Tracking #	Regulations / Standards Involved	Agency Question	QAPI Response
1	BHIN 22-019	No more treatment plans; staff may be hung up on tx plans vs. problem list. Will there be a grace plan for adjustment while people are getting used to tx plans	Yes there will be grace period. While the effective date of the problem list requirement is 07/01/2022 per BHIN 22-019 Sonoma County DHS will begin auditing with problem list included effective 09/30/22 as presented during the SUD Providers' Meeting on 09/14/22. SABG treatment plan requirements still main in effect. DHCS is providing BHIN guidance prior to end of CY 2023.
2	BHIN 21-071	Concerning LOC assessment, it states in the Perinatal State regulations, “ongoing LOC assessment while in treatment.” What is the requirement here. We are working on a monthly assessment document that will show we are doing for this. Any suggestions or input?	The requirement is that the initial ASAM LOC determination is done within the appropriate 30 or 60 day assessment window. If the monthly assessment document suggests a change in level of care is appropriate a full ASAM must be completed as the ASAM determines the LOC. We recommend the full ASAM should be completed minimally one time per year to verify the appropriate LOC even if unchanged.
3	BHIN 21-071	How will the ASAM work; will there be a modified one for NTPs; where it happens; timing, etc.? Need a lot more information on these specifics about ASAM requirements and implementation	Doing an ASAM at intake during the appropriate 30 or 60 day assessment window is required. When there is reason to believe an LOC change is needed an ASAM must be completed to determine LOC. It is recommended to complete an ASAM at a minimum annually to validate ongoing care at present LOC should there be no changes. There is no specific modified NTP ASAM planned. We would have concerns with the reliability and validity of results using a different version of the tool. In the scenario where a non NTP SUD provider in the community has completed an ASAM we would not require the NTP to duplicate this work for the LOC recommendation. This scenario assumes the provider completed an ASAM within the last year and there are no reasons to suspect a change in LOC is clinically appropriate.
4	BHIN 22-019	Reduced time of progress notes from 7 to 3 days. Is it three business days? Impacts workload. Why this change?	Yes 3 business days for non-crisis service and 1 business day for crisis services. Weekends are business days in residential settings that are 24/7. Weekly summaries are no longer required for day treatment SCBH needs to verify if weekly notes are still required for residential services.
5	CCR title 22 § 51490.1 CCR title 22 § 51516.1 Cal MHSA AOD Counselors Clinical Documentation Guide	Will all services be rounded to the hour? Or only some services?	Once payment reform goes into effect on 07/01/23 there are reimbursement, financing, and billing changes. More information on CalAIM Payment Reform Fact Sheet issued December 2022. Staff rendering services would document precisely in accordance with exact service minutes rounding is not permitted.
6	CCR title 22 § 51341.1	I wanted to follow on the family piece for ATP. We have an LPCC who is willing to do this service and being within scope of practice feel they should be qualifed.	No LPCC services would be reimbursable by Medi-Cal, unless the individual is also a registered/certified counselor, and can bill under that scope.

7	BHIN 21-071	As a narcotic treatment program (NTP) we have been waiting for clarification on how or if to conduct the ASAM assessment. Someone we consult with, Javier Moreno from Pinnacle Treatment (NTP) gave us the following guidance. As of January 1, 2022, determining medical necessity was uncoupled from an ASAM assessment, creating two separate and two independent processes. 1.Initial medical determination 2.Level of Care determination Suppose a non-LPHA completes an assessment used to determine medical necessity determination. In that case, an LPHA must still meet with the non-LPHA face-to-face as before. However, because of our advocacy work, we were able to get the State to clarify medical necessity for NTPs is determined through the H&P, which the medical provider completes therefore medical necessity will never be determined by a non LPHA. After medical necessity is determined (in the case of NTPs, after the MD admits the patient), the ASAM assessment is only used for Level of Care determination. The timeframes for completing the ASAM is as follows: •For DMC beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with a licensed professional of the healing arts (LPHA) or registered/certified counselor. •For DMC beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM criteria shall be completed within 60 days of the DMC beneficiary's first visit with an LPHA or registered/certified counselor. •If a DMC beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over Given these changes, there is no reason why an LPHA must meet with a non-LPHA to review the ASAM in an NTP setting.	As noted in question we would require an ASAM completed within the appropriate 30 or 60 day assessment window. With continued enrollment in the NTP we recommend annual completion of the ASAM thereafter AND when there is a change in LOC. Example: NTP staff suspects individual who completed their original ASAM 120 days ago needs residential treatment and is not attending any other programming. NTP staff completes ASAM and referral to level 3.1 or 3.3 residential treatment. In the scenario where a non NTP SUD provider in the community has completed an ASAM we would not require the NTP to duplicate this work for the LOC recommendation. We agree that the MN is established by the LPHA at the NTP completing the H&P which would be a doctor / NP / PA acting in appropriate scope.
9	BHIN 22-019	I was reviewing the Problem List process and we are stopping doing treatment plans soon, but how do we get paid for Problem Lists? If we loose units from this change, how does it benefit the agency in terms of funding? We only do one intake session, when the new ASAM takes longer, the assessment takes longer and I want to know if we can do 2-3 sessions for the assessment sessions? We would do the ASAM, the ASI and we have other assessments documents we use, i.e., SUD Problem List, SNAP Assessment, PTSD Checklist and ACES questionnaire. We want to do a lot of this, and want to know if we can bill for it.	We are recommending that the ASI is dropped and replaced entirely by the ASAM which should offset significant demands on assessment time. This substitution is not expected to result in any units lost, but in the event that extra sessions are needed Cal MHSA did confirm this is permitted as noted in related question #17. Problem lists are incorporated into the appropriate session with the consumer. When done during an assessment session the time spent doing the problem list would get added to this service. When a problem list is updated as a result of an individual counseling sesion the time spent updating the problem list would get incorporated into that session.
10	BHIN 21-071, CCR title 22 § 51341.1	Can we get paid to do an ASAM if the person needs a higher level of care, for instance, after 30 days, they continue to use substances, we do an ASAM for residential or IOP, can we bill for that?	Yes we can and must do the ASAM if the consumer needs a higher LOC after 30 days. It would be done as an progress note with an appropriate assessment procedure code selected. Yes we can bill for that.
11	BHIN 21-071	1. How often do we need to do ASAM updates for NTP clients? We are doing one at intake. Many people are in treatment for years. 2. And, do we have to print the ASAM out and put it in the chart?	Doing an ASAM at intake during the appropriate 30 or 60 day assessment window is required. When there is reason to believe an LOC change is needed and ASAM must be completed to determine LOC. It is recommended to complete an ASAM annually to validate ongoing care at present LOC. The completed ASAM is a part of the consumer record and should be included with any physical or electronic patient records.
12	BHIN 22-019	What are we doing with residential and Problem Lists given they are not Medical? We implemented the ASAM but not sure about Problem Lists? Do we implement those too?	Our recommendation is to implement the Problem List in residential treatment as it will make an easier transition to the future state when we move to a DMC-ODS system. Where it is unlear whether or not treatment plans are still required such as with residential treatment attached to SABG we recommend retaining the treatment plan and adding the Problem List.

13	BHIN 22-019	I thought I asked how we bill meeting with clients to do Problem lists in outpatient. Do we bill like we do for treatment plans? We need to know given we are not in waiver and these are units and we can't afford to not bill for these services that are required. Currently we are doing both treatment plan and problem list.	Problem lists are incorporated into the appropriate session with the consumer. When done during an assessment session the time spent doing the problem list would get added to this service. When a problem list is updated as a result of an individual counseling sesion the time spent updating the problem list would get incorporated into that session. Treatment plans are no longer requirement for DMC outpatient services (except for NTP programs). We are asking all non NTP providers of DMC outpatient services to stop doing treatment plans and use Problem List only.
14	BHIN 22-019	1. As we replace treatment plans with problem lists, how do providers bill for problem lists? 2. Can you still do treatment plans and problem lists? 3. And, bill for both? I was told by one of our analysts that providers can still do both and bill for both.	The time spent gathering the information for the problem list and completing it is attached to the consumer's individual session. We can still do both treatment plans and problem lists, but Sonoma County recommends dropping the treatment plan entirely for DMC outpatient programs (Except where required IE NTPs). This recommendation is consistent with guidance received from Cal MHSA. While it is still possible to bill for both it is inadvisable as it is against Cal MHSA recommendations and typically would not be in the consumer's best interests.
15	BHIN 22-019	1.How do SUD providers bill for problem lists vs billing for treatment plans? A) Along with implementing required problem lists components, can providers choose to continue to develop treatment plans and claim time spent for developing treatment plans? B) When DMC providers (not NTPs) stop updating treatment plans and move only to problem lists, can they bill DMC every time they update the problem list, regardless of whom updates problem list?. Are there billing increments? Is there any instruction on billing for problem lists?	1.How do SUD providers bill for problem lists vs billing for treatment plans? A) Unless a treatment plan is required, it is not recommended to continue developing treatment plans eventhough this time can be claimed. This time would be better spent serving the consumer in other ways. B) The time spent for any update made to the problem list should be incorporated into the progress note for the service in which information arose that informed the need for the update to be made. There is no specific code to be utilized when adding or editing a problem list.
16	N/A	We need more clarity on "care coordination" and how this applies to SUD treatment programs in state plan counties.	Care Coordination only applies to ODS counties. This item can be resolved as a non requirement, but as it benefits consumers is encouraged whenver possible with a lens to future ODS implementation.
17	BHIN 21-071 CCR title 22 § 51490.1 CCR title 22 § 51516.1	Billing for ASAM – can providers use multiple intake appointments to complete the assessment and bill for multiple intake sessions? Can providers invoice DMC every time they reassess using ASAM?	Yes to both questions
22	BHIN 22-019	I had a question regarding our Turning Point Residential Program. For Outpatient we only do the ASAM and no longer do the ASI. When I went to Turning Point the other day, they were doing both the ASI and ASAM. I'm new so I just wanted clarification from you if they should just be doing the ASAM and get rid of the ASI?	We are in agreement with your determination that there is no reason to complete multiple assessments of SUD clients. ASAM is the requirement, with the option to do a brief screen at intake if needed. The LOC determination that may be identified in the ASI is included in the full ASAM. The screening tool we recommend implementing is the BQuIP. BQuIP is a quick screening tool that anyone can use regardless of licensure provided they do the brief BQuIP training online. https://www.uclaisap.org/bquiptool/ It's mainly to do a quick LOC screen, and then validate during the appropriate assessment window with the full ASAM. If an organization has time to do the full ASAM straight away, they should just skip the BQuIP and fulfill the ASAM requirement in those instances. BQuIP is just quick routing to what we would be confident will ultimately be the LOC and has a good level of mapping (I believe the researchers say 80% plus) for mapping to full ASAM LOC.

23	CCR title 22 § 51341.1, BHIN 21-071, BHIN 22-019, Cal MHSA Clinical Staff Clinical Documentation Guide	Can an LPHA (non-physician) sign off on diagnosis in State Plan (DMC)?	In summary: For medical necessity, with the exception of NTP's, a medical director does not need to sign off on the narrative for the diagnosis. For DMC beneficiaries, the LPHA can determine and document medical necessity in the clients' record (problem list or progress note). The assessment can be completed by the LPHA or registered certified AOD counselor when counselor consults with LPHA. LPHAs are responsible for determining and documenting initial diagnoses, as this is outside the scope of practice for an AOD counselor.