SUD QA CalAIM FAQ

ASSESSMENT

1. **How does the program document the provisional diagnosis?**

   To be billable in SanWITS, at least a provisional diagnosis must be included for each client. For residential services, an F-Code is needed at admission, and a confirmed diagnosis should be determined within 10 days. For outpatient services, a diagnosis should be confirmed within 30 days. Per their scope, The LPHA may provide diagnoses that include DSM-5, F-codes, and relevant Z-Codes. An SUD counselor can provide a Z-Code from the Social Determinants of Health ranging from Z55-Z65.

2. **Are there guidelines and requirements for the Diagnosis Narrative in the AACA?**

   See Instructions for completing the ASAM Criteria Assessment on the Optum website. Page 24 of the AACA encompasses client SUD diagnoses and their severity indicators, as well as a narrative that documents the justification for diagnoses using applicable DSM-5 criteria. The first and primary diagnosis listed will be a diagnosis of substance use, although there may be additional DSM-5 diagnoses or ICD-10 codes following. The narrative will be completed by a provider within the scope of their practice. The narrative should be individualized to the client and will include specific substances involved and examples of how diagnostic criteria are met. All DSM-5 specifiers should be included, along with the date of last use and if sobriety has only been maintained in a controlled environment.

3. **What is the Z-code that outpatient providers can use as a provisional diagnosis before the full SUD diagnosis is formulated?**

   At this time, the LPHA can use the Z03.89 as a provisional diagnosis for billing purposes prior to fully diagnosing.

4. **Can you please explain what the LPHA is supposed to fill out on pages 26 thru 28 of the AACA?**

   Page 26 documents Withdrawal Management information. Page 27 documents ASAM criteria level of care: concurrent treatment and recovery services. Page 28 documents the indicated Level of Care, Actual Level of care and any discrepancy. Please see instructions for AACA on the Optum website.

5. How does the LPHA document reassessment using the AACA?

During the reassessment process the LPHA and/or the SUD counselor will update any areas of the AACA that have had a clinically significant change.
In the case of a level of care change, it would be appropriate to update the areas of the Adult ASAM Criteria Assessment that support the change in level. Please see BHIN 21-075 page 6 for additional details.

Adult ASAM Criteria Assessment has a place for the LPHA to sign on page 26 - see Instructions for completing the ASAM Criteria Assessment.

6. When does the AACA need to be completed?

Outpatient: Adult ASAM Criteria Assessment (AACA) for adults to be completed with all signatures within 30 calendar days (date of admit + 29) or 60 days (date of admit + 59) if experiencing homelessness or under 21 and updated as clinically indicated. For those under 18, the Adolescent Initial Level of Care Assessment and YAI are to be completed with all signatures within 60 calendar days (date of admit + 59).

Residential: Adult ASAM Criteria Assessment (AACA) for adults to be completed with 10 calendar days from day of admit (day of admit + 9). For those under 18, the Adolescent Initial Level of Care Assessment and YAI are to be completed with all signatures within 10 calendar days of admit (day of admit + 9).

See Instructions for completing the ASAM Criteria Assessment.

7. What are the assessment requirements for withdrawal management?

For all intakes after 9/1/22, a full Adult ASAM Criteria Assessment (AACA) is not required; however, a Brief Level of Care Screening tool should be completed.

8. What z-codes can programs enter into SanWITS?

At this time, programs are encouraged to have SUD Counselors and Peer Support Specialists utilize the Z-codes on the Priority Social Determinants of Health.

CARE COORDINATION

9. What are the expectations for the LPHA care coordinator role?

Please see the BHIN 21-075, CalMHSA documentation guides, and trainings. *Care coordination* was previously referred to as "case management" and is provided clients in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service.

Care coordination includes one or more of the following components:

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

CalAIM indicates that LPHAs are to fill the role of *Care Coordinator*; however, both LPHAs and counselors may provide the service of *care coordination*. See Module 6 Care Coordination CalMHSA training for more information on care coordination standards.

PEER SUPPORT SERVICES

10. When are Peer Support Services billable under DMC-ODS?

Peer Support Specialists are limited to rendering Care Coordination as a county billable service. Upon completion of CalAIM approved certification, PSS may bill for Behavioral Health Prevention and Education Services & Self-Help/Peer Services.

11. When can peer support specialist get certified?

DHCS has developed a statewide requirement for Peer Support Specialists through the Medi-Cal Peer Support Specialist Certification Program. Please refer to the BHS Informational Notice 21-075 and CalMHSA Peer Certification website.

12. How is the Plan of Care for Peer Support Specialist documented?

Peer Support Services must be based on an *approved plan of care* (BHIN 22-019). The plan of care shall be documented within the Peer Plan of Care Progress Note and approved by an LPHA or SUD counselor. Peer Support Specialists must provide services under the direction of a LPHA (BHIN 21-075). All Peer Support Specialists require co-signatures on Peer Plans of Care regardless of any additional certifications. See BHIN 22-019.

See Peer Plan of Care Progress Note Instructions for more information.

13. What role does the Peer Support Specialist play in service delivery in the DMC ODS SOC?

Per BHIN 21-75, Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer Support Services consist of Educational Skill Building Groups, Engagement and Therapeutic Activity.

PROBLEM LIST

14. How do we manage the Problem list?

Problem List replaces Treatment Plans in outpatient, residential, and withdrawal management programs. Available on the Optum Website, Problem lists should be initiated at client admission and updated as clinically indicated. Based on information gathered in assessment, staff operating within their scope of practice may add diagnoses and Z codes to the Problem List along with the diagnostic F code, Z code, and its corresponding DSM 5 description complete with specifiers and modifiers as indicated.

Problems are added or ended over the course of treatment and documentation should support any changes to the problem list. Documentation may include assessments, progress notes, or the Diagnostic Determination Tool (formerly DDN).

Note that if Tobacco Use is identified in assessment, it must be included as a problem on the problem list.

Examples of problem lists are available in CalMHSA documentation guides. For more information, visit the CalMHSA CalAIM documentation guide and training website linked above.

See also the Problem List instructions located on the Optum website.

15. What Z codes can SUD counselors and Peer Support Specialists use?

At this time, SUD Counselors and Peer Support Specialists may utilize the Z-codes on the Priority Social Determinants of Health Z55-Z65.

16. Can we enter physical health problems identified by the person served/support person?

Providers should add problems to the problem list that are within their scope of practice. Since medical conditions are outside the scope of practice for an LPHA, a medical problem reported by a person served should be documented in a progress note or in assessment.

PROGRESS NOTES

17. How are residential services documented?

Residential/WM must complete a daily note. The daily note should document services provided by the treatment facility that day. In residential settings, the daily progress note may be written by any qualified SUD staff operating within their scope. Daily progress note narratives should summarize the services received in the day. Care Coordination services still require separate notes. Group notes are considered a progress note and groups will be documented on the same note and a participation list will be required for groups. See BHIN 21-019. Timeline for the ASAM Criteria Assessment is 10 days, in residential placements.

18. Where can we find examples of completed documentation?

Examples of progress note narratives are provided in CalMHSA documentation guides.

19. How do I handle bugs in the new forms?

Report any bugs that are found to QI Matter at QIMatters.HHSA@sdcounty.ca.gov

20. How are group services documented?

Outpatient: All services provided will be documented on the SUD treatment Progress Note located on the Optum Website SUDURM Tab. The program will also document the attendance on a Participant Lists. The Participant List replaced the group sign in sheets. A template for participant lists will be posted to the Optum website soon.

Residential/WM: Daily notes must be completed. The daily note should document services provided by the treatment facility that day including group services and are documented on the SUD Treatment Progress Note located on the Optum Website SUDURM Tab. The program will also document the attendance on a Participant Lists. The Participant List

replaced the group sign in sheets. A template for participant lists will be posted to the Optum website soon.

21. How are care coordination services documented?

Care Coordination is documented on separate progress notes for all levels of treatment and are due within 3 days (day of service +2). Clinical consultation between LPHA and SUD Counselor to review the level of care is a billable Care Coordination service. CalAIM indicates that LPHAs are to fill the role of *Care Coordinator*; however, both LPHAs and counselors may provide *care coordination* as a service. Care coordination facilitated by an SUD Counselor does not require a co-signature. See Module 6 Care Coordination CalMHSA Training for more information on care coordination standards.

RECOVERY SERVICES

22. What are the documentation requirements for RS?

Recovery Services may be provided as a standalone service or in conjunction with any level of treatment. In general, Recovery Services require a Problem List, TEA, and progress notes; however, documentation standards may differ in each circumstance (discharge to RS vs. standalone RS vs. concurrent treatment/RS, etc.). Recovery services workflows are posted to the Optum Website Toolbox Tab.

OTHER

23. What documents are no longer required? What carried over and is still required?

Adult Initial LOC/Updated LOC, DDN, and Continuing Services Justification are no longer required. Please see the SUDURM Tab on the OPTUM website for the most up to date required forms.