Division of Behavioral Health Services
Substance Use Prevention and Treatment (SUPT)

Service Codes Definitions & Training Guide

Effective June 18, 2021

This guide includes a master list of current treatment service codes to be used by SUPT contracted providers. This guide provides definitions of service codes as well as example scenarios to be used as a training tool and for contract monitor consultation. All service codes in this guide are part of the AVATAR Electronic Health Record used for tracking treatment service provisions, billing, and claiming.

Please note the following:

- All codes are NOT used by all providers.
- Each code is tied to a specific modality of service.
- Not all programs have the same contractual scope of services, funding, or menu of services.
- It is the responsibility of contracted providers to enter services into Avatar accurately in accordance with contractually specified services and corresponding service codes.
- It is important for contracted providers to utilize the correct service codes as treatment and billing/claiming information entered into Avatar is used for provider reimbursement and Federal, State, and County monitoring and audits.
- If a contract provider is unsure of which services or service codes to utilize, **do not enter** services until you have received clarification from Quality Management and/or your contract monitor.

Outpatient Services (OS) / Intensive Outpatient Services (IOS)

1. INTAKE/ASSESSMENT: OS / IOS

Service Code: Z500 (OS) / Z600 (IOS)

Definition – Intake/assessment means the process of determining if a client meets the condition of medical necessity for substance use disorder (SUD) treatment services. The intake process includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and SUDs by conducting an SUD Assessment based on American Society of Addiction Medicine (ASAM) Criteria. The intake is held face-to-face or via telehealth between the counselor/Licensed Practitioner of the Healing Arts (LPHA) and client. Intake may also include a physical examination and laboratory testing (e.g. body specimen screening) necessary for substance use disorder treatment and evaluation. If the SUD Assessment is completed by a counselor, the Medical Director or LPHA shall evaluate the client's intake/assessment information to verify whether the client meets medical necessity criteria or not. A telephone interview is not acceptable for establishing medical necessity. The Medical Director or LPHA shall document in narrative format, separately from the Client/Treatment Plan, the basis for the DSM-5 diagnosis in the client's record within seven (7) calendar days of the client's admission to treatment. The Health Questionnaire must be completed and reviewed & signed by the Medical Director *prior to completion of the treatment plan* (Physical Exam). A Substance Use Disorder Diagnosis based on the DSM-5 must be documented, along with criteria met. Identification of level of care based on SUD Assessment shall be supported. A complete CalOMS admission form must be submitted must be submitted within 10 days from admission to treatment.

Used by: OS and IOS Programs

Example: *Met with client for intake appointment. The client is a 25 year old, English speaking, Caucasian male who denied any cultural/linguistic needs. The client was referred by CPS (Child Protective Services) for substance use issues (Meth and Marijuana) for the last five years and a recent domestic violence charge. The client reports he is unable to stop despite his verbalized desire to do so and the negative consequences continued use brings. The client reported 5x per week use of meth and daily marijuana use. The client stated, "I want to stop using [meth] and not have any more problems with my wife and the cops." The client has legal history of possession charges (2016) and incarceration time (2018) due to SUD related charges. No prior CPS involvement. The client is motivated to resolve CPS case and stop his substance use, "for good." The client reported no current medical conditions or concerns or past SUD treatment; last physical examination on Sept. 2019. The client currently works full-time in construction. The client reported, he recently has had some problems at work that are related to his use (i.e., missing work, irritable with co-workers.) The client reported his father struggled with alcohol use his entire life and was physically violent towards him, his mother, and sister. The client is a high school graduate and has his electrician certification. The client is currently out of the home due to domestic violence and is staying with his sister and her family. The client's focus of treatment is to return to his family. Plan is to continue to assess and develop a Client/Treatment Plan with the client.*

2. TREATMENT PLANNING: OS / IOS

Service Code: Z501 (OS) / Z601 (IOS)

Definition – Treatment Plan services include the provider preparing an individualized written Client/Treatment Plan, with the participation of the client, based on information obtained during the intake and assessment process, within 30 days of admission to treatment. Client/Treatment Plans must be completed, signed, and dated as well as reviewed and signed by the Licensed Practitioner of the Healing Arts (LPHA) if primary counselor is not an LPHA. Please ensure all signatures are obtained. *Updated* Client/Treatment Plans are to be developed between the client and the counselor every 90 days for OS / IOS treatment services. Please ensure all signatures are obtained.

Used by: OS and IOS Programs

Example: *For this service, this writer worked on developing the treatment plan with the client based on overall gathered information of the client's substance use history and desired goals to accomplish during treatment. Treatment goals are focused on American Society of Addiction Medicine (ASAM) Dimensions, as evidence by the client's rating of the ASAM Dimensions 5: Continued problem/use and 6: Environmental-relationship issues. The client is fully committed to his treatment and support from this agency's staff. This counselor and client signed the treatment plan and the LPHA will sign at next consult meeting. The client was offered and accepted a copy of treatment plan. This counselor and client will conduct ongoing review of treatment goals to monitor progress, changes, challenges, and ongoing needs.*

3. COLLATERAL SERVICES: OS / IOS

Service Code: Z504 (OS) / Z605 (IOS)

Definition – Collateral Services include face-to-face or telehealth contact with significant persons in the life of the client. Significant persons are defined as individuals that have a personal, not official or professional, relationship with the client. For example, a client's social worker would not meet the "*significant persons*" criteria. Each Collateral Service must focus on the treatment needs of the client to support the achievement of Client/Treatment Plan goals. A client does not need to be present for Collateral Services to be billable.

Used by: OS and IOS Programs

Example: *Writer met with client's spouse (significant person) in the office. Provided on-line resources to spouse that would provide information about the client's substance use issues and how it affects interpersonal relationships. Also assisted in finding a local Al-Anon support group for spouse.*

4. INDIVIDUAL COUNSELING: OS / IOS

Service Code: Z502 (OS) / Z602 (IOS)

Definition – Individual Counseling services include face-to-face or telehealth contacts between a client and counselor. Individual Counseling sessions between a counselor and a client must be conducted in a confidential setting where individuals not participating in the counseling session cannot hear the comments of the client or counselor. These services can be provided in an office, outpatient facility, through telehealth, or when appropriate, the home of the client or other confidential setting. Individual Counseling sessions are designed to support direct communication and dialogue between the staff and client and focus on psychosocial issues related to substance use and goals outlined in the client's individualized Client/Treatment Plan. Individual Counseling sessions need to incorporate Evidence-Based Practices.

Used by: OS and IOS Programs

Example: *For this services session, this writer met face-to-face with client for an Individual Counseling session. Client/Treatment Plan goal addressed is to improve trigger identification to prevent relapse [Dimension 5]. Client reports, "I saw my family over the holiday and wanted to drink within an hour. Thankfully, I used the mindfulness skills and realized the tone of my dad's voice scares me inside, which makes me want to numb out. I was able to find a meeting and went. Overall, I'm feeling pretty proud of myself for not relapsing" [Dimension 4: process of change]. Action Step: writer reviewed client's comments with client to identify successes towards goal of trigger identification. Staff used Motivational Interviewing with client and reviewed mindfulness strategies to explore reaction to father's voice and response to feelings to use. Psychoeducation on how holidays can be triggering due to dynamics and acknowledgement of strength to participate in family activities and use of stress ball and meeting. Response: the client is able to recognize positive choices and that he could manage the uncomfortable feelings sober. Client expressed new awareness that physical activities and mindfulness strategies are helping his trigger management. Plan: Writer will schedule another session to review current SUD (substance use disorder) scoring and talk with client about planning for discharge to OS services.*

5. GROUP COUNSELING: OS / IOS

Service Code: Z503 (OS) / Z603 (IOS)

Definition – Group Counseling services include both process-oriented and psycho-educational group services. The purpose of psycho-educational groups is the expansion of awareness about the behavioral, medical, and psychological consequences of substance use. All Group Counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. All Group Counseling sessions must contain a minimum of 2 and a maximum of 12 participants in the group, focusing on the needs of the individuals served. Anyone who is 17 years of age or younger shall not participate in Group Counseling with any clients who are 18 years of age or older. A counselor must be present at all times during the group. Self-study groups do not constitute a billable group. Movies cannot be claimed as Group Counseling. All Group Counseling sessions must be documented with a sign-in sheet for group members and that document must be maintained in a binder or other easily accessible format. The sign-in sheet must include the date of service, the printed and signed name of the counselor(s), counselor's credentials, and the printed and signed name of each client and their time signed in, group name, and topic. It must also include the duration of the Group Counseling session: start and end time.

Used by: OS and IOS Programs

Example: ***Title of Group****: Sobriety Now*

Goal of Today's Group*: The focus of today's group was the subject of sobriety management. Group members were first encouraged to examine the ways substance use has adversely effected their lives. Group members were then directed to share and explore methods and strategies for remaining sober in the outpatient setting.*

Group Interventions that link to the SUD (substance use disorder) condition*: Group Leader facilitated discussion about sobriety management techniques, facilitated group process, involved all group members, kept group focused, and helped group members set limits and boundaries. Therapist provided psycho-education regarding clarifying areas of difficulty and identifying coping skills, Therapist provided support and structure and assigned worksheet/activity with topic of finding a sober peer group.*

Group Receptivity/Response: *In today's session, client appeared calm, friendly, communicative, and relaxed. His participation today was normal, with responses to others and sharing of personal experiences and feelings. He was active and participated fully in discussions today. A normal amount of physical activity was exhibited by the client today. Client today spoke of self-defeating behavior. Client spoke of issues associated with substance use. Client describes substance cravings. Client admits he was tempted to use. Client denies use. Suicidal ideas or intentions are not in evidence and not expressed. No suicidal plans are present.*

Plan: *Have the client continue to attend groups and focus on treatment goals. Client has been identified as a group leader by his peers. Client will develop a written relapse prevention plan.*

6. CASE MANAGEMENT: OS / IOS

Service Code: Z514 (OS / IOS) ***Add modifier based on modality***

Definition – Case Management services include assisting a client in accessing medical, educational, social, pre-vocational, vocational, rehabilitative, housing, escaping domestic violence, escaping human trafficking, or other community services as well as a plan that provides for seamless transitions of care for clients without disruption to services. Case Management must be identified as a service modality within the Client/Treatment Plan directly related to the client's recovery and American Society of Addiction Medicine (ASAM) Dimension treatment continuum. Case Management services may provide to the client face-to-face/telehealth, on the telephone, or in service for the client without the client's presence. Prior to completing the initial Client/Treatment Plan, Case Management may be billed in circumstances in which staff are supporting the client with linkage and referral for urgent needs identified during completion of the Substance Use Disorder (SUD) Assessment.

Used by: OS and IOS Programs

Example: *Writer received a call and spoke to client's Child Protective Services (CPS) social worker (SW), Ms. Twinkle Star (Release of Information-ROI on file), who followed up on client's treatment progress. This writer also collaborated on treatment goal of "Enrolling client into anger management and domestic violence classes in compliance to CPS requirements." Ms. Star shared steps to enrolling in classes, which will be discussed with client at his next session. This counselor discussed the client's progress in OS program (i.e., maintaining abstinence and consistent employment attendance, as well as having consistent attendance in OS program with this agency). Ms. Star expressed her concern about lack of client contact with CPS since the client's last meeting with her. This counselor will continue to encourage the client to maintain contact with CPS in order for successful completion and family re-unification. Plan is for this writer to continue to check-in with CPS SW at least 2x/month and continue to monitor the client's treatment progress. Client's next session is on Dec. 23, 2019.*

7. CRISIS MANAGEMENT/INTERVENTION: OS / IOS

Service Code: Z506 (OS) / Z607 (IOS)

Definition – Services shall focus on alleviating crisis problems. "Crisis" means an *actual relapse* or an unforeseen event or circumstance that presents to the client an *imminent threat of relapse*. Crisis Intervention services shall be limited to the stabilization of the client's emergency situation. Crisis Intervention services must be provided face-to-face between a therapist or a counselor and a client in crisis. A crisis must be an actual relapse or an unforeseen event or circumstance causing imminent threat of relapse. Crisis Intervention services must include a focus on alleviating crisis challenges and must be limited to stabilization of the client's emergency situation. Crisis Intervention services are responses in which a regularly scheduled visit will not meet the urgent or emergency nature of an individual crisis. An immediate assessment of risk and a time sensitive plan is developed and executed by service staff. Crisis Intervention is utilized to stabilize an individual in order to prevent imminent relapse, deterioration in individual functioning that may lead to a high level of care hospitalization or involuntary treatment. It typically requires face-to-face contact in addition to multiple other time sensitive service activities. Service activities are not limited to any single treatment modality and may include assessment, treatment or other appropriate collateral services that are clinically determined to be needed to resolve the crisis. Once the crisis is resolved, aftercare services are billed to appropriate codes. Crisis Intervention is provided when an immediate response or intervention is needed to help the client stabilize and continue to function in a community setting.

Used by: OS and IOS Programs

Example: *For this services session this writer consulted with co-counselor, John Wagner, and client, regarding strategy and resources for client who has recently been displaced from housing due to apartment house fire and at high-risk for relapse. The client stated, "I'm so scared I'm going to use when I leave here and go back to the streets." Discussed options for emergency and short-term placement as well as other support services for client (i.e. family/friends). Plan: Writer will adjust Client/Treatment Plan to focus on housing and emergency needs until situation is stabilized. John agreed to meet with client to assist with applications for emergency placement following this meeting. Having a safe place to live will benefit the client by allowing him to focus on maintaining sobriety and established treatment goals.*

8. DISCHARGE SERVICES: OS / IOS

Service Code: Z507 (OS) / Z608 (IOS)

Definition – Discharge Services are defined as the process to prepare the client for completion of their program, referral into another level of care, re-entry into the community, and/or the linkage of the individual to essential community, housing and human services. This includes both the process of developing the ***Discharge Plan*** with the client and completing the ***Discharge Summary***. The Plan must include description of relapse triggers and a support plan to avoid relapse. Discharge Services are to be documented no sooner than 30 days prior to discharge.

Used by: OS and IOS Programs

Example: *For this service session this writer met with the client face-to-face to collaborate on discharge plan in identifying triggers and plan to address triggers, enlist supports, as well as identify needs in order to make appropriate referrals and linkages to community resources. A copy of the client's discharge plan was provided to client. Self-help (i.e., AA, Wellness and Recovery Center, Life Ring, and Celebrate Recovery) would be the most appropriate next step in his treatment to allow him to continue with his treatment and recovery. Plan: The client's next session is on 12/7/21 and his last day of services is planned for 12/15/21.*

9. PHYSICAN CONSULTATION: OS / IOS

Service Code: Z515 (OS/IOS) ***Add modifier based on modality***

Definition – Physician Consultation services include consultation provided to Drug Medi-Cal Organized Delivery System (DMC-ODS) contracted physicians by addiction medicine physicians, addiction psychiatrist or clinical pharmacist to assist with providing expert advice on designing Client/Treatment Plans for clients. Physician Consultation services are designed to support DMC-ODS contracted providers with complex cases and may also include medication selection, dosing, side effect management, medication compliance, drug-to-drug interactions, or level of care considerations. Physician Consultation services are designed to assist DMC-ODS contracted physicians with seeking expert advice on designing Client/Treatment Plans for specific DMC-ODS clients.

Used by: OS and IOS Programs: Only by LPHA Prescribers

Example: *This Medical Director spoke over the phone with the client's mental health psychiatrist (Release of Information-ROI on file) to consult on the client's current medication care issues/side effects (i.e., weight gain, loss of energy, increased negative thoughts, sleep terrors) with the focus of reinforcing the client's treatment plan success. Item discussed were the client's recent behavior changes since Depakote medication dosage increased in Nov, 2019. Behavior changes have been observed by this writer, staff, and per client report, as well as impact on the client's treatment progress and engagement. This writer shared no other changes in the client's life have happened to impact behavior beside dosage increase. This writer recommended review of medication and possible change as indicated. The client's psychiatrists reported the client is consistent with his medication appointments and medication compliance, and will plan to discuss this staff's concerns at his next appointment on Jan. 2, 2020 to re-evaluate dosage. Both staff agreed blood work analysis would be recommended at this time for further follow-up. This writer will make blood work tests request and plan to continue to collaborate with psychiatrist on client's treatment services. This writer will also follow up with client over psychiatrist recommendations.*

10. PATIENT EDUCATION: OS / IOS

Service Code: Z604 (IOS Only)

Definition – Patient Education is a 1:1 learning experience that uses a combination of methods such as teaching, counseling, writing assignments, and other techniques to develop a client's knowledge and understanding of the impact of substance use on their psychological and physical health, family and other relationships, including work and legal issues. Patient Education is not considered a clinical service.

Used by: IOS Programs Only

Example: *This counselor met with client for face-to-face session for the purpose of going over findings on "The Prevalence of Anxiety, Depression, and Substance Abuse on Women" (Addresses Dimensions 3 and 5). The client was engaged in session, inquired about findings, and made connections with information discussed to her own history of use and mental health struggles over the years. The client stated, "I didn't know that sleep was so important to mental well-being, I'm going to start a consistent sleep routine." (Dimension 4: process of change). The client was provided information as reading material, will journal insight, and share at her next individual and group sessions. Today's session appears to have positively impacted the client's health decisions. Plan: The client will continue with IOS and her next session is on Dec. 11, 2019. This counselor will follow up on sleep routine.*

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

1. INDIVIDUAL COUNSELING: OTP / NTP

Service Code: Z702 (Note: 1 unit per 10-minute increment)

Definition – Individual Counseling services include face-to-face or telehealth contacts between a client and counselor. Individual counseling sessions between a counselor and a client must be conducted in a confidential setting where individuals not participating in the counseling session cannot hear the comments of the client or counselor. These services can be provided in an office, outpatient facility, telehealth, or when appropriate, the home of the client or other confidential setting. Individual Counseling sessions are designed to support direct communication and dialogue between the staff and client and focus on psychosocial issues related to substance use and goals outlined in the client's individualized Client/Treatment Plan. Individual Counseling sessions need to incorporate Evidence-Based Practices. Clients must receive a minimum of 50 minutes of counseling per calendar month except when the Medical Director adjusts or waives services. This must include a rationale for adjusting or waiving counseling services. The maximum reimbursable is 200 minutes per calendar month unless justified by the Medical Director in writing, in the client record.

MEDICAL PSYCHOTHERAPY SESSIONS

For clients in OTP/NTP programs, medical psychotherapy sessions are defined as face-to-face discussions between the Medical Director and/or physician and the client on issues identified in the Client/Treatment Plan.

There are no individual service codes for OTP/NTP Intake/Assessment, Treatment Planning, Collateral Services, Crisis Management/Intervention Services, or Discharge Services. These services are billed as Individual Counseling (Z702).

All OTP/NTP providers are required to conduct Intake/Assessment and Treatment Planning and document these activities.

- **INTAKE/ASSESSMENT:** The intake process includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders (SUDs) by conducting an SUD Assessment based on ASAM (American Society of Addiction Medicine) Criteria. All OTP/NTP providers must have a complete initial SUD Assessment for all clients. OTP/NTP programs will be required to offer and record proof of client's understanding on choices of medications and treatment without medications. The Health Questionnaire must be completed and reviewed & signed by the Medical Director *prior to completion of the treatment plan* (Physical Exam). A Substance Use Disorder Diagnosis based on the DSM-5 must be documented, along with criteria met. Identification of level of care based on SUD Assessment shall be supported. A complete CalOMS admission form must be submitted must be submitted within 10 days from admission to treatment.
- **TREATMENT PLANNING**: Treatment Planning services include the provider preparing an individualized written Client/Treatment Plan, with the participation of the client, based on information obtained during the intake and assessment process. The initial Client/Treatment Plan must be written within 28 days and must be signed by the Medical Director within 14 days. Subsequent, *Updated* Client/Treatment Plans are required every 90 days from the date of admission. For OTP/NTP, the Medical Director or LPHA shall **annually** re-evaluate and document in the client record the facts

justifying the decision to continue treatment. For OTP/NTP providers, *Updated* Client/Treatment Plans must be reviewed and signed within 14 calendar days from the effective date by the certified/registered counselor or LPHA and by the medical director. *Updated* Client/Treatment Plans also must include:

- A summary of the client's progress or lack of progress toward each goal identified on the previous Client/Treatment Plan,
- New goals and behavioral tasks for any newly identified needs or related changes in the type and frequency of counseling services to be provided to the client; and
- An effective date based on the day the primary counselor signed the *Updated* Client/Treatment Plan.

- **COLLATERAL SERVICES:** Collateral Services include face-to-face or telehealth contact with significant persons in the life of the client. Significant persons are defined as individuals that have a personal, not official or professional, relationship with the client. For example, a client's social worker would not meet the "*significant persons*" criteria. Each Collateral Service must focus on the treatment needs of the client to support the achievement of Client/Treatment Plan goals. A client does not need to be present for Collateral Services to be billable.
- **CRISIS MANAGEMENT/INTERVENTION:** Services shall focus on alleviating crisis problems. "Crisis" means an *actual relapse* or an unforeseen event or circumstance that presents to the client an *imminent threat of relapse*. Crisis Intervention services shall be limited to the stabilization of the client's emergency situation. Crisis Intervention services must be provided face-to-face between a therapist or a counselor and a client in crisis. A crisis must be an actual relapse or an unforeseen event or circumstance causing imminent threat of relapse. Crisis Intervention services must include a focus on alleviating crisis challenges and must be limited to stabilization of the client's emergency situation. Crisis Intervention services are responses in which a regularly scheduled visit will not meet the urgent or emergency nature of an individual crisis. An immediate assessment of risk and a time sensitive plan is developed and executed by service staff. Crisis Intervention is utilized to stabilize an individual in order to prevent imminent relapse, deterioration in individual functioning that may lead to a high level of care hospitalization or involuntary treatment. It typically requires face-to-face contact in addition to multiple other time sensitive service activities. Service activities are not limited to any single treatment modality and may include assessment, treatment or other appropriate collateral services that are clinically determined to be needed to resolve the crisis. Once the crisis is resolved, aftercare services are billed to appropriate codes. Crisis Intervention is provided when an immediate response or intervention is needed to help the client stabilize and continue to function in a community setting.
- **DISCHARGE SERVICES:** Discharge Services are defined as the process to prepare the client for completion of their program, referral into another level of care, re-entry into the community, and/or the linkage of the individual to essential community, housing and human services. This includes both the process of developing the ***Discharge Plan*** with the client and completing the ***Discharge Summary***. The Plan must include description of relapse triggers and a support plan to avoid relapse. Discharge Services are to be documented no sooner than 30 days prior to discharge.

Used by: OTP and NTP Programs

Example: *Writer met face-to-face with client for Individual Session. Client/Treatment Plan goal addressed: Improve trigger identification to prevent relapse [Dimension 5]. Client reports "I saw my family over the holiday and wanted to use within an hour. I ended up getting high on weed. I realized the tone of my dad's voice scares me inside, which makes me want to numb out. Shortly after leaving my family, I was able to find a meeting and went. Overall, I do feel good about not slamming, but I know I still need work because I don't want to use weed either" [Dimension4: process of change]. Action Step: writer reviewed client's comments with client to identify successes and barriers towards goal of trigger identification. Staff also addressed positive urinalysis test from THC. Staff used Motivational Interviewing with client and reviewed mindfulness strategies to explore reaction to father's voice and response to feelings to use. Psychoeducation on how holidays can be triggering due to dynamics and acknowledgement of strength to participate in family activities and use of stress ball and meeting. Response: the client is able to recognize triggers at a much faster rate, yet still struggles with impulse control. The client made positive choice to follow-up with meeting. Client expressed new awareness that physical activities and mindfulness strategies are helping his trigger management. Plan: next session is on May 28, 2020.*

2. GROUP COUNSELING: OTP / NTP

Service Code: Z703

Definition – Group Counseling services include both process-oriented and psycho-educational group services. The purpose of psycho-educational groups is the expansion of awareness about the behavioral, medical, and psychological consequences of substance use. All Group Counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. All Group Counseling sessions must contain a minimum of 2 and a maximum of 12 participants in the group, focusing on the needs of the individuals served. Anyone who is 17 years of age or younger shall not participate in Group Counseling with any clients who are 18 years of age or older. A counselor must be present at all times during the group. Self-study groups do not constitute a billable group. Movies cannot be claimed as Group Counseling. All Group Counseling sessions must be documented with a sign-in sheet for group members and that document must be maintained in a binder or other easily accessible format. The sign-in sheet must include the date of service, the printed and signed name of the counselor(s), counselor's credentials, and the printed and signed name of each client and their time signed in, group name, and topic. It must also include the duration of the Group Counseling session: start and end time. OTP/NTP programs are also required to offer and record proof of client understanding on choices of medications and treatment without medications. Services provided as part of an OTP/NTP Program include Group Counseling.

Used by: OTP and NTP Programs

Example: ***Title of Group**: Sobriety Now*

***Goal of Today's Group**: The focus of today's group was the subject of sobriety management. Group members were first encouraged to examine the ways substance use has adversely effected their lives. Group members were then directed to share and explore methods and strategies for remaining sober in the outpatient setting.*

***Group Interventions that link to the SUD (substance use disorder) condition**: Group Leader facilitated discussion about sobriety management techniques, facilitated group process, involved all group members, kept group focused, and helped group members set limits and boundaries. Therapist provided psycho-education regarding clarifying areas of difficulty and identifying coping skills, Therapist provided support and structure and assigned worksheet/activity with topic of finding a sober peer group.*

Group Receptivity/Response: *In today's session, client appeared calm, friendly, communicative, and relaxed. His participation today was normal, with responses to others and sharing of personal experiences and feelings. He was active and participated fully in discussions today. A normal amount of physical activity was exhibited by the client today. Client today spoke of self-defeating behavior. Client spoke of issues associated with substance use. Client describes substance cravings. Client admits he was tempted to use. Client denies use. Suicidal ideas or intentions are not in evidence and not expressed. No suicidal plans are present.*

Plan: *Have the client continue to attend groups and focus on treatment goals. Client has been identified as a group leader by his peers. Client will develop a written relapse prevention plan.*

3. CASE MANAGEMENT: OTP / NTP

Service Code: ***No service code—document as an Independent Note***

Definition – Case Management services include assisting a client in accessing medical, educational, social, pre-vocational, vocational, rehabilitative, housing, escaping domestic violence, escaping human trafficking, or other community services as well as a plan that provides for seamless transitions of care for clients without disruption to services. Case Management must be identified as a service modality within the Client/Treatment Plan directly related to the client's recovery and American Society of Addiction Medicine (ASAM) Dimension treatment continuum. Case Management services may provide to the client face-to-face/telehealth, on the telephone, or in service for the client without the client's presence. Prior to completing the initial Client/Treatment Plan, Case Management may be billed in circumstances in which staff are supporting the client with linkage and referral for urgent needs identified during completion of the Substance Use Disorder (SUD) Assessment.

Example: *Client informed this writer that she is losing weight, feels fatigued, and is experiencing an increase in depressive symptoms after a change in her thyroid medication. Client asked this writer to contact her primary care physician because he has not yet called her back. Spoke with client's physician (Release of Information-ROI on file) on the phone regarding the client's symptoms. Physician noted that client's thyroid medication was changed last week and requested the client go to the lab that afternoon for a blood test. Writer will follow up with client.*

4. PHYSICIAN CONSULTATION: OTP / NTP

Service Code: Z515 ***Add modifier based on modality***

Definition – Physician Consultation services include consultation provided to Drug Medi-Cal Organized Delivery System (DMC-ODS) contracted physicians by addiction medicine physicians, addiction psychiatrist or clinical pharmacist to assist with providing expert advice on designing Client/Treatment Plans for clients. Physician Consultation services are designed to support DMC-ODS contracted providers with complex cases and may also include medication selection, dosing, side effect management, medication compliance, drug-to-drug interactions, or level of care considerations. Physician Consultation services are designed to assist DMC-ODS contracted physicians with seeking expert advice on designing Client/Treatment Plans for specific DMC-ODS clients.

Used by: OTP and NTP Programs: Only by LPHA Prescribers

Example: *This Medical Director spoke over the phone with the client's mental health psychiatrist (Release of Information-ROI on file) to consult on the client's current medication care issues/side effects (i.e., weight gain, loss of energy, increased negative thoughts, sleep terrors) with the focus of reinforcing the client's treatment plan success. Item discussed were the client's recent behavior changes since Depakote medication dosage increased in Nov, 2019. Behavior changes have been observed by this writer, staff, and per client report, as well as impact on the client's treatment progress and engagement. This writer shared no other changes in the client's life have happened to impact behavior beside dosage increase. This writer recommended review of medication and possible change as indicated. The client's psychiatrists reported the client is consistent with his medication appointments and medication compliance, and will plan to discuss this staff's concerns at his next appointment on Jan. 2, 2020 to re-evaluate dosage. Both staff agreed blood work analysis would be recommended at this time for further follow-up. This writer will make blood work tests request and plan to continue to collaborate with psychiatrist on client's treatment services. This writer will also follow up with client over psychiatrist recommendations.*

5. MEDICATION/DOSING SERVICE CODES: OTP / NTP

Service Code	Medication/Dosing
Z707	**Bup-Nalox 2-0.5MG SL-2003 generic**
Z709	**Bup-Nalox 2-0.5MG SL-0503 generic**
Z711	**Bup-Nalox 2-0.5MG SL-2303 generic**
Z713	**Bup-Nalox 8-2MG SL-8913 generic**
Z715	**Bup-Nalox 2-0.5MG SL-8813 generic**
Z717	**Nalox 4 MG (Nasal)- 5302 generic**
Z719	**Disulfiram 500 MG tab-5725 generic**
Z721	**Disulfiram 250 MG tab-5613 generic**
Z723	**Bup 8 MG Tablet-7713 generic**
Z725	**Bup 2 MG Tablet-7613 generic**
Z728	**Naltrexone-generic**
Z729	**Naltrexone-brand name**
Z730	**OTP/NTP Methadone Dosing**

Bup = buprenorphine **Nalox =** naloxone

Residential Treatment Services

- **Please Note:** If transportation services are included, provide the following: date of transportation, time out and in, purpose of trip and signature with printed name and date of person logging the transportation (transportation services alone do not justify billing for a daily rate). The daily note must be completed by a treatment staff who provided one of the claimable services for the day claimed.
- Document all other services including Intake/Assessment, Individual Counseling, Collateral Services, Crisis Interventions, Client/Treatment Planning, Group Counseling, Discharge Services, Physician Consultation and Case Management with an individual Progress Note recorded by the LPHA or counselor who performed the service.
- Source: P&P #03-07 DMC-ODS Residential Treatment Services

1. INTAKE/ASSESSMENT: Residential

Service Code: Z508 (3.1) / Z510 (3.5) ***This is a Day Rate***

Definition – Intake/assessment means the process of determining if a client meets the condition of medical necessity for substance use disorder (SUD) treatment services. The intake process includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and SUDs by conducting an SUD Assessment based on American Society of Addiction Medicine (ASAM) Criteria. The intake is held face-to-face or via telehealth between the counselor/Licensed Practitioner of the Healing Arts (LPHA) and client. Intake may also include a physical examination and laboratory testing (e.g. body specimen screening) necessary for substance use disorder treatment and evaluation. If the SUD Assessment is completed by a counselor, the Medical Director or LPHA shall evaluate the client's intake/assessment information to verify whether the client meets medical necessity criteria or not. A telephone interview is not acceptable for establishing medical necessity. The initial SUD Assessment is to be completed within the first 48 hours and subsequent SUD Assessments are to be completed every thirty days thereafter. The Health Questionnaire must be completed and reviewed & signed by the Medical Director *prior to completion of the treatment plan* (Physical Exam). A Substance Use Disorder Diagnosis based on the DSM-5 must be documented, along with criteria met. Identification of level of care based on SUD Assessment shall be supported. A complete CalOMS admission form must be submitted must be submitted within 10 days from admission to treatment.

Used by: Residential 3.1 and 3.5 Programs

Example: *Met with client for intake appointment. The client is a 25 year old, English speaking, Caucasian male who denied any cultural/linguistic needs. The client was referred by CPS (Child Protective Services) for substance use issues (Meth and Marijuana) for the last five years and a recent domestic violence charge. The client reports he is unable to stop despite his verbalized desire to do so and the negative consequences continued use brings. The client reported 5x per week use of meth and daily marijuana use. The client stated, "I want to stop using [meth] and not have any more problems with my wife and the cops." The client has legal history of possession charges (2016) and incarceration time (2018) due to SUD related charges. No prior CPS involvement. The client is motivated to resolve CPS case and stop his substance use, "for good." The client reported no current medical conditions or concerns or past SUD treatment; last physical examination on Sept. 2019. The client currently works full-time in construction. The client reported, he recently has had some problems at work that are related to his use (i.e., missing work, irritable with co-workers.) The client reported his father struggled with alcohol use his entire life and was physically violent towards him, his mother, and sister. The client is a high school graduate and has his electrician certification. The client is currently out of the home due to domestic violence and is staying with his sister and her family. The client's focus of treatment is to return to his family. Plan is to continue to assess and develop a Client/Treatment Plan with the client.*

2. TREATMENT PLANNING: Residential

<u>Service Code</u>: Z508 (3.1) / Z510 (3.5) ***This is a Day Rate***

Definition – Treatment Plan services include the provider preparing an individualized written Client/Treatment Plan, with the participation of the client, based on information obtained in the intake and assessment process within the first 10 days of admission to treatment. Client/Treatment Plans must be completed, signed, and dated as well as reviewed and signed by the Licensed Practitioner of the Healing Arts (LPHA) if primary counselor is not an LPHA. *Updated* Client/Treatment plans are to be developed between the client and the counselor every 30 days for residential treatment services. Please ensure all signatures are obtained.

Used by: Residential 3.1 and 3.5 Programs

<u>Example</u>: *For this service, this writer worked on developing treatment plan with the client based on overall gathered information of the client's substance use struggles and desired goals. Treatment goals are focused on effectively managing chronic pain, effectively managing anxiety, and developing an increased awareness of relapse triggers and the coping strategies needed to effectively deal with them – impacted by medical condition, which appears to be related to client's presenting symptoms of Alcohol Use Disorder. Writer and client reviewed potential strategies and interventions to support goal attainment – including PCP (primary care physician) contact, use of natural supports, symptom management, and skill building. The client is fully committed to his treatment and support from this agency's staff. This counselor and client signed treatment plan and the LPHA will sign at next consult meeting. The client was offered and accepted a copy of his treatment plan. This counselor and client will conduct ongoing review of treatment goals to monitor progress, changes, barriers, and ongoing needs.*

3. INDIVIDUAL COUNSELING: Residential

<u>Service Code</u>: Z508 (3.1) / Z510 (3.5) ***This is a Day Rate***

Definition – Individual Counseling services include face-to-face or telehealth contacts between a client and counselor. Individual Counseling sessions between a counselor and a client must be conducted in a confidential setting where individuals not participating in the counseling session cannot hear the comments of the client or counselor. These services can be provided in an office, outpatient facility, through telehealth, or when appropriate, the home of the client or other confidential setting. Individual Counseling sessions are designed to support direct communication and dialogue between the staff and client and focus on psychosocial issues related to substance use and goals outlined in the client's individualized Client/Treatment Plan. Individual Counseling sessions need to incorporate Evidence-Based Practices. For 3.1 Residential Treatment, an Individual Counseling Session must be provided on a weekly basis based on medical necessity. For 3.5 Residential Treatment, an Individual Counseling Session must be provided on a weekly basis based on medical necessity. Sacramento County's expectation is that Residential Providers choose **Option 1 or Option 2** of documentation standards (*inquire within your own agency). Please reference: P&P #03-07 DMC-ODS Residential Treatment Services*

Used by: Residential 3.1 and 3.5 Programs

Example: *For this services session, this writer met face-to-face with client for an Individual Counseling session. Client/Treatment Plan goal addressed is to improve trigger identification to prevent relapse [Dimension 5]. Client reports, "I saw my family over the holiday and wanted to drink within an hour. Thankfully, I used the mindfulness skills and realized the tone of my dad's voice scares me inside, which makes me want to numb out. I was able to find a meeting and went. Overall, I'm feeling pretty proud of myself for not relapsing" [Dimension 4: process of change]. Action Step: writer reviewed client's comments with client to identify successes towards goal of trigger identification. Staff used Motivational Interviewing with client and reviewed mindfulness strategies to explore reaction to father's voice and response to feelings to use. Psychoeducation on how holidays can be triggering due to dynamics and acknowledgement of strength to participate in family activities and use of stress ball and meeting. Response: the client is able to recognize positive choices and that he could manage the uncomfortable feelings sober. Client expressed new awareness that physical activities and mindfulness strategies are helping his trigger management. Plan: Writer will schedule another session to review current SUD (substance use disorder) scoring and talk with client about planning for discharge to OS services.*

4. GROUP COUNSELING: Residential

Service Code: Z508 (3.1) / Z510 (3.5) ***This is a Day Rate***

Definition – Group Counseling services include both process-oriented and psycho-educational group services. The purpose of psycho-educational groups is the expansion of awareness about the behavioral, medical, and psychological consequences of substance use. All Group Counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. All Group Counseling sessions must contain a minimum of 2 and a maximum of 12 participants in the group, focusing on the needs of the individuals served. Anyone who is 17 years of age or younger shall not participate in Group Counseling with any clients who are 18 years of age or older. A counselor must be present at all times during the group. Self-study groups do not constitute a billable group. Movies cannot be claimed as Group Counseling. All Group Counseling sessions must be documented with a sign-in sheet for group members and that document must be maintained in a binder or other easily accessible format. The sign-in sheet must include the date of service, the printed and signed name of the counselor(s), counselor's credentials, and the printed and signed name of each client and their time signed in, group name, and topic. It must also include the duration of the Group Counseling session: start and end time. Sacramento County's expectation is that Residential Providers choose **Option 1 or Option 2** of documentation standards (*inquire within your own agency).*

Used by: Residential 3.1 and 3.5 Programs

Example: ***Title of Group***: *Sobriety Now*

Goal of Today's Group: *The focus of today's group was the subject of sobriety management. Group members were first encouraged to examine the ways substance use has adversely effected their lives. Group members were then directed to share and explore methods and strategies for remaining sober in the outpatient setting.*

Group Interventions that link to the SUD (substance use disorder) condition: *Group Leader facilitated discussion about sobriety management techniques, facilitated group process, involved all group members, kept group focused, and helped group members set limits and boundaries. Therapist provided psycho-education regarding clarifying areas of difficulty and identifying coping skills, Therapist provided support and structure and assigned worksheet/activity with topic of finding a sober peer group.*

Group Receptivity/Response: *In today's session, client appeared calm, friendly, communicative, and relaxed. His participation today was normal, with responses to others and sharing of personal experiences and feelings. He was active and participated fully in discussions today. A normal amount of physical activity was exhibited by the client today. Client today spoke of self-defeating behavior. Client spoke of issues associated with substance use. Client describes substance cravings. Client admits he was tempted to use. Client denies use. Suicidal ideas or intentions are not in evidence and not expressed. No suicidal plans are present.*

Plan: *Have the client continue to attend groups and focus on treatment goals. Client has been identified as a group leader by his peers. Client will develop a written relapse prevention plan.*

5. CASE MANAGEMENT: Residential

Service Code: Z514 ***Add modifier based on modality***

Definition – Case Management services include assisting a client in accessing medical, educational, social, pre-vocational, vocational, rehabilitative, housing, escaping domestic violence, escaping human trafficking, or other community services as well as a plan that provides for seamless transitions of care for clients without disruption to services. Case Management must be identified as a service modality within the Client/Treatment Plan directly related to the client's recovery and American Society of Addiction Medicine (ASAM) Dimension treatment continuum. Case Management services may provide to the client face-to-face/telehealth, on the telephone, or in service for the client without the client's presence. Prior to completing the initial Client/Treatment Plan, Case Management may be billed in circumstances in which staff are supporting the client with linkage and referral for urgent needs identified during completion of the Substance Use Disorder (SUD) Assessment.

Used by: Residential 3.1 and 3.5 Programs

Example: *Data Staff provided case management service to assist client with establishing a relationship with newly assigned primary care physician (Release of Information-ROI on file). Intervention Staff provided linkage assistance to ensure client arrived at appointment on time and completed new client paperwork to accurately report current physical symptoms and possible physical impact of substance use disorder. Response:* **Naltrexone-generic** *Client asked staff to help communicate self-reported needs to medical staff. Staff reminded client to ask for an appointment summary report that also includes any follow-up recommendations by primary care physician. Plan Staff to follow up with client on receipt of primary care physician's evaluation and assist with additional medical linkages as indicated on report.*

6. PHYSICIAN CONSULTATION: Residential

Service Code: Z515 ***Add modifier based on modality***

Definition – Physician Consultation services include consultation provided to Drug Medi-Cal Organized Delivery System (DMC-ODS) contracted physicians by addiction medicine physicians, addiction psychiatrist or clinical pharmacist to assist with providing expert advice on designing Client/Treatment Plans for clients. Physician Consultation services are designed to support DMC-ODS contracted providers with complex cases and may also include medication selection, dosing, side effect management, medication compliance, drug-to-drug interactions, or level of care considerations. Physician Consultation services are designed to assist DMC-ODS contracted physicians with seeking expert advice on designing Client/Treatment Plans for specific DMC-ODS clients.

Used by: Residential 3.1 and 3.5 Programs: Only by LPHA Prescribers

Example: *This Medical Director spoke over the phone with the client's mental health psychiatrist (Release of Information-ROI on file) to consult on the client's current medication care issues/side effects (i.e., weight gain, loss of energy, increased negative thoughts, sleep terrors) with the focus of reinforcing the client's treatment plan success. Item discussed were the client's recent behavior changes since Depakote medication dosage increased in Nov, 2019. Behavior changes have been observed by this writer, staff, and per client report, as well as impact on the client's treatment progress and engagement. This writer shared no other changes in the client's life have happened to impact behavior beside dosage increase. This writer recommended review of medication and possible change as indicated. The client's psychiatrists reported the client is consistent with his medication appointments and medication compliance, and will plan to discuss this staff's concerns at his next appointment on Jan. 2, 2020 to re-evaluate dosage. Both staff agreed blood work analysis would be recommended at this time for further follow-up. This writer will make blood work tests request and plan to continue to collaborate with psychiatrist on client's treatment services. This writer will also follow up with client over psychiatrist recommendations.*

7. RESIDENTIAL WITHDRAWAL MANAGEMENT

Service Code: Z512 (3.2) ***This is a Day Rate***

Definition – Withdrawal Management Services (Level 3.2-WM) are provided as medically necessary to clients and include: assessment, observation, medication services, and discharge planning and coordination. Clients receiving residential withdrawal management, 3.2-WM shall reside at the facility for monitoring during the detoxification process. Residential Withdrawal Management (sometimes referred to as "social setting detoxification") is an organized service that may be delivered by an appropriately trained staff member who provides 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than medical and nursing care. This level provides care for consumers whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support.

Used by: Residential 3.2 Programs

Example: *Writer met with client for the purpose of evaluating client's current withdrawal symptoms and potential risk. Writer utilized Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) = score of 1. The client was able to sit up without any trouble. Client presented with mild symptoms: agitation, sweating (moist palms), nausea with no vomiting, and elevated heart rate. Client's orientation was fair (x3) and improved coordination. Writer assessed client's emotional state. The client appeared to be in slight irritable mood, cooperative, lethargic and stated to be "thirsty." The client inquired about his treatment stay. This writer informed the client he would transition to residential treatment stay once withdrawal symptoms have dissipated and vitals are stable. The plan is to continue with ongoing 30 minute check-ins and to provide water and light meals/snacks. No current identified risks at this time.*

8. RESIDENTIAL WITHDRAWAL MANAGEMENT: MEDICATION SERVICES

Service Code: Z513 (3.2) ***This is a Day Rate***

Definition – The prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.

Used by: Residential 3.2. Programs

Example: *Staff (Nurse Practitioner) met with client for the purpose of managing client's current mild withdrawal symptoms. Staff administered client 5mg of diazepam via oral absorption. The client was moderately tremulous with some nausea and insomnia, and afebrile (i.e., without fever), and Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) score = 12, indicating mild withdrawal. The client was receptive to medication and staff's interventions and reported, "I just want to get some sleep." Staff will continue to monitor client's withdrawal symptoms and medication effects. Staff will follow up every 15 minutes.*

Medication Assisted Treatment (MAT) Services

1. MEDICATION SERVICES—PRESCRIBING/ORDERING

Service Code: No services code as this service is tied to medication rate

Definition – The prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.

Used by: Medication Services SUD Programs

2. MEDICATION SERVICES—ADMINISTERING/DISPENSING/MONITORING

Service Code: No service code as this service is tied to medication rate

Definition – Medication Services are administered, dispensed, and monitored in accordance with an individualized treatment care plan determined by a licensed prescriber. MAT programs will be required to offer and record proof of beneficiary understanding on choices of medications and treatment without medications. All MAT providers must have a completed initial SUD Assessment for all clients.

Used by: Medication Services SUD Programs

3. PHYSICIAN CONSULTATION

Service Code: No service code as this service is tied to medication rate

Definition – Physician Consultation services include consultation provided to Drug Medi-Cal Organized Delivery System (DMC-ODS) contracted physicians by addiction medicine physicians, addiction psychiatrist or clinical pharmacist to assist with providing expert advice on designing Client/Treatment Plans for clients. Physician Consultation services are designed to support DMC-ODS contracted providers with complex cases and may also include medication selection, dosing, side effect management, medication compliance, drug-to-drug interactions, or level of care considerations. Physician Consultation services are designed to assist DMC-ODS contracted physicians with seeking expert advice on designing Client/Treatment Plans for specific DMC-ODS clients.

Used by: Medication Services SUD Programs

Example: *This Medical Director spoke over the phone with the client's mental health psychiatrist (Release of Information-ROI on file) to consult on the client's current medication care issues/side effects (i.e., weight gain, loss of energy, increased negative thoughts, sleep terrors) with the focus of reinforcing the client's treatment plan success. Item discussed were the client's recent behavior changes since Depakote medication dosage increased in Nov, 2019. Behavior changes have been observed by this writer, staff, and per client report, as well as impact on the client's treatment progress and engagement. This writer shared no other changes in the client's life have happened to impact behavior beside dosage increase. This writer recommended review of medication and possible change as indicated. The client's psychiatrists reported the client is*

consistent with his medication appointments and medication compliance, and will plan to discuss this staff's concerns at his next appointment on Jan. 2, 2020 to re-evaluate dosage. Both staff agreed blood work analysis would be recommended at this time for further follow-up. This writer will make blood work tests request and plan to continue to collaborate with psychiatrist on client's treatment services. This writer will also follow up with client over psychiatrist recommendations.

4. MEDICATION PSYCHOTHERAPY

Service Code: No service code as this service is tied to medication rate

Definition – For clients in MAT programs, medical psychotherapy sessions are defined as face-to-face discussions between the Medical Director and/or physician and the client on issues identified in the client treatment plan.

Used by: Medication Services SUD Programs

Perinatal Services (OS, IOS, OTP/NTP)

1. INTAKE/ASSESSMENT: PERINATAL

Service Code: Z400 (OS), Z414 (OTP/NTP), Z430 (IOS)

Definition - Intake/assessment means the process of determining if a client meets the condition of medical necessity for substance use disorder (SUD) treatment services. The intake process includes the evaluation or analysis of the cause or nature of prenatal and postpartum care, mental, emotional, psychological, behavioral, and SUDs by conducting an SUD Assessment based on American Society of Addiction Medicine (ASAM) Criteria. The intake is held face-to-face or via telehealth between the counselor/Licensed Practitioner of the Healing Arts (LPHA) and client. The client must be pregnant or 60 days postpartum to participate in a perinatal program. For pregnant and postpartum women, medical documentation that substantiates the client's pregnancy and the last day of pregnancy is required. Parents with only adult children (18 years-old or older) do not qualify for perinatal services Intake may also include a physical examination and laboratory testing (e.g. body specimen screening) necessary for substance use disorder treatment and evaluation. If the SUD Assessment is completed by a counselor, the Medical Director or LPHA shall evaluate the client's intake/assessment information to verify whether the client meets medical necessity criteria or not. A telephone interview is not acceptable for establishing medical necessity. The Medical Director or LPHA shall document, in narrative format, separately from the treatment plan, the basis for the DSM-5 diagnosis in the client's record within seven (7) calendar days of each client's admission to treatment date. If the client is pregnant and not receiving prenatal care, a referral for such services are to be provided at intake. For pregnant and postpartum women, medical documentation that substantiates the client's pregnancy ***and*** the last day of pregnancy is required to bill perinatal rates. The Health Questionnaire must be completed and reviewed & signed by the Medical Director *prior to completion of the treatment plan* (Physical Exam). A Substance Use Disorder Diagnosis based on the DSM-5 must be documented, along with criteria met. Identification of level of care based on SUD Assessment shall be supported. A complete CalOMS admission form must be submitted must be submitted within 10 days from admission to treatment.

Used by: Perinatal Programs (OS, OTP/NTP, IOS)

Example: *Met with client for first appointment. Client is monolingual Spanish speaking; writer is bi-lingual and conducted session in Spanish. Client is a 33 year-old Latina female who was referred due to alcohol use struggles. Diagnosis provided by LPHA is Alcohol Use Disorder-mild. No suicidal ideation/homicidal ideation reported. Explained how services will be provided, problem resolution, confidentiality, and began gathering biopsychosocial history (SUD). The client provided copy of pregnancy test. The client reported current prenatal care from Kaiser medical provider. Plan: continue to assess and develop a treatment plan with the client.*

2. TREATMENT PLANNING: PERINATAL

Service Code: Z407 (OS), Z415 (OTP/NTP), Z431 (IOS)

Definition – Treatment Plan services include the provider preparing an individualized written Client/Treatment Plan, with the participation of the client, based on information obtained during the intake and assessment process within 30 days of admission to treatment. Client/Treatment Plans must be completed, signed, and dated as well as reviewed and signed by the Licensed Practitioner of the Healing Arts (LPHA) if primary counselor is not an LPHA. *Updated* Client/Treatment plans are to be developed between the client and the counselor every 90 days for outpatient/intensive outpatient treatment services. Please ensure all signatures are obtained. Treatment may include Individual and Group counseling, but must include parenting classes, pregnancy education, health, and nutrition counseling, coordination of care with OB-GYN, smoking cessation program, and childcare is provided as needed and if available. Transportation and Case Management services are also offered. Client/Treatment Plan must reference prenatal and/or postpartum issues. Urinalyses are conducted randomly for all clients and weekly for pregnant women.

Used by: Perinatal Programs (OS, OTP/NTP, IOS)

Example: *For this service, this writer worked on developing treatment plan with the client based on overall gathered information of the client's substance use struggles and desired goals. Treatment goals are focused on effectively managing chronic pain, effectively managing anxiety, having a healthy pregnancy, and developing an increased awareness of relapse triggers and the coping strategies needed to effectively deal with them – impacted by medical condition, which appears to be related to client's presenting symptoms of Alcohol Use Disorder. Writer and client reviewed potential strategies and interventions to support goal attainment – including PCP (primary care physician) contact, use of natural supports, symptom management, and skill building. The client is fully committed to her treatment and support from this agency's staff. This counselor and client signed treatment plan and the LPHA will sign at next consult meeting. The client was offered and accepted a copy of her treatment plan. This counselor and client will conduct ongoing review of treatment goals to monitor progress, changes, barriers, and ongoing needs.*

3. INDIVIDUAL COUNSELING: PERINATAL

Service Code: Z408 (OS), Z416 (OTP/NTP), Z432 (IOS)

Definition – Individual Counseling services include face-to-face or telehealth contacts between a client and counselor. Individual Counseling sessions between a counselor and a client must be conducted in a confidential setting where individuals not participating in the counseling session cannot hear the comments of the client or counselor. These services can be provided in an office, outpatient facility, through telehealth, or when appropriate, the home of the client or other confidential setting. Individual Counseling sessions are designed to support direct communication and dialogue between the staff and client and focus on psychosocial issues related to substance use and goals outlined in the client's individualized Client/Treatment Plan. Individual Counseling sessions need to incorporate Evidence-Based Practices.

Used by: Perinatal Programs (OS, OTP/NTP, IOS)

Example: *Counselor met with client for face-to-face session. Session was focused on exploring client's increased emotional distress based on impending birth and fears of birth complications (Dimensions: 2, 3, and 6). The client talked about her thoughts and emotions, coping skills, supports, and birthing plan. The plan is to check in with client twice a week in this last month of pregnancy. The client was engaged in session and open to this counselors support.*

4. GROUP COUNSELING: PERINATAL

Service Code: Z409 (OS), Z417 (OTP/NTP), Z433 (IOS)

Definition – Group Counseling services include both process-oriented and psycho-educational group services. The purpose of psycho-educational groups is the expansion of awareness about the behavioral, medical, and psychological consequences of substance use. All Group Counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. All Group Counseling sessions must contain a minimum of 2 and a maximum of 12 participants in the group, focusing on the needs of the individuals served. Anyone who is 17 years of age or younger shall not participate in Group Counseling with any clients who are 18 years of age or older. A counselor must be present at all times during the group. Self-study groups do not constitute a billable group. Movies cannot be claimed as Group Counseling. All Group Counseling sessions must be documented with a sign-in sheet for group members and that document must be maintained in a binder or other easily accessible format. The sign-in sheet must include the date of service, the printed and signed name of the counselor(s), counselor's credentials, and the printed and signed name of each client and their time signed in, group name, and topic. It must also include the duration of the Group Counseling session: start and end time.

Used by: Perinatal Programs (OS, OTP/NTP, IOS)

Example: ***Title of Group***: *Sobriety Now*

Goal of Today's Group: *The focus of today's group was the subject of sobriety management. Group members were first encouraged to examine the ways substance use has adversely effected their lives. Group members were then directed to share and explore methods and strategies for remaining sober in the outpatient setting.*

Group Interventions that link to the SUD (substance use disorder) condition: *Group Leader facilitated discussion about sobriety management techniques, facilitated group process, involved all group members, kept group focused, and helped group members set limits and boundaries. Therapist provided psycho-education regarding clarifying areas of difficulty and identifying coping skills, Therapist provided support and structure and assigned worksheet/activity with topic of finding a sober peer group.*

Group Receptivity/Response: *In today's session, client appeared calm, friendly, communicative, and relaxed. His participation today was normal, with responses to others and sharing of personal experiences and feelings. He was active and participated fully in discussions today. A normal amount of physical activity was exhibited by the client today. Client today spoke of self-defeating behavior. Client spoke of issues associated with substance use. Client describes substance cravings. Client admits he was tempted to use. Client denies use. Suicidal ideas or intentions are not in evidence and not expressed. No suicidal plans are present.*

Plan: *Have the client continue to attend groups and focus on treatment goals. Client has been identified as a group leader by his peers. Client will develop a written relapse prevention plan.*

5. COLLATERAL SERVICES: PERINATAL

<u>Service Code</u>: Z410 (OS), Z418 (OTP/NTP), Z435 (IOS)

Definition – Collateral Services include face-to-face or telehealth contact with significant persons in the life of the client. Significant persons are defined as individuals that have a personal, not official or professional, relationship with the client. For example, a client's social worker would not meet the "*significant persons*" criteria. Each Collateral Service must focus on the treatment needs of the client to support the achievement of Client/Treatment Plan goals. A client does not need to be present for Collateral Services to be billable.

Used by: Perinatal Programs (OS, OTP/NTP, IOS)

<u>Example</u>: *Writer met with client's spouse (significant person) in the office. Provided on-line resources to spouse that would provide information about the client's substance use issues and how it affects interpersonal relationships. Also assisted in finding a local Al-Anon support group for spouse.*

6. CRISIS INTERVENTION: PERINATAL

<u>Service Code</u>: Z412 (OS), Z419 (OTP/NTP), Z437 (IOS)

Definition – Services shall focus on alleviating crisis problems. "Crisis" means an *actual relapse* or an unforeseen event or circumstance that presents to the client an *imminent threat of relapse*. Crisis intervention services shall be limited to the stabilization of the client's emergency situation. Crisis intervention counseling must be provided face-to-face between a therapist or a counselor and a client in crisis. A crisis must be an actual relapse or an unforeseen event or circumstance causing imminent threat of relapse. Crisis intervention services must include a focus on alleviating crisis challenges and must be limited to stabilization of the client's emergency situation. Crisis intervention services are responses where a regularly scheduled visit will not meet the urgent or emergency nature of an individual crisis. An immediate assessment of risk and a time sensitive plan is developed and executed by service staff. Crisis intervention is utilized to stabilize an individual with psychiatric illness, prevent deterioration in individual functioning that may lead to a high level of care hospitalization or involuntary treatment. It typically requires face-to-face contact in addition to multiple other time sensitive service activities. Service activities are not limited to any single treatment modality and may include assessment, treatment or other appropriate collateral services that are clinically determined to be needed to resolve the crisis. Once the crisis is resolved, aftercare services are billed to appropriate codes. Crisis Intervention is provided when an immediate response or intervention is needed to help the client stabilize and continue to function in a community setting.

Used by: Perinatal Programs (OS, OTP/NTP, IOS)

<u>Example</u>: *Client's mother called writer to report that the client was screaming and throwing objects in the home. Client's mother said that client is not taking her medications and caller asked for immediate assistance. This writer assessed the situation and provided guidance to the mother during possible crisis in order to help the client de-escalate. This writer also provided instruction of safety measures (i.e., calling 911/law enforcement or going to ER) the mother can apply if the client's behavior becomes unmanageable. Writer will assess if emergency services are needed and attempt to de-escalate the client.*

7. DISCHARGE SERVICES: PERINATAL

Service Code: Z413 (OS), Z420 (OTP/NTP), Z438 (IOS)

Definition – Discharge Services are defined as the process to prepare the client for completion of their program, referral into another level of care, re-entry into the community, and/or the linkage of the individual to essential community, housing and human services. This includes both the process of developing the ***Discharge Plan*** with the client and completing the ***Discharge Summary***. The Plan must include description of relapse triggers and a support plan to avoid relapse. Discharge Services are to be documented no sooner than 30 days prior to discharge.

Used by: Perinatal Programs (OS, OTP/NTP, IOS)

Example: *For this service session this writer met with the client face-to-face to collaborate on discharge plan in identifying triggers and plan to address triggers, enlist supports, as well as identify needs in order to make appropriate referrals and linkages to community resources. A copy of the client's discharge plan was provided to client. Self-help (i.e., AA, Wellness & Recovery, Life Ring, and Celebrate Recovery) would be the most appropriate next step in her treatment to allow her to continue with her treatment and recovery. Plan: The client's next session is on 12/7/21 and her last day of services is planned for 12/15/21.*

8. CASE MANAGEMENT: PERINATAL

Service Code: Z445 ***Add modifier based on modality***

Definition – Case Management services include assisting a client in accessing medical, educational, social, pre-vocational, vocational, rehabilitative, housing, escaping domestic violence, escaping human trafficking, or other community services as well as a plan that provides for seamless transitions of care for clients without disruption to services. Case Management must be identified as a service modality within the Client/Treatment Plan directly related to the client's recovery and American Society of Addiction Medicine (ASAM) Dimension treatment continuum. Case Management services may be provided to the client face-to-face/telehealth, on the telephone, or in service for the client without the client's presence. Prior to completing the initial Client/Treatment Plan, Case Management may be billed in circumstances in which staff are supporting the client with linkage and referral for urgent needs identified during completion of the Substance Use Disorder (SUD) Assessment.

Used by: Perinatal Programs (OS, OTP/NTP, IOS)

Example: *Client informed this writer that she is losing weight, feels fatigued, and is experiencing an increase in depressive symptoms after a change in her thyroid medication. Client asked this writer to contact her primary care physician because he has not yet called her back. Spoke with client's physician (Release of Information-ROI on file) on the phone regarding the client's symptoms. Physician noted that client's thyroid medication was changed last week and requested the client go to the lab that afternoon for a blood test. Writer will follow up with client.*

9. PHYSICIAN CONSULTATION: PERINATAL

Service Code: Z446 ***Add modifier based on modality***

Definition – Physician Consultation services include consultation provided to Drug Medi-Cal Organized Delivery System (DMC-ODS) contracted physicians by addiction medicine physicians, addiction psychiatrist or clinical pharmacist to assist with providing expert advice on designing Client/Treatment Plans for clients. Physician Consultation services are designed to support DMC-ODS contracted providers with complex cases and may also include medication selection, dosing, side effect management, medication compliance, drug-to-drug interactions, or level of care considerations. Physician Consultation services are designed to assist DMC-ODS contracted physicians with seeking expert advice on designing Client/Treatment Plans for specific DMC-ODS clients.

Used by: Perinatal Programs (OS, OTP/NTP, IOS) - Only by LPHA Prescribers

Example: *This Medical Director spoke over the phone with the client's mental health psychiatrist (Release of Information-ROI on file) to consult on the client's current medication care issues/side effects (i.e., weight gain, loss of energy, increased negative thoughts, sleep terrors) with the focus of reinforcing the client's treatment plan success. Item discussed were the client's recent behavior changes since Depakote medication dosage increased in Nov, 2019, which have been observed by this writer, staff and per client report, as well as impact on the client's treatment progress and engagement. This writer shared no other changes in the client's life have happened to impact behavior beside dosage increase. This writer recommended review of medication and possible change as indicated. The client's psychiatrists reported the client is consistent with her medication appointments and medication compliance, and will plan to discuss this staff's concerns at her next appointment on Jan. 2, 2020 to re-evaluate dosage. Both staff agreed blood work analysis would be recommended at this time for further follow up. This writer will make blood work tests request and plan to continue to collaborate with psychiatrist on client's treatment services. This writer will also follow up with client over psychiatrist recommendations.*

10. OTP/NTP ONLY-METHADONE DOSING: PERINATAL

Service Code: Z429

Definition – For pregnant women with opioid use disorders, MAT (medication-assisted treatment) such as methadone and buprenorphine are the standard of care. In these instances, informed consent needs to be obtained, including discussions regarding Neonatal Abstinence Syndrome and what to expect at delivery. Opioid detoxification should also be reserved for selected women because of the high risk and potential consequences of relapse on both mother and baby. The risks and benefits of breastfeeding while clients are receiving medication-assisted treatments need to be weighed on an individual basis. Methadone and buprenorphine maintenance therapy are not contraindications to breastfeeding.

Used by: Perinatal Program (OTP/NTP)

11. PATIENT EDUCATION: PERINATAL

Service Code: Z434

Definition – Patient Education is a 1:1 learning experience, using a combination of methods such as teaching, counseling, writing assignments and other techniques to develop a client's knowledge and understanding of the impact of substance use on their psychological and physical health, family and other relationships in the community including work and legal issues. Patient Education is not considered a clinical service.

Used by: Perinatal Program (IOS ONLY)

<u>Example</u>: *This counselor met with client for face-to-face session for the purpose of going over findings on "The Prevalence of Anxiety, Depression, and Substance Use on Women" (Addresses Dimensions 3 and 5). The client was engaged in session, inquired about findings, and made connections with information discussed to her own history of use and mental health struggles over the years. The client stated, "I didn't know that sleep was so important to mental well-being, I'm going to start a consistent sleep routine" (Dimension 4-process of change). The client was provided information as reading material, will journal insight, and share at her next IS and Group. Today's session appears to have positively impacted the client's health decisions. Plan: The client will continue with IOS and her next session is on Dec. 11, 2019. This counselor will follow up on sleep routine.*

Perinatal Residential Treatment: Withdrawal Management/Detox

1. INTAKE/ASSESSMENT: PERINATAL RESIDENTIAL WM/DETOX

<u>Service Code</u>: Z439 (3.1) / Z441 (3.5) ***This is a Day Rate***

Definition – Intake/assessment means the process of determining if a client meets the condition of medical necessity for substance use disorder (SUD) treatment services. The intake process includes the evaluation or analysis of the cause or nature of prenatal and postpartum care, mental, emotional, psychological, behavioral, and SUDs by conducting an SUD Assessment based on American Society of Addiction Medicine (ASAM) Criteria. The intake is held face-to-face or via telehealth between the counselor/Licensed Practitioner of the Healing Arts (LPHA) and client. The client must be pregnant or 60 days postpartum to participate in a perinatal program. For pregnant and postpartum women, medical documentation that substantiates the client's pregnancy and the last day of pregnancy is required. Parents with only adult children (18 years-old or older) do not qualify for perinatal services Intake may also include a physical examination and laboratory testing (e.g. body specimen screening) necessary for substance use disorder treatment and evaluation. If the SUD Assessment is completed by a counselor, the Medical Director or LPHA shall evaluate the client's intake/assessment information to verify whether the client meets medical necessity criteria or not. A telephone interview is not acceptable for establishing medical necessity. The Medical Director or LPHA shall document, in narrative format, separately from the treatment plan, the basis for the DSM-5 diagnosis in the client's record within seven (7) calendar days of each client's admission to treatment date. If the client is pregnant and not receiving prenatal care, a referral for such services are to be provided at intake. For pregnant and postpartum women, medical documentation that substantiates the client's pregnancy ***<u>and</u>*** the last day of pregnancy is required to bill perinatal rates. The Health Questionnaire must be completed and reviewed & signed by the Medical Director *prior to completion of the treatment plan* (Physical Exam). A Substance Use Disorder Diagnosis based on the DSM-5 must be documented, along with criteria met. Identification of level of care based on SUD Assessment shall be supported. A complete CalOMS admission form must be submitted must be submitted within 10 days from admission to treatment.

Used By: Perinatal Residential WM/Detox Programs 3.1 and 3.5

<u>Example</u>: *Met with client for first appointment. Client is monolingual Spanish speaking; writer is bi-lingual and conducted session in Spanish. Client is a 33 year-old Latina female who was referred due to Alcohol Use withdrawal symptom struggles. Diagnosis provided by LPHA is Alcohol Use Disorder-moderate. No suicidal ideation/homicidal ideation reported. Explained how services will be provided, problem resolution, confidentiality, and began gathering biopsychosocial history (SUD). The client provided copy of pregnancy test. The client reported she is not receiving any prenatal care at this time. Plan: continue to evaluate current withdrawal symptoms and potential risks, develop a Client/Treatment Plan with the client, and provide linkage to primary care physician/prenatal care.*

2. INDIVIDUAL COUNSELING: PERINATAL RESIDENTIAL WM/DETOX

Service Code: Z439 (3.1) / Z441 (3.5) ***This is a Day Rate***

Definition – Individual Counseling services include face-to-face or telehealth contacts between a client and counselor. Individual counseling sessions between a counselor and a client must be conducted in a confidential setting where individuals not participating in the counseling session cannot hear the comments of the client or counselor. These services can be provided in an office, outpatient facility, or when appropriate, the home of the client or other confidential setting. Individual Counseling sessions are designed to support direct communication and dialogue between the staff and client and focus on psychosocial issues related to substance use and goals outlined in the client's individualized Client/Treatment Plan. Individual Counseling sessions need to incorporate Evidence-Based Practices.

Used By: Perinatal Residential WM/Detox Programs 3.1 and 3.5

Example: *Met with client for the purpose of individual counseling. Interventions were to teach, practice, and model healthy communication skills. This staff explored the client's recent communication challenges and impact on her relationships. The client was responsive to practicing skills. The client reported, "I feel this [skills taught] has been helpful." The plan is for the client to practice skills outside of session and in the community. This staff will f/u with client at next session on today's learned communication skills.*

3. GROUP COUNSELING: PERINATAL RESIDENTIAL WM/DETOX

Service Code: Z439 (3.1) / Z441 (3.5) ***This is a Day Rate***

Definition – Group Counseling services include both process-oriented and psycho-educational group services. The purpose of psycho-educational groups is the expansion of awareness about the behavioral, medical, and psychological consequences of substance use. All Group Counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. All Group Counseling sessions must contain a minimum of 2 and a maximum of 12 participants in the group, focusing on the needs of the individuals served. Anyone who is 17 years of age or younger shall not participate in Group Counseling with any clients who are 18 years of age or older. A counselor must be present at all times during the group. Self-study groups do not constitute a billable group. Movies cannot be claimed as Group Counseling. All Group Counseling sessions must be documented with a sign-in sheet for group members and that document must be maintained in a binder or other easily accessible format. The sign-in sheet must include the date of service, the printed and signed name of the counselor(s), counselor's credentials, and the printed and signed name of each client and their time signed in, group name, and topic. It must also include the duration of the Group Counseling session: start and end time.

Used by: Perinatal Residential WM/Detox Programs 3.1 and 3.5

Example: ***Title of Group****: Sobriety Now*

Goal of Today's Group*: The focus of today's group was the subject of sobriety management. Group members were first encouraged to examine the ways substance use has adversely effected their lives. Group members were then directed to share and explore methods and strategies for remaining sober in the outpatient setting.*

Group Interventions that link to the SUD (substance use disorder) condition*: Group Leader facilitated discussion about sobriety management techniques, facilitated group process, involved all group members, kept group focused, and helped group members set limits and boundaries. Therapist provided psycho-education regarding clarifying areas of difficulty and identifying coping skills, Therapist provided support and structure and assigned worksheet/activity with topic of finding a sober peer group.*

Group Receptivity/Response: *In today's session, client appeared calm, friendly, communicative, and relaxed. His participation today was normal, with responses to others and sharing of personal experiences and feelings. He was active and participated fully in discussions today. A normal amount of physical activity was exhibited by the client today. Client today spoke of self-defeating behavior. Client spoke of issues associated with substance use. Client describes substance cravings. Client admits he was tempted to use. Client denies use. Suicidal ideas or intentions are not in evidence and not expressed. No suicidal plans are present.*

Plan: *Have the client continue to attend groups and focus on treatment goals. Client has been identified as a group leader by his peers. Client will develop a written relapse prevention plan.*

4. CASE MANAGEMENT: PERINATAL RESIDENTIAL WM/DETOX

Service Code: Z445 ***Add modifier based on modality***

Definition – Case Management services include assisting a client in accessing medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services. As well as, a plan that provides for seamless transitions of care for clients in the Drug Medi-Cal-Organized Delivery System (DMC-ODS) of care without disruption to services. Case management must be identified as a service modality within the client's Client/Treatment Plan directly related to the client's recovery and ASAM Dimension treatment continuum. Case management services may be offered with the client face-to-face/telehealth, on the telephone, or in service for the client without the client's presence. Prior to completing the initial Client/Treatment Plan, Case Management may be billed in circumstances where staff are supporting the client with linkage & referral for urgent needs identified during completion of the SUD Assessment.

Used by: Perinatal Residential WM/Detox Programs 3.1 and 3.5

Example: *Staff provided case management service to assist client with establishing a relationship with newly assigned primary care physician (Release of Information-ROI on file) and to request pre-natal care referral. Client asked staff to help communicate self-reported needs to medical staff. Staff was able to assist the client on communicating needs since she was not feeling well enough to due to moderate withdrawal symptoms. This staff provided accurate report of current physical symptoms and possible physical impact of substance use disorder. Both staff and client were informed they would receive a return call once referral was submitted. The plan is for this staff to assist the client in confirming prenatal care referral within the next day.*

5. PHYSICIAN CONSULTATION: PERINATAL RESIDENTIAL WM/DETOX

Service Code: Z446 ***Add modifier based on modality***

Definition – Physician Consultation services include consultation provided to Drug Medi-Cal Organized Delivery System (DMC-ODS) contracted physicians by addiction medicine physicians, addiction psychiatrist or clinical pharmacist to assist with providing expert advice on designing Client/Treatment Plans for clients. Physician Consultation services are designed to support DMC-ODS contracted providers with complex cases and may also include medication selection, dosing, side effect management, medication compliance, drug-to-drug interactions, or level of care considerations. Physician Consultation services are designed to assist DMC-ODS contracted physicians with seeking expert advice on designing Client/Treatment Plans for specific DMC-ODS clients.

Used by: Perinatal Residential WM/Detox Programs 3.1 and 3.5

Only by LPHA Prescribers

Example: *This Medial Director (MAT physician) spoke over the phone with the client's mental health psychiatrist (Release of Information-ROI on file) to consult on the client's current medication care issues/side effects (i.e., weight gain, loss of energy, increased negative thoughts, sleep terrors) with the focus of reinforcing the client's treatment plan success. Item discussed were the client's recent behavior changes since Depakote medication dosage increased in Nov, 2019. Behavior changes have been observed by this writer, staff, and per client report, as well as impact on the client's treatment progress and engagement. This writer shared no other changes in the client's life have happened to impact behavior beside dosage increase. This writer recommended review of medication and possible change as indicated. The client's psychiatrists reported the client is consistent with his medication appointments and medication compliance, and will plan to discuss this staff's concerns at his next appointment on Jan. 2, 2020 to re-evaluate dosage. Both staff agreed blood work analysis would be recommended at this time for further follow-up. This writer will make blood work tests request and plan to continue to collaborate with psychiatrist on client's treatment services. This writer will also follow up with client over psychiatrist recommendations.*

6. RESIDENTIAL WITHDRAWAL MANAGEMENT: PERINATAL

Service Code: Z443 (3.2)

Definition – Withdrawal Management Services (Level 3.2-WM) are provided as medically necessary to clients and include: assessment, observation, medication services, and discharge planning and coordination. Clients receiving residential withdrawal management, 3.2-WM shall reside at the facility for monitoring during the detoxification process. Residential Withdrawal Management (sometimes referred to as "social setting detoxification") is an organized service that may be delivered by an appropriately trained staff member who provides 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than medical and nursing care. This level provides care for consumers whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support.

Used by: Perinatal Residential WM/Detox Programs 3.2

Example: *Writer met with client for the purpose of evaluating client's current withdrawal symptoms and potential risk. Writer utilized Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) = score of 1. The client was able to sit up without any trouble. Client presented with mild symptoms: agitation, sweating (moist palms), nausea with no vomiting, and elevated heart rate. Client's orientation was fair (x3) and improved coordination. Writer assessed client's emotional state. The client appeared to be in slight irritable mood, cooperative, lethargic and stated to be "thirsty." The client inquired about his treatment stay. This writer informed the client he would transition to residential treatment stay once his withdrawal symptoms have dissipated and vitals are stable. The plan is to continue with ongoing 30 minute check-ins and to provide water and light meals/snacks. No current identified risks at this time.*

7. RESIDENTIAL WITHDRAWAL- MEDICATION SERVICES: PERINATAL

Service Code: Z444 (3.2)

Definition – The prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.

Used by: Perinatal Residential WM/Detox Programs 3.2

Example: *Staff (Nurse Practitioner) met with client for the purpose of managing client's current mild withdrawal symptoms. Staff administered client 5mg of diazepam via oral absorption. The client was moderately tremulous with some nausea and insomnia, and afebrile (i.e., without fever), and Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) score = 12, indicating mild withdrawal. The client was receptive to medication and staff's interventions and reported, "I just want to get some sleep." Staff will continue to monitor client's withdrawal symptoms and medication effects. Staff will follow up every 15 minutes.*

8. PERINATAL: MEDICATION/DOSING CODES

Service Code	Medication/Dosing
Z451	**(Peri) Bup-Nalox 2-0.5MG SL-2003 generic**
Z453	**(Peri) Bup-Nalox 2-0.5MG SL-0503 generic**
Z455	**(Peri) Bup-Nalox 2-0.5MG SL-2303 generic**
Z457	**(Peri) Bup-Nalox 8-2MG SL-8913 generic**
Z459	**(Peri) Bup-Nalox 2-0.5MG SL-8813 generic**
Z461	**(Peri) Nalox 4 MG (Nasal)- 5302 generic**
Z463	**(Peri) Disulfiram 500 MG tab-5725 generic**
Z465	**(Peri) Disulfiram 250 MG tab-5613 generic**
Z467	**(Peri) Bup 8 MG Tablet-7713 generic**
Z469	**(Peri) Bup 2 MG Tablet-7613 generic**

Bup = buprenorphine **Nalox =** naloxone

Recovery Services : OS, IOS, OTP/NTP, Residential

Recovery Support Services (RSS) are aftercare support services designed to help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse. RSS emphasizes the client's central role in managing their health and recovery and promotes the use of effective self-management and coping strategies, as well as internal and community resources to support ongoing self-management. Medical necessity is considered established for any individual transitioning directly into RSS from treatment. If there is a lapse between treatment discharge and receipt of RSS, or RSS is discontinued, a screening needs to occur to determine if RSS is still the appropriate service level.

1. RECOVERY – INDIVIDUAL COUNSELING: OS, IOS, OTP/NTP, Residential

Service Code: Z516

Definition – Individual Counseling means face-to-face, telehealth, or telephone contacts between a client and counselor. Individual counseling sessions between a counselor and a client must be conducted in a confidential setting where individuals not participating in the counseling session cannot hear the comments of the client or counselor. These services can be provided in an office, outpatient facility, or when appropriate, the home of the client or other confidential setting. Each individual session should continue the on-going process of assessment and evaluation of progress with the Client/Treatment Plan.

Used by: OS, IOS, OTP/NTP, Residential

Example: *Met with client for the purpose of individual counseling. Interventions were to teach, practice, and model healthy communication skills. This staff explored the client's recent communication challenges and impact on her relationships. The client was responsive to practicing skills. The client reported, "I feel this [skills taught] has been helpful." The plan is for the client to practice skills outside of session and in the community. This staff will follow-up with client on today's learned communication skills at next session.*

2. RECOVERY – GROUP COUNSELING: OS, IOS, OTP/NTP, Residential

Service Code: Z517

Definition – Group Counseling services include both process-oriented and psycho-educational group services. The purpose of psycho-educational groups is the expansion of awareness about the behavioral, medical, and psychological consequences of substance use. All Group Counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. All Group Counseling sessions must contain a minimum of 2 and a maximum of 12 participants in the group, focusing on the needs of the individuals served. Anyone who is 17 years of age or younger shall not participate in Group Counseling with any clients who are 18 years of age or older. A counselor must be present at all times during the group. Self-study groups do not constitute a billable group. Movies cannot be claimed as Group Counseling. All Group Counseling sessions must be documented with a sign-in sheet for group members and that document must be maintained in a binder or other easily accessible format. The sign-in sheet must include the date of service, the printed and signed name of the counselor(s), counselor's credentials, and the printed and signed name of each client and their time signed in, group name, and topic. It must also include the duration of the Group Counseling session: start and end time.

Used by: OS, IOS, OTP/NTP, Residential

Example: ***Title of Group**: Sobriety Now*

***Goal of Today's Group**: The focus of today's group was the subject of sobriety management. Group members were first encouraged to examine the ways substance use has adversely effected their lives. Group members were then directed to share and explore methods and strategies for remaining sober in the outpatient setting.*

***Group Interventions that link to the SUD (substance use disorder) condition**: Group Leader facilitated discussion about sobriety management techniques, facilitated group process, involved all group members, kept group focused, and helped group members set limits and boundaries. Therapist provided psycho-education regarding clarifying areas of difficulty and identifying coping skills, Therapist provided support and structure and assigned worksheet/activity with topic of finding a sober peer group.*

***Group Receptivity/Response:** In today's session, client appeared calm, friendly, communicative, and relaxed. His participation today was normal, with responses to others and sharing of personal experiences and feelings. He was active and participated fully in discussions today. A normal amount of physical activity was exhibited by the client today. Client today spoke of self-defeating behavior. Client spoke of issues associated with substance use. Client describes substance cravings. Client admits he was tempted to use. Client denies use. Suicidal ideas or intentions are not in evidence and not expressed. No suicidal plans are present.*

***Plan:** Have the client continue to attend groups and focus on treatment goals. Client has been identified as a group leader by his peers. Client will develop a written relapse prevention plan.*

3. RECOVERY – CASE MANAGEMENT: OS, IOS, OTP/NTP, Residential

Service Code: Z518

Definition – Case Management services include assisting a client in accessing medical, educational, social, pre-vocational, vocational, rehabilitative, housing, escaping domestic violence, escaping human trafficking, or other community services as well as a plan that provides for seamless transitions of care for clients without disruption to services. Case Management must be identified as a service modality within the Client/Treatment Plan directly related to the client's recovery and American Society of Addiction Medicine (ASAM) Dimension treatment continuum. Case Management services may be provided to the client face-to-face/telehealth, on the telephone, or in service for the client without the client's presence. Prior to completing the initial Client/Treatment Plan, Case Management may be billed in circumstances in which staff are supporting the client with linkage and referral for urgent needs identified during completion of the SUD Assessment.

Used by: OS, IOS, OTP/NTP, Residential

Example: *Writer received a call and spoke to client's CPS (Child Protective Services) social worker (SW), Ms. Twinkle Star (Release of Information-ROI in file), who followed up on client's treatment progress. This writer also collaborated on treatment goal of "Enrolling client into anger management and domestic violence classes in compliance to CPS requirements." Ms. Star shared steps to enrolling in classes, which will be discussed with client at his next session. This counselor discussed the client's progress in Recovery Services (i.e., maintaining abstinence and consistent employment attendance, as well as having participating in Recovery Services with this agency, at least 1x/month). Ms. Star expressed her concern about lack of client contact with CPS since the client's last meeting with her. This counselor will continue to encourage the client to maintain contact with CPS in order for successful completion and family re-unification. Plan is for this writer to continue check in with CPS SW at least 1x/month and continue to monitor the client's treatment progress. Client's next session is on Dec. 23, 2020.*

4. RECOVERY MONITORING: OS, IOS, OTP/NTP, Residential

Service Code: Z519

Definition – Recovery Monitoring means recovery coaching and monitoring via telephone, telehealth, and internet. Recovery Monitoring is only available in Recovery Services.

Used by: OS, IOS, OTP/NTP, Residential

Example: *This writer spoke to client via phone call with purpose of discussing the client's recent housing admission to Women's Shelter and monitor the client's SU (substance use) recovery. This staff inquired into the client's in-house SU support group experience. The client described feeling "better" and "supported" in her current placement with staff and residents. The client spoke about the communication skills learned in Residential treatment which have "really" helped her in getting her needs met and building boundaries. Staff modeled and reviewed previously introduced assertive communication skills in order to reinforce the client's empowered feelings. The client stated, "I feel more sure of myself and strong." This staff emphasized the client's progress during her treatment and dedication to her recovery. The staff will continue to support the client in reviewing and practicing learned skills in the community in order to maintain her shelter placement and establish stable housing in order to maintain her SU recovery.*

Recovery Services: Perinatal

1. RECOVERY – INDIVIDUAL COUNSELING: PERINATAL

Service Code: Z447

Definition – Individual Counseling services include face-to-face or telehealth contacts between a client and counselor. Individual Counseling sessions between a counselor and a client must be conducted in a confidential setting where individuals not participating in the counseling session cannot hear the comments of the client or counselor. These services can be provided in an office, outpatient facility, through telehealth, or when appropriate, the home of the client or other confidential setting.

Used by: Perinatal Programs

Example: *Met with client for the purpose of individual counseling. Interventions were to teach, practice, and model healthy communication skills. This staff explored the client's recent communication challenges and impact on her relationships. The client was responsive to practicing skills. The client reported, "I feel this [skills taught] has been helpful." The plan is for the client to practice skills outside of session and in the community. This staff will follow-up with client about today's learned communication skills at next session.*

2. RECOVERY – GROUP COUNSELING: PERINATAL

Service Code: Z448

Definition – Group Counseling services include both process-oriented and psycho-educational group services. The purpose of psycho-educational groups is the expansion of awareness about the behavioral, medical, and psychological consequences of substance use. All Group Counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. All Group Counseling sessions must contain a minimum of 2 and a maximum of 12 participants in the group, focusing on the needs of the individuals served. Anyone who is 17 years of age or younger shall not participate in Group Counseling with any clients who are 18 years of age or older. A counselor must be present at all times during the group. Self-study groups do not constitute a billable group. Movies cannot be claimed as Group Counseling. All Group Counseling sessions must be documented with a sign-in sheet for group members and that document must be maintained in a binder or other easily accessible format. The sign-in sheet must include the date of service, the printed and signed name of the counselor(s), counselor's credentials, and the printed and signed name of each client and their time signed in, group name, and topic. It must also include the duration of the Group Counseling session: start and end time.

Used by: Perinatal Programs

Example: ***Title of Group**: Sobriety Now*

***Goal of Today's Group**: The focus of today's group was the subject of sobriety management. Group members were first encouraged to examine the ways substance use has adversely effected their lives. Group members were then directed to share and explore methods and strategies for remaining sober in the outpatient setting.*

***Group Interventions that link to the SUD (substance use disorder) condition**: Group Leader facilitated discussion about sobriety management techniques, facilitated group process, involved all group members, kept group focused, and helped group members set limits and boundaries. Therapist provided psycho-education regarding clarifying areas of difficulty and identifying coping skills, Therapist provided support and structure and assigned worksheet/activity with topic of finding a sober peer group.*

Group Receptivity/Response: *In today's session, client appeared calm, friendly, communicative, and relaxed. His participation today was normal, with responses to others and sharing of personal experiences and feelings. He was active and participated fully in discussions today. A normal amount of physical activity was exhibited by the client today. Client today spoke of self-defeating behavior. Client spoke of issues associated with substance use. Client describes substance cravings. Client admits he was tempted to use. Client denies use. Suicidal ideas or intentions are not in evidence and not expressed. No suicidal plans are present.*

Plan: *Have the client continue to attend groups and focus on treatment goals. Client has been identified as a group leader by his peers. Client will develop a written relapse prevention plan.*

3. RECOVERY – CASE MANAGEMENT: PERINATAL

Service Code: Z449

Definition – Case Management services include assisting a client in accessing medical, educational, social, pre-vocational, vocational, rehabilitative, housing, escaping domestic violence, escaping human trafficking, or other community services as well as a plan that provides for seamless transitions of care for clients without disruption to services. Case Management must be identified as a service modality within the Client/Treatment Plan directly related to the client's recovery and American Society of Addiction Medicine (ASAM) Dimension treatment continuum. Case Management services may be provided to the client face-to-face/telehealth, on the telephone, or in service for the client without the client's presence. Prior to completing the initial Client/Treatment Plan, Case Management may be billed in circumstances in which staff are supporting the client with linkage and referral for urgent needs identified during completion of the SUD Assessment.

Used by: Perinatal Programs

Example: *Staff provided case management service to assist the client in connecting with housing resources (Release of Information-ROI on file). Staff provided linkage assistance to ensure client contacted the housing authority to begin the Housing Voucher Program application process. Client called the housing department with the number provided by staff. With client's permission, staff assisted with communicating the client's need and request for an application. Department staff collected client's needed information and indicated an application will be sent to the provided address within 7 days. Staff to follow up with client on receipt of Housing Voucher Program application after 7 days and assist with additional housing linkage needs as indicated by client.*

4. RECOVERY MONITORING: PERINATAL

Service Code: Z450

Definition – Recovery Monitoring means recovery coaching and monitoring via telephone, telehealth and internet. Recovery Monitoring is only available in Recovery Services.

Used by: Perinatal Programs

Example: *This writer spoke to client via phone call with purpose of discussing the client's recent housing admission to Women's Shelter and monitor the client's SU (substance use) recovery. This staff inquired into the client's in-house SU support group experience. The client described feeling "better" and "supported" in her current placement with staff and residents. The client spoke about the communication skills learned in Residential treatment which have "really" helped her in getting her needs met and building boundaries. Staff modeled and reviewed previously introduced assertive communication skills in order to reinforce the client's empowered feelings. The client stated, "I feel more sure of myself and strong." This staff emphasized the client's progress during her treatment and dedication to her recovery. The staff will continue to support the*

client in reviewing and practicing learned skills in the community in order to maintain her shelter placement and establish stable housing in order to maintain her SU recovery.

Engagement

1. ENGAGEMENT ATTEMPT

Service Code: 22222

Definition – Provider staff efforts to engage clients prior to the initial face-to-face (Program Assigning Date) when no face-to-face or real time phone contact is made. This may include, but is not limited to the following activities:

- Leaving a message regarding setting up an initial assessment appointment.
- Writing a letter providing the client with general information about services offered or appointment notifications.
- Driving to the client's home or known whereabouts for the purposes of engaging the client in services.

Used by: All Programs

Example: *Staff was present at the client's Drug Court hearing for the purposes of engaging the client to the program. The client did not attend his hearing. The plan is for the writer to continue engagement efforts and will call the client tomorrow.*

Non-Billable Codes

1. NO-SHOW (CLIENT MISSED APPOINTMENT)

Service Code: 90500

Definition – Client does not show for a scheduled office appointment or is not present for appointment at the home or location in the field. No-shows must be documented in the client record but are not a billable activity.

Used by: All Programs

Example: *Client is a no-show for appointment scheduled today, 3pm, at the family home. Client's mother reports that the client had not returned home from school and that she will call back to reschedule appointment.*

2. NO-SHOW (STAFF MISSED APPOINTMENT)

Service Code: 90600

Definition – Writer did not show for a scheduled office appointment or is not present for appointment at the home or location in the field. No-shows must be documented in the client record but are not a billable activity.

Used by: All Programs

Example: *This writer was a no-show for appointment scheduled yesterday at 3pm, at the family home. This writer was not in the office yesterday and unfortunately not able to cancel this appointment prior to the appointment time. This writer will call the client's mother to reschedule appointment.*

3. CANCELLATION (CLIENT CANCELLED SCHEDULED APPOINTMENT)

Service Code: 90501
Definition – A scheduled appointment is cancelled by the client. Cancellations should be documented in the client record but are not a billable activity.
Used by: All Programs

Example: *Client called writer to cancel scheduled appointment due to conflict in schedule at the job. Appointment was rescheduled for October 10, 2021, at 11am.*

4. CANCELLATION (STAFF CANCELLED SCHEDULED APPOINTMENT)

Service Code: 90601
Definition - A scheduled appointment is cancelled by the provider. Cancellations should be documented in the client record but are not a billable activity.
Used by: All Programs

Example: *Writer called client to cancel scheduled appointment due to emergency conflict. Appointment was rescheduled for October 20, at 9 am.*

5. CLIENT NON-BILLABLE ACTIVITY

Service Code: 11111
Definition – Service activities that are not billable to Drug Medi-Cal or other funding sources. Activities that are solely administrative and identified as "non-billable."
Used by: All Programs

Examples:

- *Travel time associated with a home-visit or field activity that results in a client no-show; or there is no contact and no other service code applies*
- *Completing a form where no review of case or billable activity occurs*
- *Time associated with administrative activities such as appointment scheduling, faxing, filing, or leaving voicemails*
- *Providing interpretation services for a client*
- *Researching a topic or developing a curriculum in preparation for a client or group service*