 0.5 early intervention 1 outpatient 1-wm amb-w/o onsite 2.1 iop 2.5 partial hospital 2-wm amb-w/ext monitoring 3.1 low res 3.2-wm clinical res 3.3 sp-pop high-int res 3.5 high res 3.7 med-monitored in 3.7-wm med-monitored -in 4 med-managed in 4-wm med-managed-in none ntp/opiate tx program 	<p>2. Actual Level of Care</p> <ul style="list-style-type: none"> 0.5 early intervention 1 outpatient 1-wm amb-w/o onsite 2.1 iop 2.5 partial hospital 2-wm abm-w/ext monitoring 3.1 low res 3.2-wm clinical res 3.3 sp-pop high-int res 3.5 high res 3.7 med-monitored in 3.7-wm med-monitored-in 4 med-managed in 4-wm med-managed-in none ntp/opiate tx program
<ul style="list-style-type: none"> • Select from "1. Additional Indicated Level of Care" from drop down if applicable • Select from "2. Additional Actual Level of Care" from drop down if applicable 	<p>1. Additional Indicated Level of Care</p> <ul style="list-style-type: none"> 0.5 early intervention 1 outpatient 1-wm amb-w/o onsite 2.1 iop 2.5 partial hospital 2-wm amb-w/ext monitoring 3.1 low res 3.2-wm clinical res 3.3 sp-pop high-int res 3.5 high res 3.7 med-monitored in 3.7-wm med-monitoring-in 4 med-managed in 4-wm med-managed-in none ntp/opiate tx program 	<p>2. Additional Actual Level of Care (if any)</p> <ul style="list-style-type: none"> 0.5 early intervention 1 outpatient 1-wm amb-w/o onsite 2.1 iop 2.5 partial hospital 2-wm amb-w/ext monitoring 3.1 low res 3.2-wm clinical res 3.3 sp-pop high-int res 3.5 high res 3.7 med-monitored in 3.7-wm med-monitored-in 4 med-managed in 4-wm med-managed-in none ntp/opiate tx program
<ul style="list-style-type: none"> • Select a "Level of Care Reason for Difference" from drop down if applicable • If "Other" is selected in "Level of Care Reason for Difference", type the reason into this dialog box 	<p>Level of Care Reason for Difference</p> <ul style="list-style-type: none"> clinical judgement family responsibility geographic accessibility lack of insurance/payment source language legal issues level of care not available managed care refusal not applicable - no difference other (please explain below) patient preference used 2 residential stays in year already <p>Level of Care Reason for Difference other (please explain below) ▼</p> <p>Other Level of Care Reason for Difference</p> <div style="border: 1px solid red; height: 30px; width: 100%;"></div>	
<ul style="list-style-type: none"> • For "Additional Recommended Services", check all that apply <p>If "other" is selected, in the "Other Additional Recommended Services" dialog box, type the other recommended services.</p>	<p>Additional Recommended Services (Must also choose an indicated Level of Care)</p> <ul style="list-style-type: none"> <input type="checkbox"/> aftercare/relapse prevention <input type="checkbox"/> case management <input type="checkbox"/> long term program <input type="checkbox"/> other <input type="checkbox"/> recovery residence <input type="checkbox"/> self help 	

	<p>Other Additional Recommended Services</p> <div style="border: 1px solid gray; height: 40px; width: 100%;"></div>																								
<ul style="list-style-type: none"> • Scroll down to the "I certify..." section and type in your name. (REQUIRED) 	<p>I certify, that to the best of my knowledge and belief, this is in all respects true, correct, and in accordance with law.</p> <input type="text" value="My Name"/>																								
<ul style="list-style-type: none"> • Scroll down past the **PLACER COUNTY STAFF ONLY**** section, select the "Save Changes" button (REQUIRED) 																									
<p>ASAM - Delayed Admission Reason</p>																									
<ul style="list-style-type: none"> • Select the "Delayed Admission Reason" (REQUIRED) • If "other" is selected, type the Reason in the "Other Delayed Admission Reason" dialog box 	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Delayed Admission Reason</p> <input type="radio"/> hospitalized <input type="radio"/> incarcerated <input type="radio"/> other (please explain below) <input type="radio"/> patient preferences <input type="radio"/> waiting for ada accommodation <input type="radio"/> waiting for language-specific services <input type="radio"/> waiting for level of care availability <input type="radio"/> waiting-special popn services </div> <div style="width: 45%;"> <p>Other Delayed Admission Reason</p> <div style="border: 1px solid gray; height: 40px; width: 100%;"></div> </div> </div>																								
<ul style="list-style-type: none"> • Select or type in the date of the Initial ASAM in the "Initial ASAM Date" box. Date format xx/xx/xxxx. (REQUIRED) 	<p>Initial ASAM Date</p> <input type="text"/> <div style="display: flex; gap: 10px;"> <div style="border: 1px solid gray; padding: 2px 5px;">Today</div> <div style="border: 1px solid gray; padding: 2px 5px;">Yesterday</div> </div>																								
<ul style="list-style-type: none"> • Scroll down to the "I certify..." section and type in your name. (REQUIRED) 	<p>I certify, that to the best of my knowledge and belief, this is in all respects true, correct, and in accordance with law.</p> <input type="text" value="My Name"/>																								
<ul style="list-style-type: none"> • Scroll down past the **PLACER COUNTY STAFF ONLY**** section, select the "Save Changes" button (REQUIRED). 																									
<p>Reviewing and Correcting a Rejected ASAM</p>																									
<ul style="list-style-type: none"> • View all ASAMs for this client 	<p>Provider ASAM</p>																								
<ul style="list-style-type: none"> • Locate the Provider ASAM you wish to correct • Note: Do not select an ASAM that shows (do not edit) in the "Data Entry by Login" • Select the "Select" button for the ASAM needing to be corrected 	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #0056b3; color: white;"> <th colspan="4">Provider ASAM Items</th> </tr> <tr style="background-color: #0056b3; color: white;"> <th></th> <th>ASAM Date</th> <th>CIN Number</th> <th>Data Entry By Login</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">ASAM</td> <td>10/02/2018</td> <td>999999999</td> <td>ProviderConnect WebSvcs (do not edit)</td> </tr> <tr> <td style="text-align: center;">ASAM</td> <td>10/04/2018</td> <td>11011</td> <td>ProviderConnect WebSvcs (do not edit)</td> </tr> <tr> <td style="text-align: center;">Select</td> <td>10/15/2018</td> <td>1234567</td> <td>[Your name]</td> </tr> <tr> <td style="text-align: center;">Select</td> <td>10/17/2018</td> <td>123456789</td> <td>Justin Sherman</td> </tr> </tbody> </table>	Provider ASAM Items					ASAM Date	CIN Number	Data Entry By Login	ASAM	10/02/2018	999999999	ProviderConnect WebSvcs (do not edit)	ASAM	10/04/2018	11011	ProviderConnect WebSvcs (do not edit)	Select	10/15/2018	1234567	[Your name]	Select	10/17/2018	123456789	Justin Sherman
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Select	10/15/2018	1234567	[Your name]																						
Select	10/17/2018	123456789	Justin Sherman																						

<ul style="list-style-type: none"> • Once the Provider ASAM is open, scroll to the bottom • Read the notes explaining why the ASAM was rejected and what is necessary to correct the ASAM • Make the necessary corrections 	<p>Placer County Staff Narrative</p> <p>Please correct the CIN number date. It appears to be incorrect.</p>
<ul style="list-style-type: none"> • Resubmit the ASAM by selecting "Save Changes" at the bottom of the page 	<p>Save Changes</p>

4. Authorization

Under the new DMC-ODS, Medi-Cal Beneficiaries are eligible to receive two residential stays per 365 days. Each stay requested may be for up to 30 days, and can be extended up to 90 days when Medical Necessity is met and is indicated per the ASAM assessment, except for youth. Youth, up to age 21, may be authorized up to 30 days maximum per 365 days, unless medical necessity warrants a one-time extension of up to 30 days per 365-day period. Only two non-continuous 30-day stays may be authorized in a 365-day period.

Requesting re-authorization

- Providers will request re-authorization or Extended Treatment Requests through PCONN, 7 days in advance.

1. To Create an Authorization, follow the process below:

<p>Lookup Client either in the "Navigation bar" or "Main Menu"</p>	<p>Lookup Client Main Menu Log Out</p> <p>Lookup Client</p>																								
<ul style="list-style-type: none"> • Enter any combination of Search Criteria • Select the Search by Criteria button to search <p>Note: Only clients with authorization requests, and pended or approved authorizations for your agency will be displayed</p>	<table border="1"> <thead> <tr> <th colspan="2">Search Criteria</th> </tr> </thead> <tbody> <tr> <td>Member ID:</td> <td><input type="text"/></td> </tr> <tr> <td>SSN:</td> <td><input type="text"/></td> </tr> <tr> <td>Last Name:</td> <td>test <input type="text"/></td> </tr> <tr> <td>First Name:</td> <td>boris <input type="text"/> x</td> </tr> <tr> <td>Date of Birth:</td> <td><input type="text"/></td> </tr> <tr> <td>Agency:</td> <td>Testing Testing</td> </tr> </tbody> </table> <p>Note: Only clients with authorization requests, pended or approved authorizations, and/or provider-initiated Admissions will display.</p> <p>Search by Criteria</p>	Search Criteria		Member ID:	<input type="text"/>	SSN:	<input type="text"/>	Last Name:	test <input type="text"/>	First Name:	boris <input type="text"/> x	Date of Birth:	<input type="text"/>	Agency:	Testing Testing										
Search Criteria																									
Member ID:	<input type="text"/>																								
SSN:	<input type="text"/>																								
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First Name:	boris <input type="text"/> x																								
Date of Birth:	<input type="text"/>																								
Agency:	Testing Testing																								
<p>All clients that meet the search criteria will be displayed.</p> <ul style="list-style-type: none"> • Select the Client ID to open client information • Select Search Criteria to take you back to search page 	<table border="1"> <thead> <tr> <th colspan="8">Search Results</th> </tr> <tr> <th>Client ID</th> <th>Last Name</th> <th>First Name</th> <th>Date of Birth</th> <th>Social Security Number</th> <th>City</th> <th>Zip Code</th> <th>Agency</th> </tr> </thead> <tbody> <tr> <td>233279</td> <td>TEST</td> <td>BORIS</td> <td>1/1/1960</td> <td>000-00-0000</td> <td>SACRAMENTO</td> <td>95827</td> <td>Testing Testing</td> </tr> </tbody> </table> <p>Search Criteria</p>	Search Results								Client ID	Last Name	First Name	Date of Birth	Social Security Number	City	Zip Code	Agency	233279	TEST	BORIS	1/1/1960	000-00-0000	SACRAMENTO	95827	Testing Testing
Search Results																									
Client ID	Last Name	First Name	Date of Birth	Social Security Number	City	Zip Code	Agency																		
233279	TEST	BORIS	1/1/1960	000-00-0000	SACRAMENTO	95827	Testing Testing																		

Select **Demographic** link in Navigation bar

Demographic link gives you more information on selected client

Member ID
233279

ProviderConnect - Demographic Testing Testing 9/6/2018 2:58:28 PM Lookup Client | Main Menu | Log Out

Client Name: TEST, BORIS
Member ID: 233279
SSN: ***-**-0000

Member Demographics

Social Security Number 000-00-0000	Date of Birth 1/1/1960	Facility Chart Number
Member Street 1 1111 BORIS LN	Member Street 2	Member City SACRAMENTO
Member County		Member State CA - CALIFORNIA
Member Zip Code 95827	Member Phone Number 555-555-5554	Member Work Number
Member Language	Sex	Are you heterosexual, lesbian, gay, bisexual, transgender or do you question your sexual orientation?
Ethnicity	Race	Client Maiden Name
Veteran	Education Level At Admission	Pre-Admission Disposition
Employment Status		
Marital Status		

Create Authorization Request

Select **Authorizations** link in Navigation bar

- View all Authorizations for this client
- Select **Create Request** button to create new authorization request

Authorizations

Member ID
233279

ProviderConnect - Authorization Requests Testing Testing 9/6/2018 3:03:33 PM Lookup Client | Main Menu | Log Out

Client Name: TEST, BORIS
Member ID: 233279
SSN: ***-**-0000

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
Testing Testing	Unassigned	ProviderConnect	Test Program	Pending	Not Reviewed	9/6/2018 9:11:02 AM	9/6/2018 8:11:01 AM	9/6/2018	9/15/2018		
Testing Testing	93452	MSO			Approved		9/6/2018 8:20:41 AM	9/6/2018	9/13/2018	Health Services	Add New
Testing Testing	Unassigned	ProviderConnect	Test Program	Pending	Not Reviewed	9/5/2018 2:45:49 PM	9/5/2018 1:45:49 PM	9/5/2018	9/14/2018		
Testing Testing	Unassigned	ProviderConnect	Test Program	Pending	Not Reviewed	9/5/2018 3:55:25 PM	9/5/2018 2:55:25 PM	9/5/2018	9/12/2018		
Testing Testing	93446	MSO			Approved		9/4/2018 9:59:39 AM	9/4/2018	9/14/2018		Add New
Testing Testing	93448	MSO			Approved		9/4/2018 1:15:26 PM	8/28/2018	9/7/2018	Health Services	Add New

Create Request

On the Authorization Request page:

- Add the Authorization Start Date and Authorization End Date
- (or)
- Add Authorization Start Date and the Set authorization for (---) number of days
- Select Set (This will auto fill the Authorization Requested End Date)

Authorization Request

Client Information

CLIENT NAME BORIS TEST	MEMBER ID 233279	PROVIDER NAME Testing Testing
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Authorization Dates

Authorization Requested Start Date:	<input type="text"/>	Set authorization for <input type="text"/> days	<input type="button" value="Set"/>
Authorization Requested End Date:	<input type="text"/>		

- Add **Funding Source, Benefit Plan, and Program**
- Note:** The red boxes will disappear once data is selected. These indicate required fields.

Funding Source & Benefit Plan Information

Funding Source: <input type="text" value="Please Choose One -"/>	Benefit Plan: <input type="text" value="Please Choose One -"/>	Provider Registration Date For Funding Source: <input type="text"/>
Program: <input type="text" value="Please Choose One -"/>		

Funding Source & Benefit Plan Information

Funding Source: System Of Care	Benefit Plan: SOG Plan	Provider Registration Date For Funding Source: 3/9/2013
Program: Test Program		

<p>In the Procedure Code section:</p> <ul style="list-style-type: none"> • Select Add Code Add Code • Select Procedure Code • Add Number of Units Requested 																																																	
<ul style="list-style-type: none"> • Add comments in the Comments on Authorization section, which include ASAM scores 																																																	
<ul style="list-style-type: none"> • Select File Request to save and submit the Authorization Request AFTER completing the Comments on Authorization field 																																																	
<p>The next page will display the Authorization Information:</p> <ul style="list-style-type: none"> • An Authorization Number is assigned once reviewed by Placer County personnel • Check Review Status column for updates on status of authorization • Select the Authorization Number link for more details on that authorization 	<p style="text-align: center;">Authorization Information</p> <table border="1"> <thead> <tr> <th>Provider</th> <th>Auth Number</th> <th>Origin</th> <th>CP Program</th> <th>Status</th> <th>Review Status</th> <th>Request Date</th> <th>Review Date</th> <th>Begin Date</th> <th>Expiration Date</th> <th>Tx Codes</th> <th>Attachments</th> </tr> </thead> <tbody> <tr> <td>Testing Testing</td> <td>Unassigned</td> <td>ProviderConnect</td> <td>Test Program</td> <td>Pending</td> <td>Not Reviewed</td> <td>9/6/2018 9:11:02 AM</td> <td>9/6/2018 8:11:01 AM</td> <td>9/6/2018</td> <td>9/15/2018</td> <td></td> <td></td> </tr> <tr> <td>Testing Testing</td> <td>93452</td> <td>MSO</td> <td></td> <td></td> <td>Approved</td> <td></td> <td>9/6/2018 6:20:41 AM</td> <td>9/6/2018</td> <td>9/13/2018</td> <td>Health Services</td> <td>Add New</td> </tr> <tr> <td>Testing Testing</td> <td>Unassigned</td> <td>ProviderConnect</td> <td>Test Program</td> <td>Pending</td> <td>Not Reviewed</td> <td>9/5/2018 2:45:49 PM</td> <td>9/5/2018 1:45:48 PM</td> <td>9/5/2018</td> <td>9/14/2018</td> <td></td> <td></td> </tr> </tbody> </table>	Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments	Testing Testing	Unassigned	ProviderConnect	Test Program	Pending	Not Reviewed	9/6/2018 9:11:02 AM	9/6/2018 8:11:01 AM	9/6/2018	9/15/2018			Testing Testing	93452	MSO			Approved		9/6/2018 6:20:41 AM	9/6/2018	9/13/2018	Health Services	Add New	Testing Testing	Unassigned	ProviderConnect	Test Program	Pending	Not Reviewed	9/5/2018 2:45:49 PM	9/5/2018 1:45:48 PM	9/5/2018	9/14/2018		
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<p>Details regarding the specific Authorization Request</p>	<p style="text-align: center;">ProviderConnect - Authorization Request</p> <p style="text-align: right;">Testing Testing 9/6/2018 4:24:07 PM Lookup Client Main Menu Log Out</p> <p style="text-align: center;">Authorization Request Approved</p> <p>Client Information</p> <table border="1"> <tr> <td>CLIENT NAME BORIS TEST</td> <td>MEMBER ID 233279</td> <td>PROVIDER NAME Testing Testing</td> </tr> </table> <p style="text-align: center;">Authorization Dates</p> <table border="1"> <tr> <td>Authorization Requested Start Date:</td> <td></td> <td></td> </tr> <tr> <td>Authorization Requested End Date:</td> <td></td> <td></td> </tr> <tr> <td>Authorization Authorized Start Date:</td> <td>9/6/2018</td> <td>Authorization Authorized End Date: 9/13/2018</td> </tr> </table> <p>Care Manager</p> <table border="1"> <tr> <td>CARE MANAGER ASSIGNED: KSILES</td> <td>DATE ASSIGNED: 11/17/2017</td> </tr> </table> <p>Authorization Information</p> <table border="1"> <tr> <td>AUTHORIZATION NUMBER: 93452</td> <td>CURRENT AUTHORIZATION STATUS: A - Approved</td> <td>CURRENT AUTHORIZATION STATUS REASON:</td> </tr> <tr> <td>AUTHORIZED LEVEL OF CARE: 0 - Standard</td> <td>TYPE OF AUTHORIZATION: A - Mental Health OIP</td> <td>PERFORMING PROVIDER TYPE: 01 - LCSW - Licensed Clinical Social Worker</td> </tr> <tr> <td>PLANNED ADMIT DATE:</td> <td>INITIAL OR CONTINUING AUTH: 1 - Initial</td> <td>NEXT REVIEW DATE:</td> </tr> </table> <p>Diagnosis</p> <table border="1"> <tr> <td>Primary Diagnosis</td> <td></td> </tr> <tr> <td>Secondary Diagnosis</td> <td></td> </tr> </table> <p>Funding Source & Benefit Plan Information</p> <table border="1"> <tr> <td>Funding Source: System Of Care</td> <td>Benefit Plan: SOC Plan</td> <td>Provider Registration Date For Funding Source: 3/9/2013</td> </tr> </table>	CLIENT NAME BORIS TEST	MEMBER ID 233279	PROVIDER NAME Testing Testing	Authorization Requested Start Date:			Authorization Requested End Date:			Authorization Authorized Start Date:	9/6/2018	Authorization Authorized End Date: 9/13/2018	CARE MANAGER ASSIGNED: KSILES	DATE ASSIGNED: 11/17/2017	AUTHORIZATION NUMBER: 93452	CURRENT AUTHORIZATION STATUS: A - Approved	CURRENT AUTHORIZATION STATUS REASON:	AUTHORIZED LEVEL OF CARE: 0 - Standard	TYPE OF AUTHORIZATION: A - Mental Health OIP	PERFORMING PROVIDER TYPE: 01 - LCSW - Licensed Clinical Social Worker	PLANNED ADMIT DATE:	INITIAL OR CONTINUING AUTH: 1 - Initial	NEXT REVIEW DATE:	Primary Diagnosis		Secondary Diagnosis		Funding Source: System Of Care	Benefit Plan: SOC Plan	Provider Registration Date For Funding Source: 3/9/2013																		
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5. Authorization Requests Status Report

You can view the **Status** of the Authorization in the Authorization Request Report

<p>You can get to Reports from the Main Menu by selecting Reports</p>	<p>Main Menu</p> <p>Reports</p>																																																
<p>Select Authorization Request Status</p>	<p>Reports</p> <p>Authorization Request Status</p>																																																
<p>After selecting this report, you must enter the criteria for the report before it displays.</p> <p>It can be any combination of Member ID, Last Name, Record Date, and Status</p>	<p>Search Criteria</p> <p>Member ID: <input type="text"/></p> <p>Last Name: <input type="text" value="Test"/></p> <p>Record Date: <input type="text" value="8/7/2018"/> - <input type="text" value="9/6/2018"/></p> <p>Status: <input type="text" value="-- All Statuses --"/></p> <p>Search by Criteria</p>																																																
<ul style="list-style-type: none"> • Status of Authorization Request Status report will display • Sort by selecting the up or down arrows in the column headings 	<p>Search: <input type="text"/></p> <table border="1"> <thead> <tr> <th>No.</th> <th>Request Date / Time</th> <th>Member ID</th> <th>Provider</th> <th>Origin</th> <th>Request Status</th> <th>Last Name</th> <th>First Name</th> <th>Begin Date</th> <th>End Date</th> <th>Authorization No.</th> <th>User</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>9/6/2018 4:20:22 PM</td> <td>233279</td> <td>Testing Testing</td> <td>ProviderConnect</td> <td>Not Reviewed</td> <td>TEST</td> <td>BORIS</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td>9/6/2018 9:20:10 AM</td> <td>233279</td> <td>Testing Testing</td> <td>MSO</td> <td>Approved</td> <td>TEST</td> <td>BORIS</td> <td>9/6/2018</td> <td>9/13/2018</td> <td>93452</td> <td>admin (Avatar User)</td> </tr> <tr> <td>3.</td> <td>9/6/2018 9:11:01 AM</td> <td>233279</td> <td>Testing Testing</td> <td>ProviderConnect</td> <td>Not Reviewed</td> <td>TEST</td> <td>BORIS</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	No.	Request Date / Time	Member ID	Provider	Origin	Request Status	Last Name	First Name	Begin Date	End Date	Authorization No.	User	1.	9/6/2018 4:20:22 PM	233279	Testing Testing	ProviderConnect	Not Reviewed	TEST	BORIS					2.	9/6/2018 9:20:10 AM	233279	Testing Testing	MSO	Approved	TEST	BORIS	9/6/2018	9/13/2018	93452	admin (Avatar User)	3.	9/6/2018 9:11:01 AM	233279	Testing Testing	ProviderConnect	Not Reviewed	TEST	BORIS				
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<ul style="list-style-type: none"> • You can filter out entries further using the Search field 	<p>Search: <input type="text" value="boris"/></p>																																																

6. Case Management

Prior to submitting request for Case Management please consult with SOC Case Manager prior to request. We want to assure we are not duplicating services. This request is outside of the automatic 6 hours that are pre-authorized for residential Case Management.

ASAM Date <input type="text"/> Today Yesterday	
SCORE	
Dimension 1 <input type="text"/>	Dimension 2 <input type="text"/>
Dimension 3 <input type="text"/>	Dimension 4 <input type="text"/>
Dimension 5 <input type="text"/>	Dimension 6 <input type="text"/>
Unit(s) of Time Requested (in minutes) <input type="text"/>	
Specific Need/Service <input type="text"/>	
Related Treatment Goal <input type="text"/>	
*****PLACER COUNTY STAFF ONLY*****	
Request for Case Management Needs <input type="radio"/> Approved <input type="radio"/> Denied	Approved Program <input type="text"/>
Case Assigned To Search for: <input type="text"/> Search <input type="button"/> <input type="text"/>	Contact Phone Number <input type="text"/>
Supervisor Search for: <input type="text"/> Search <input type="button"/> <input type="text"/>	
Reason for Denial <input type="text"/>	
Draft/Final <input checked="" type="radio"/> Draft <input type="radio"/> Final	Provider Connect User <input type="text"/>

Save Changes Cancel Changes

Print

Request for Case Management Needs	
SOC authorizes up to 6h CM per Tx Ep for qualified Ct, according to frequency in authorized Tx plan and ASAM. Additional auth approved as per Ct need. Additional authorization may be approved based on the Ct need and capacity of SOC CM.	
ASOC/CSOC <input type="radio"/> ASOC <input type="radio"/> CSOC	CIN (ALL CAPS) <input type="text"/>
Diagnosing Practitioner Search for: <input type="text"/> Search <input type="button"/> <input type="text"/>	Case Manager Search for: <input type="text"/> Search <input type="button"/> <input type="text"/>
Primary Diagnosis Search for: <input type="text"/> Search <input type="button"/> <input type="text"/>	Client Admit Date <input type="text"/> Today Yesterday
Current Level of Care <input type="radio"/> Outpatient 1.0 <input type="radio"/> Outpatient 2.1 <input type="radio"/> Residential 3.1 <input type="radio"/> Residential 3.2 <input type="radio"/> Residential 3.5	Provider Contact Name (Last,First Middle) <input type="text"/>
Provider Phone Number <input type="text"/>	Estimate Discharge Date <input type="text"/> Today Yesterday
Request For <input type="checkbox"/> 60 Minutes for MD/LPHA Case Consult <input type="checkbox"/> SUDS CM (if not already assigned to one) <input type="checkbox"/> Supplemental CM Hours for Provider	Specialty Population <input type="checkbox"/> Challenge engage sobriety and recovery <input type="checkbox"/> Child Welfare involvement <input type="checkbox"/> Criminal justice involvement <input type="checkbox"/> High medical needs <input type="checkbox"/> High utilizers of SUD services <input type="checkbox"/> JDF <input type="checkbox"/> MAT treatment needs <input type="checkbox"/> Perinatal
Additional Information <input type="text"/>	

7. Discharge

Discharges are due within 5 days of discharge, at every LOC change OR at Discharge. Discharges should also include information on who was involved in the discharge planning and a follow up appointments for the next LOC. If there was no follow-up appointment made during discharge planning assure there is justification on to why.

Discharge	
Date of Discharge <input type="text"/> Today Yesterday	Program <input type="text"/>
Discharge Time <input type="text"/> Current Time	Discharge Practitioner/Counselor Search for: <input type="text"/> Search <input type="text"/>
Discharge Type <input type="radio"/> Against Medical/Agency Advice <input type="radio"/> Client Relocated <input type="radio"/> Death <input type="radio"/> Discharged To Jail <input type="radio"/> Referred Higher LOC <input type="radio"/> Successfully Comp.Referred Lower LOC <input type="radio"/> Successfully Completed Treatment	
Discharge Remarks/Comments <input type="text"/>	
Does client have a follow up appointment? <input type="radio"/> No <input type="radio"/> Yes	Date of Next Service <input type="text"/> Today Yesterday
Next Service Location <input type="text"/>	Level of Care <input type="text"/>
Does client have a follow up appointment? <input type="radio"/> No <input type="radio"/> Yes	Date of Next Service <input type="text"/> Today Yesterday
Next Service Location <input type="text"/>	Level of Care <input type="text"/>
Why is there no follow up appointment? <input type="text"/>	
Provider Connect User <input type="text"/>	
*****PLACER COUNTY STAFF ONLY*****	
Provider Discharge <input type="radio"/> Accept <input type="radio"/> Reject	
Accept Date <input type="text"/> Today Yesterday	
Placer County Staff Comments <input type="text"/>	
Draft/Final <input type="radio"/> Draft <input type="radio"/> Final	

8. Request for a Notice of Adverse Benefit Determination (NOABD)

NOABD requests are to send information to Placer County on the reason for the denial, termination or modification of services. The NOABD will be sent to the client by Placer County. Include clinical reasons for the authorization denial decision regarding necessity.

To Complete a NOABD request use the steps below.

<p>Always Ensure that you are logged into Avatar in the correct Agency, ODS or Non-ODS. You can check which Agency you are logged in as by looking at the top-left corner of the page.</p>	<p>Please select the agency you wish to log in as:</p> <p>CORR-ROSEVILLE-ODF,OR (730 SUNRISE AVE BUILDING 200 STE 201 ROSEVILLE, CA) ODS - CORR-ROSEVILLE,OR (730 SUNRISE BUILDING 200 STE 201 ROSEVILLE)</p> <p>Submit</p> <p>Note: If you wish to change agencies once logged in, you will need to log out and then log in again.</p> <p>CORR-ROSEVILLE-ODF,OR 10/16/2018 12:03:23 PM Lookup Client Main Menu Log Out</p>
<p>Lookup Client either in the Navigation bar or Main Menu</p>	<p>Lookup Client Main Menu Log Out</p> <p>Lookup Client</p>
<p>Select NOABDs Request</p>	<p>Member ID</p> <p>202513</p> <p>Demographic</p> <p>Authorizations</p> <p>ASAM</p> <p>NOABDs Request</p> <p>Exit to Main Menu</p>
	<p>Client Name: TESTCLIENT, ERICK Member ID: 202513 SSN: ***.**.9999</p> <p>Print</p> <p>NOABD Request</p> <p>Date of NOABD Decision</p> <p>Today Yesterday</p> <p>Provider Name</p> <p><input type="radio"/> CoRR <input type="radio"/> Progress House</p> <p>Provider Address</p> <p>Preferred Language</p> <p>Instructions: Select one (1) applicable Notice of Adverse Benefit Determination listed below and complete all pertaining items</p> <p>Notice of Adverse Benefit Determination Form</p> <p><input type="radio"/> Delay Processing Auth of Services <input type="radio"/> Denial of Auth For Requested Services <input type="radio"/> Denial of Payment Service Rendered <input type="radio"/> Failure to Provide Timely Access To Srvc <input type="radio"/> Modification of Requested Services <input type="radio"/> Termination of Previous Auth Services</p> <p>Service Requested</p> <p><input type="radio"/> Case Management <input type="radio"/> Intensive Outpatient <input type="radio"/> Opioid Treatment Program <input type="radio"/> Outpatient <input type="radio"/> Recovery Services <input type="radio"/> Residential Treatment <input type="radio"/> Withdrawal Management</p> <p>Provide clinical reasons for the authorization denial decision regarding necessity</p>

V. Other Services

1. Recovery Residence

Recovery Residence is available to beneficiaries who require housing assistance to support their health, wellness and recovery. All Recovery Residents shall have a client file. The file shall record the following:

- a. A signed residential agreement;
- b. A statement of non-discrimination;
- c. Signed evidence the resident has been informed of the house rules and resident's rights and requirements;
- d. Documentation that residents was informed of fees;
- e. The amount of resident fee due and the date and amount of actual payment;
- f. Documentation that residents were oriented to emergency procedures. Personal data that provides an identification profile and emergency contact;
- g. Length of sobriety, prior recovery experience and source of referral are appropriate;
- h. Documentation of enrollment in treatment or recovery services;
- i. Documentation of any recovery support activities; and
- j. Evidence of drug testing.

Outpatient treatment programs that lease, manage or own recovery residences offered to individuals receiving outpatient substance use disorder treatment services shall maintain separate contracts for the housing. Certified outpatient programs' housing contracts shall:

- a. Clearly state that payment for housing is the responsibility of the individual and does not depend on insurance benefits;
- b. Include a repayment plan for any subsidized rent and that the treatment program shall make a good faith effort to collect the debt; and
- c. Specify that the offer for housing does not depend on the individual's agreement to receive services from the treatment program.

Such providers are prohibited from offering an individual discounted housing, unless the following conditions are met:

- a. The individual has been discharged from the licensed adult alcoholism or drug abuse recovery or treatment facility;
- b. The licensed adult alcoholism or drug abuse recovery or treatment facility and the individual enter into a written contract for housing that is separate from the contract for treatment, if the individual also pursues outpatient treatment;
- c. The housing contract includes a repayment plan for any subsidized rent, and the licensed adult alcoholism or drug abuse recovery or treatment facility makes a good faith effort to collect the debt; and

- d. The offer for housing is not dependent upon the individual's agreement to attend outpatient treatment at a program that is owned or operated by the licensed adult alcoholism or drug abuse recovery or treatment facility.

2. Recovery Services

Recovery services are important to an individual's recovery and wellness. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria, and during the transition planning process, beneficiaries will be linked to applicable recovery services. The treatment community becomes a therapeutic agent through which individuals are empowered and prepared to manage their health and healthcare. Placer County has additionally elected to provide Recovery Residence Services as a contractor specific ancillary service which falls under the Recovery Services program.

Recovery services are to be offered to beneficiaries when a Medical Director or LPHA has determined recovery services are medically necessary and after the beneficiary has been discharged from a SUD treatment provider. Services shall be made available to DMC-ODS beneficiaries in accordance with their individualized treatment plan. This may include the plan for ongoing recovery and relapse prevention that was developed during discharge planning when treatment was completed. Services shall not be provided while the beneficiary is receiving SUD treatment services.

Recovery services shall include the following components as specified on the treatment plan:

- a. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
- b. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
- c. Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
- d. Education and Job Skills: Linkages to life skills, employment services, job training, and education services;
- e. Family Support: Linkages to childcare, parent education, child development support services, and family/marriage education;
- f. Support Groups: Linkages to self-help and support, spiritual and faith-based support; and
- g. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

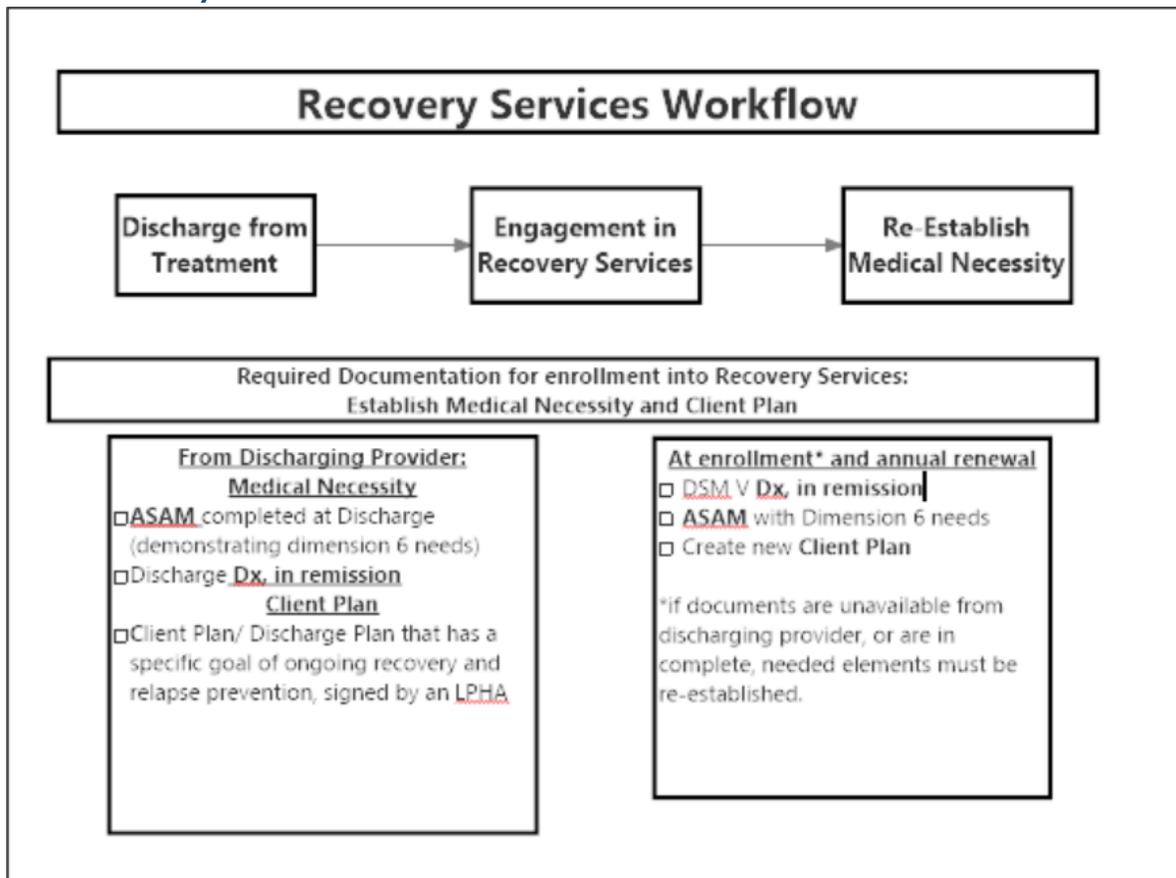
Recovery services shall be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. Documentation of progress notes shall follow DMC-ODS Documentation standards and recorded in the beneficiaries file.

Recovery Services shall be provided by a certified DMC-ODS provider. Services may be provided by a LPHA, Counselor, or Peer (for substance abuse assistance) acting within their scope of practice. Services may be provided either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary where confidentiality is maintained.

Beneficiaries enrolled into Recovery Services shall have the following documented in their chart within 30 days of enrollment:

- a. Medical necessity as established by a Medical Director or LPHA. Medical Necessity may be established at the time of discharge from treatment, or upon enrollment. Medical Necessity and renewed annually.
- b. A treatment or client plan for ongoing recovery or relapse prevention that adheres to the treatment plan requirements of the DMC-ODS, including the amount duration and scope of the intervention. This plan may be created at the time of discharge from the treatment provider during discharge planning or upon enrollment and shall:
 - i. Emphasize the beneficiary's central role in managing their health.
 - ii. Be individualized to the beneficiary.
 - iii. Promote the use of effective self-management support strategies.
 - iv. Be based on the LOC assessment needs
 - v. Include meaningful participation by the beneficiary.
 - vi. Provide internal and community resources to support ongoing self-management.
 - vii. Be approved by the Medical Director or LPHA with a printed name, signature and date

1. Recovery Services Work Flow



VI. Program Integrity and Compliance

1. Monitoring

Under the DMC-ODS waiver, SUD providers are subject to monitoring by DHCS for AOD compliance, DMC compliance and by Postservice Postpayment and Postservice Prepayment (PSPP) Utilization Reviews of the contracted DMC providers. Providers are required to make available, for the purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, financial books, records, contracts, computer or other electronic systems related to its Medi-Cal consumers. In the event DHCS, CMS or the OIG determines there is reasonable possibility of fraud or similar risk, DHCS, CMS or the OIG may inspect, evaluate and audit providers at any time unannounced.

In addition, Placer County QM conducts onsite reviews of Providers to determine whether services were provided in accordance with the DHCS-Placer County Intergovernmental Agreement. Placer County conducts provider site reviews annually, consistent with statutes, regulations and service delivery requirements under the DMC-ODS. Recovery residences will receive reviews at the minimum every two years. During reviews, Placer County QM will identify deficiencies or areas for improvement through

issuance of a Findings Letter and Corrective Action Plan (CAP). Placer County QM will monitor to ensure Providers are taking corrective action on both Placer and DHCS issued CAPs.

2. Grievance and Complaint Logs

A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The definition specifies that grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the Plan to make an authorization decision. There is no distinction between an informal and formal grievance. A complaint is the same as a grievance.

The county nor provider shall discourage the filing of grievances. A beneficiary need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. Even if a beneficiary expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance. As with other grievances, these grievances will be analyzed to monitor trends.

When a complaint is voiced to a staff member/provider, and that complaint is resolved to the beneficiary's satisfaction by the staff member/provider by the close of the next business day following receipt of the complaint, the staff member/provider will document the complaint using the *Placer County SOC Complaint Form*.

When a complaint cannot be resolved to the beneficiary's satisfaction by the close of the next business day following receipt of the complaint, it must be reported to QM. QM will resolve these complaints. This report will include the date of receipt, the name and contact information for the client, the nature of the complaint, and contact information for the person who received the complaint. Complaint report will be emailed to: JSoto@placer.ca.gov

By the 5th day of the following month, QM will receive copies of all monthly complaint logs. SOC staff and providers will email a copy of the previous month's complaint log(s). Complaint logs will be emails to: JSoto@placer.ca.gov

3. Notice of Adverse Benefit Determination (NOABD)

A Notice of Adverse Benefit Determination (NOABD), formally Notice of Action (NOA), is written notification to advise Medi-Cal beneficiaries when SOC acts including determinations involving medical necessity, appropriateness and setting of covered benefits, and financial liability. An Adverse Benefit Determination is defined to mean any of the following actions taken by the SOC:

- a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- b. The reduction, suspension, or termination of a previously authorized service;

- c. The denial, in whole or in part, of payment for a service;
- d. The failure to provide services in a timely manner;
- e. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
- f. The denial of a beneficiary's request to dispute financial liability.

The SOC is required to give the beneficiary written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Beneficiaries must be given timely and adequate notice of an adverse benefit determination, in writing, within at least 10 days BEFORE the date the adverse determination occurs (i.e. termination, suspension, or reduction) of previously authorized Medi-cal covered services. This time frame is important to allow adequate time for a beneficiary to appeal or request a state fair hearing.

Providers who intend to take any actions listed above are to submit a *Placer County DMC-ODS NOABD Request Form* to placergm@placer.ca.gov within the required timeframes. Placer will issue the NOABD to the consumer. For Providers who utilize the Provider Connect Portal, a form shall be submitted via the portal.

If a consumer contacts the Quality Management team to appeal the NOABD all actions to be taken will cease, and services are to continue, until QM decides on the appeal either in favor of the beneficiary or the provider.

4. Personnel Specifications

The following requirements shall apply to Providers and their staff, county-operated or contracted.

1. Professional Staff

The professional staff shall be licensed, registered, certified or recognized under California 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.

2. Non-professional Staff

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

Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hire. Youth case managers shall have additional trainings as outlined in the *Youth Treatment Guidelines* prior to being credentialed. Documentation of trainings, certifications and licensure shall be contained in personnel files. Professional staff (LPHAs) shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year. Registered and certified AOD counselors shall adhere to all requirements in Title 9, Chapter 8.

3. Providers

Providers will ensure personnel are competent, trained and qualified to provide any services necessary. Providers will maintain records of current certification and NPI registration. Providers shall maintain proof of participation in all mandated training. Providers shall employ and utilize staff who are culturally and ethnically representative of the population being served.

Providers will ensure staff members working with individuals receiving services are fingerprinted (LiveScan), and pass Department of Justice (DOJ), and Federal Bureau of Investigations (FBI) background checks.

4. Personnel Files

Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:

- a. Application for employment and/or resume
- b. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
- c. Signed employment confirmation statement/duty statement
- d. Training documentation relative to substance use disorders and treatment
- e. Job description
- f. Current registration, certification, intern status, or licensure
- g. Performance evaluations
- h. Proof of continuing education required by licensing or certifying agency and program
- i. Health records/status as required by Provider, AOD certification or Title 9
- j. Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well.

5. Job Descriptions

Job descriptions shall be developed, revised as needed and approved by the Provider's governing body. The job descriptions shall include:

- a. Position title and classification;
- b. Duties and responsibilities;
- c. Lines of supervision; and
- d. Education, training, work experience, and other qualifications for the position.

6. Code of Conduct

Written Provider code of conduct for employees and volunteers/interns shall be established. Providers may opt to utilize the Placer County issued template or their own. At the minimum, it shall address the following:

- a. Use of drugs and/or alcohol;

- b. Prohibition of social/business relationship with client's or their family members for personal gain;
- c. Prohibition of sexual conduct with clients;
- d. Conflict of interest;
- e. Providing services beyond scope;
- f. Discrimination against client's or staff;
- g. Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff;
- h. Protection client confidentiality;
- i. The elements found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under; and
- j. Cooperate with complaint investigations.

7. Use of Volunteers

If a Provider utilizes volunteers and/or interns, procedures shall be implemented which address:

- a. Recruitment
- b. Screening
- c. Selection
- d. Training and orientation
- e. Duties and assignments
- f. Scope of practice
- g. Supervision
- h. Evaluation
- i. Protection of client confidentiality

8. Use of Peers

If a provider utilizes Peers, the following additional requirements shall also be implemented

- a. SUD peer support staff will be supervised by professional and or administrative staff acting within their scope and designated by each provider;
 - i. Each provider will develop procedures to ensure that peer support staff will receive regular supervision focused on Professional development & training, client interactions, documentation training and practices, and the provision of direct service;
 - ii. Supervisors will additionally ensure that peer support staff remain in compliance with regulatory personnel requirements; and

- iii. Peer Support Specialist chart documentation will be reviewed and approved by the supervisor or designee, acting within their scope.
- b. Peer Support Specialists will have ongoing evaluation during the supervision process and a performance evaluation after one year of hire and annually thereafter.
 - i. Annual evaluations will include but are not limited to a review of the employee's utilization of skills and abilities as a peer support specialist, documentation and billing practices adherence to the supervisory process, punctuality/attendance, and the ability to form relationships

9. Personnel Credentialing and Exclusion Verification

Code of Federal Regulations requires States to establish, and subsequently Providers under pilot DMC-ODS counties 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.

Additionally, Providers are required to have staff checked against four exclusion lists: Office of Inspector General (prior to hire and monthly thereafter), System for Award Management (prior to hire and monthly thereafter), Medi-Cal Suspension and Ineligible Provider List (prior to hire and monthly thereafter), and the Social Security Death Master List (once prior to hire). Placer County Quality Management will provide oversight to the ongoing credentialing and re-credentialing for both county-operated and contracted DMC-ODS providers. Providers have the option to conduct exclusion checks on their own or utilize Placer County's third-party vendor to conduct the checks. Completed credentialing packets are to be submitted to PlacerQM@placer.ca.gov.

10. Training

All non-professional and professional staff shall receive onsite training prior to performing assigned duties. At the time of hire, Service Providers are expected to ensure staff have the training required to carry out their assigned duties. Providers will maintain documented training history, certifications and licensure for each staff in their respective personnel files and be readily accessible for review. Documentation of training history will indicate provider staff have

- a. Received an annual DMC-ODS Documentation Training;
- b. Received a minimum of one Cultural Competency Training that meet the National CLAS standards each year;
- c. Received training in at least two EBPs (listed below);
- d. Professional Staff (LPHAs) shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year;

- e. Staff conducting assessments are required to complete two (2) e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care" annually. All new staff are required to complete these e-Trainings upon hire and prior to conducting assessments;
- f. Staff conducting assessments are required to complete one in-person ASAM training; and
- g. Staff who are providing Peer Support Services will complete Placer Peer Skills Training Modules.

11. Evidence Based Practices

Service Providers will implement at the minimum two (2) Evidence Based Practices (EBPs) per provider per service modality. As aforementioned, documentation of ongoing regular training of EBPs shall be contained in each employee's personnel file. Documentation shall be in the form of a certificate of completion/attendance that indicates the course name, staff name, and date of the training. Providers who opt to conduct internal trainings must maintain a sign-in sheet that includes the date, name of training, printed staff name, and staff signature. Reoccurrence of EBPs trainings are to be conducted at the minimum annually. The applicable EBPs must be at least two (2) of the following:

- a. Motivational Interviewing (MI)
 - b. Cognitive-Behavioral Therapy (CBT)
 - c. Relapse Prevention
 - d. Trauma-Informed Treatment
 - e. Psycho-Education

Service Providers will provide to Placer County SOC Quality Management a Training Plan outlining the agency's guidelines to verifying, administering, and record retention of its trainings as consistent with their contract specifications and timelines.

12. Provider Directory Update

The SOC will maintain on its website a provider directory that meets the requirements established in MHSUDS IN 18-020. Providers are to verify the provider directory monthly and submit updates and amendments to the provider directory via email to placerqm@placer.ca.gov within 30 days of any change. This includes organizational information and direct service staff information. Updates, additions or changes to direct Service Staff shall include practitioner type, NPI number, licensure type and number, if cultural competency training has been completed, language capabilities and cultural capabilities.

VII. Data Submission

1. Quarterly Reports and QIC

Continuous quality improvement is the goal of the SOC in order to provide easily accessible, timely, and high-quality services to Placer beneficiaries. Each provider shall participate in the Quarterly Quality Improvement Committee (QIC), held during the monthly provider meetings, and develop a Performance Improvement Plan, each fiscal year.

The QIC will review the quality of the SUD treatment services provided to beneficiaries, and recommend policy decisions, review Performance Improvement Plan (PIP) progress, institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken.

Performance Improvement Plans will identify at least two goals that will enhance the quality of services being provided. The goals shall be based on analysis of data collected during the quality assurance process. The plan is to be submitted to QM annually by August 1st. The Plan shall include measurable indicators that improve the quality of services and the efforts communicated in quarterly reports using the *Placer County Substance Use Services Provider Annual Quality Improvement Plan & Quarterly Reporting Requirements* or equivalent, submitted to QM as well as reported out to the QIC. Plans and reports can be submitted at placerm@placer.ca.gov. Below is a schedule of quarterly report submission dates.

Annual Report (July 1 through June 30)	Due: August 1 st
Quarterly Reports: 1 st Quarter	Due: October 31
2 nd Quarter	Due: January 31
3 rd Quarter	Due: April 30
4 th Quarter	Due: July 31

2. California Outcomes Measurement System (CalOMS)

California Outcomes Measurement System (CalOMS) is California's data collection and reporting system for SUD treatment. By entering SUD and recovery data in California, CalOMS provides information for improving treatment client outcomes, supporting cost effective services, and meeting legally mandated federal and state reporting requirements. Regardless of DMC certification status, all SUD treatment providers must input client treatment data which is sent to DHCS each month.

Outcome data is necessary to identify what is working well for SUD service recipients and what is not. Therefore, collecting outcomes information facilitates the improvement of service delivery. In this respect development of an outcomes measurement system is the key to ensuring continuous quality improvement and thus to positively impacting the lives of SUD service recipients and their families, communities, and public health and social systems.

All Placer County SUD treatment providers, regardless of DMC certification status, must enter required CalOMS Treatment data into Avatar. In addition to client demographic data, data entered into Avatar builds a comprehensive picture of client behavior including data for alcohol and drug use, employment and education, criminal justice, medical and physical health, mental health, and family and social life. Providers will collect client data at admission and at discharge or administrative discharge from the same treatment program. Data will also be collected annually, as an annual update, for clients in treatment for over twelve months.

Summary reports created from CalOMS outcome data contribute to the understanding of treatment and the improvement of substance use disorder treatment programs in the continuum of prevention, treatment and recovery services.

DHCS has established the following data compliance standards for California Outcomes Measurement System –Treatment (CalOMS Tx) reporting. These data standards are intended to provide counties, their providers and direct providers with clear direction on submitting complete and accurate CalOMS Tx data in a timely manner.

Standard: Counties and direct providers shall submit CalOMS Tx data to DHCS within 45 days after the end of the report month.

Standard: Total late submissions or re-submissions shall not exceed five percent (5%) for any report month.

Standard: The rate of fatal record errors detected shall not exceed five percent (5%) for each CalOMS Tx data batch file submitted.

Refer to the CalOMS Tx website at

<http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx> for updates and information about CalOMS Tx.

3. DATAR Reporting Requirements

The Drug and Alcohol Treatment Access Report (DATAR) is the Department of Health Care Services' system to collect data on treatment capacity and waiting lists and is considered a supplement to the California Outcomes Measurement System (CalOMS) client reporting system. DATAR assists in identifying specific categories of individuals awaiting treatment and identifies available treatment facilities for these individuals.

DATAR has information on the program's capacity to provide different types of Substance Use Disorder treatment to clients and how much of the capacity was utilized that month. If the provider has a waiting list for publicly funded SUD treatment services, DATAR includes summary information about the people on the waiting list. These are the applicants who cannot be admitted due to the facility's lack of capacity.

All SUD treatment providers that receive SUD treatment funding from DHCS are required to submit the one-page DATAR form to DHCS each month. In addition, certified Drug

Medi-Cal providers and Licensed Narcotic Treatment Programs (NTP) must report, whether or not they receive public funding.

DATAR is a web based system accessed through the DHCS website. To access DATAR, please visit the following website:

<https://adpapps.dhcs.ca.gov/datar/UserLogin.aspx?o=1>

4. ASAM Level of Care Reporting Requirements

DMC-ODS will demonstrate how organized SUD care increases the success of DMC beneficiaries while decreasing other system health care costs. A critical element of the DMC-ODS Pilot includes providing a continuum of care modeled after the ASAM criteria for SUD treatment services.

A primary goal underlying the ASAM Criteria is for the beneficiary to be placed in the most appropriate LOC. For both clinical and financial reasons, the preferable LOC is that which is the least intensive while still meeting treatment objectives and providing safety and security for the beneficiary. The ASAM Criteria is a single, common standard for assessing patient needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement.

DMC-ODS Waiver counties, including Placer County, are required to use the ASAM Criteria to ensure that eligible beneficiaries have access to the SUD services that best align with their treatment needs. Waiver counties are required to have a Utilization Management Program to ensure that beneficiaries have appropriate access to SUD services; medical necessity has been established, the beneficiary is in the appropriate ASAM LOC, and that the interventions are appropriate for the diagnosis and LOC. Waiver counties are also required to have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at the appropriate ASAM LOC following initial request or referral for all DMC-ODS services.

Counties participating in the DMC-ODS are required to provide DHCS with data and information in order to comply with the evaluation and quarterly reporting established by the DMC-ODS special terms and conditions. This includes information from ASAM criteria-based screenings and assessments. DHCS will utilize this data to monitor appropriate use of ASAM criteria in the DMC-ODS.

DMC-ODS Waiver counties are required to submit their ASAM LOC data for all DMC beneficiaries to DHCS' Behavioral Health Information Systems (BHIS), which is the same system counties use to submit data to the California Outcomes Measurement System (CalOMS). Although ASAM LOC and CalOMS data must be submitted in separate files, submission rules will be similar. ASAM LOC data submission will be cumulative and must be submitted at least once monthly, no later than 45 days after the month of service. Placer County staff will compile and submit ASAM LOC data for all providers within the Organized Delivery System.

5. Treatment Perception Survey

As part of the DMC-ODS waiver evaluation, counties are required to have their network of providers administer the client Treatment Perceptions Survey (TPS) on an annual basis for adults and youth. The information collected will be used to measure clients' perceptions of access to services and the quality of care. The TPS is required to fulfill the county External Quality Review Organization (EQRO) requirement related to having a valid client survey. In addition, the TPS addresses the requirement by the Centers for Medicare and Medicaid Services (CMS) for DMC-ODS waiver evaluation. The data may also be used by counties (and service providers) to evaluate and improve the quality of care and client experience. California Department of Health Care Services (DHCS) Information Notices: [Information Notice 17-026](#) (adults) [Information Notice 18-032](#) (youth).

The Treatment Perception Survey will occur once per year in October. The Placer County will provide the survey forms to providers. All clients receiving face-to-face services during the specified survey period should be offered a survey form to complete. Detailed instructions on the administration of the survey will be provided by the county. A designated county staff person will compile the completed forms from the providers and return them to UCLA Integrated Substance Abuse Program (ISAP). The UCLA ISAP compiles and analyzes the data and provides reports to the counties. The county will share data with the providers.

6. Timeliness

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that works in partnership with state governments to administer Medicaid. CMS approves the Special Terms and Conditions (STC) which outline the requirements to participate in the DMC-ODS. The STC states the county must comply with timely access requirements and ensure that service providers comply with those requirements as specified in the state-county intergovernmental agreement (IA). The IA timely access requirements are:

- a. For outpatient and intensive outpatient services, the Contractor (county) shall ensure a face-to-face appointment within ten business days of the service authorization request.
- b. For OTP, the Contractor shall ensure a face-to-face appointment within three business days of the service authorization request.

Placer County will provide a spreadsheet on which data related to the above two standards above will be detailed by the providers. Additional timeliness data will be requested on the spreadsheet which will be used to assess the quality of services as part of the County's external quality review process. The spreadsheet will be submitted to the county weekly. The County will review the data periodically as part of the County's quality improvement process to ensure the above standards are being met.

7. Network Adequacy Certification Tool – NACT

The Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule) establishes network adequacy standards in Medicaid and CHIP managed care for certain providers and provides flexibility to states to set state specific standards. California currently has network adequacy standards in place that meet many of these requirements. The State also maintains network adequacy standards/requirements that exceed those that are required in the Final Rule. Assembly Bill (AB) 205 (Chapter 738, Statutes of 2017) codified and amended California's network adequacy standards.

CMS provided flexibility in the Final Rule with respect to network adequacy – requiring states to implement state specific standards under the broad requirements set forth in the Final Rule. These requirements are specific to time and distance and timely access.

In addition, states must now annually certify networks to CMS demonstrating compliance with the state established standards and the adequacy of health plan networks to provide timely access to care for all Medicaid managed care beneficiaries.

DHCS is responsible for ensuring that plans, like the DMC-ODS, provide timely access to care for Medi-Cal beneficiaries. Counties opting in to the DMC-ODS pilot program will be required to demonstrate compliance with the network adequacy standards. To demonstrate this compliance, counties are required to complete and submit the Network Adequacy Certification Tool, along with other materials to DHCS. The NACT details information about all the providers and staff in the ODS.

Placer will prepare the NACT with as much information as possible and then require providers to review, correct, and complete the tool. At a minimum, this will be required yearly, but could change to a monthly requirement.

<https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx>

VIII. Regulatory and Legislative References

The following list of references are incorporated by reference into the DMC-ODS Waiver contract, they are not attached to this document, they are listed here for your convenience.

1. Reporting Requirement Matrix – County Submission Requirements for the Department of Health Care Services
2. Perinatal Practice Guidelines
3. http://www.dhcs.ca.gov/individuals/Documents/Perinatal_Practice_Guidelines_FY1819.pdf
4. Drug and Alcohol Treatment Access Report (DATAR)
5. <http://www.dhcs.ca.gov/provgovpart/Pages/DATAR.aspx>
6. Alcohol and/or Other Drug Program Certification Standards (May 1, 2017)
7. http://www.dhcs.ca.gov/Documents/DHCS_AOD_Certification_Standards.pdf
8. Youth Treatment Guidelines
9. http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guidelines.pdf
10. Sobky v. Smoley, Judgment, Signed February 1, 1995
11. Drug Medi-Cal Billing Manual
12. http://www.dhcs.ca.gov/formsandpubs/Documents/DMC_Billing_Manual_2017-Final.pdf
13. Good Cause Certification (6065A)
14. Good Cause Certification (6065B)
15. County Certification - Cost Report Year-End Claim For Reimbursement
16. DMC-ODS Cost Report Excel Workbook
17. California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 4 – Narcotic Treatment Programs
18. <https://govt.westlaw.com/calregs/Search/Index>
19. California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors
20. <https://govt.westlaw.com/calregs/Search/Index>
21. CalOMS Treatment Data Collection Guide
22. http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf
23. CalOMS Treatment Data Compliance Standards
24. http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Data_Compliance%20Standards%202014.pdf
25. Culturally and Linguistically Appropriate Services (CLAS) National Standards
26. <https://www.thinkculturalhealth.hhs.gov/clas>
27. Drug Medi-Cal Certification for Federal Reimbursement (DHCS 100224A)
28. Drug Medi-Cal (DMC) MC # 5312 Services Quarterly Claim for Reimbursement of County Administrative Expenses

29. Confidentiality Agreement
30. <https://www.dhcs.ca.gov/provgovpart/Pages/County-Implementation-Plans-.aspx>
31. MH SUDS IN
32. https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx

X. Placer County Policies & Resources

The following list of Placer resources are not attached to this document, they are listed here for reference and where possible links to documents are incorporated. If you wish to receive a copy of these please email placergm@placer.ca.gov.

1. EA 535 DMC-ODS Treatment Authorization and Timely Access
2. EA 570 Continuity of Care for SMH and DMC-ODS
3. QM 311 Uniform Registration and Credentialing and RE-credentialing for Placer MHP and DMC-ODS
4. QM 312 DMC-ODS Network Provider Selection
5. QM 315 DMC-ODS Medical Director Monitoring
6. RE 102 Complaint Reporting Under Final Rule
7. RE 841 Out of Network Services for DMC-ODS and MHP Beneficiaries
8. SP 1331 SUS Provision for Tuberculosis Services
9. SP 1809 SUS Site Review Procedure
10. SP 1810 DMC-ODS Coordination and Continuity of Care.
11. SP 1815 DMC-ODS Intake
12. SP 1842 DMC-ODS Service Plan Development
13. SP 1845 DMC-ODS Recover Services Program
14. SP 1864 DMC-ODS Provider Training
15. SP 1922 DMC-ODS Medication Monitoring
16. SP1840 DMC-ODS Case Management
17. Beneficiary Eligibility Form
18. Substance Use Services Recovery Residence Readiness Review
19. Placer County DMC-ODS NOABD Request Form
20. Pconn Request Form
21. Provider Directory Request Form
22. Provider Directory
<https://www.placer.ca.gov/DocumentCenter/View/34517/Placer-County-Substance-Use-Treatment-Providers-PDF?bidId=>
23. Beneficiary Handbook English
<https://www.placer.ca.gov/DocumentCenter/View/34520/Placer-County-Drug-Medi-Cal-Beneficiary-Handbook-PDF?bidId=>
24. Beneficiary handbook Spanish
25. https://www.placer.ca.gov/DocumentCenter/View/34519/DMC-ODS_Member_Handbook-Spanish?bidId=
26. LOC Rationale Cheat Sheet (rev 2-6-19)
27. Placer County LOC Screening Tool (rev. 12/18/19)
28. New Clinician Form
29. Provider Connect Access Request Form

XII. Acronyms

AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction medicine
BHIS	Behavioral Health Information Systems
CALOMS	California Outcome Measurement System
CAP	Corrective Action Plan
CBT	Cognitive Behavioral Therapy
CLAS	Culturally and Linguistically Appropriate Services
CMS	Center for Medicare and Medicaid Services
DATAR	Drug and Alcohol Treatment Access Report
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Deliver System
DOJ	DOJ: Department of Justice
EBP	Evidence Based Practices
EQRO	External Quality Review organization
IA	Intergovernmental Agreement.
LOC	Level of Care
LPHA	Licensed Professional of the Healing Arts
MI	Motivational Interviewing
NTP	Narcotic Treatment Program
PCONN	Provider Connect
PIP	Performance Improvement Project
PSP	Post Service Post Payment
QIC	Quality Improvement Committee
QM	Quality Management
SOC	System of Care
STC	Standard Terms and Conditions
SUD	Substance Use Disorder
SUS	Substance Use Services
TPS	Treatment Perception Surveys

XIV. Contacts

1. Quality Management

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Recovery Coach Line

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3. HHS Fiscal

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