Medicaid Managed Care

Healthy Blue

For behavioral health providers: This spreadsheet contains Provider Monitoring Elements that inform behavioral health providers of the required quality standards. There is a tab for each specific provider type because the requirements vary for each provider type.

https://provider.healthybluela.com

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Core scoring grid
General
The record is accurate and clearly legible to someone other than the writer.
All entries in the record identify the name of member.
Each record includes member's social security number.
Each record includes member's address. BHSP
Each record includes member's employer and/or school, if applicable.
Each record includes member's home, school, and/or work telephone numbers. Behavioral health service provider (BHSP)
Each record includes member's emergency contact information. BHSP
Each record includes member's date of birth. BHSP
Each record includes member's gender. BHSP
Each member has a separate record.
All entries and forms completed by staff in member records include the name of the person making the entry's functional title, applicable educational degree, and/or professional license of the person making the entry (including electronic signature for electronic medical record [EMR] systems).
All entries and forms completed by staff in member records include full date of documentation.
All entries and forms completed by staff in member records include signature (including electronic signature for electronic medical record [EMR] systems).
For members zero to 17: Documentation of authorized representative is included in the record and proof of authorized representative, if applicable. BHSP
For members zero to 17: There is evidence that services are in context of the family.
For members zero to 17: There is evidence of ongoing communication with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.
For members zero to 17: There is evidence of ongoing coordination with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.
Member rights
There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian. BHSP/LMHP
For members over the age of 18 years of age, the member is given information to create an advance directive, or refusal is documented. *N/A for Crisis Response Services (CRS)
There is evidence of the member being given information regarding member's rights to confidentiality. BHSP
Telemedicine/telehealth **LMHPs practicing independently and CMS has approved telehealth for CPST effective May 1, 2023.

Telemedicine use is documented, if applicable. ***Telehealth does *not* include the use of text, email, or facsimile (fax) for the delivery of healthcare services.**
The member's record includes informed consent for services provided through the use of telehealth
If assessments and/or re-evaluations are completed via telecommunication system, the Louisiana Department of Health has approved using telemedicine/telehealth for assessments conducted by licensed mental health practitioners. Exclusions: Methadone admission visits conducted by the admitting physician within opioid treatment programs are not allowed via telecommunication technology.
If using telemedicine/telehealth services, the consent form includes the rationale for using telemedicine/telehealth in place of in-person services
If using telemedicine/telehealth services, the consent form includes the risks of telemedicine/telehealth, including privacy related risks.
If using telemedicine/telehealth services, the consent form includes the benefits of telemedicine/telehealth.
If using telemedicine/telehealth services, the consent form includes possible treatment alternatives as well as risks and benefits.
If using telemedicine/telehealth services, the consent form includes the risks and benefits of no treatment.
For telemedicine/telehealth services, when possible (such as at the next in-person treatment planning meeting), providers must have the recipients sign all documents that had verbal agreements previously documented.
For telemedicine/telehealth services, there is evidence in the record of a back-up plan (such as a phone number where the recipient can be reached) to restart the session or to reschedule it in the event of technical problems.
For telemedicine/telehealth services, there is evidence in the record of a safety plan that includes at least one emergency contact and the closest ER location in the event of a crisis.
For telemedicine/telehealth services, there is evidence in the record that the member was informed of all persons who are present.
For telemedicine/telehealth services, there is evidence in the record the member was informed of the role of each person.
For telemedicine/telehealth services, there is evidence of documentation if the recipient refused services delivered through telehealth or requested that services be delivered in-person, the provider must provide an in-person service or refer to an equally qualified licensed practitioner.
For members zero to 17 receiving telemedicine/telehealth services, providers need the consent of the recipient and/or the recipient's parent or legal guardian (and their contact information) prior to initiating a telemedicine/telehealth service with the recipient.
Initial evaluation
An initial/annual assessment is in the record and completed by a licensed mental health professional.
For members zero to 17:There is evidence the legal guardian is involved in the assessment.

An initial primary treatment DSM diagnosis is present in the record. BHSP
The reasons for admission or initiation of treatment are appropriate to services being rendered.
A mental status exam is in the record.
A current behavioral health history is present.
The medical treatment history includes known medical conditions. BHSP
The medical treatment history includes allergies and/or adverse reactions and dates. BHSP
The medical treatment history includes current treating clinicians.
The medical treatment history includes family history.
Current medications are listed (physical health [PH] and behavorial health [BH]).
Prescriber of current medications are listed (PCP and BH).
Medication dosage is listed.
Medication frequency is listed.
The initial history for members under the age of 21 includes prenatal and perinatal events, if information is available.
The initial history for members under the age of 21 includes a complete developmental history (physical, psychological, social, intellectual, and academic).
Assessment of risk includes the presence or absence of **current** suicidal or homicidal risk, danger toward self or others.
Assessment of risk includes the presence or absence of **previous** suicidal or homicidal risk, danger toward self or others.
The record includes documentation of dates of previous suicidal or homicidal behaviors.
The record includes documentation of methods and lethality of previous suicidal or homicidal behaviors.
The record includes documentation of any abuse the member has experienced.
The record includes documentation of whether the member has been the perpetrator of abuse.
Substance use assessment documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications and nicotine use.
The record documents the presence or absence of relevant legal issues of the member and/or family.
There is documentation that the member was asked about community resources (family, support groups, social services, school based services, educational groups, other social supports) that they are currently using.
The record documents the assessment of the member's strengths.
The record documents the assessment of the member's needs.
The assessment documents any financial concerns.
The assessment documents any challenges related to transportation.
The member's desired outcomes of treatment are clearly documented in the record.
There is indication and identification of any standardized assessment tool or comprehensive screening completed (for example, a PHQ-9, GAD-7) as dictated by diagnosis. BHSP

An initial health screening, such as the Healthy Living Questionnaire or the PBHCI, is included in the record. (Unless directed by the plan, this is for informational purposes and not counted against a provider in the compliance rating.)
Treatment plan
The treatment plan is in the record. *Based on most recent tx plan; can review prior tx plan to see progression and updates.
Treatment plan is signed by the member.
Treatment plan is signed by member's guardian, if applicable.
Treatment plan is developed by and signed by treating LMHP including credentials in signature.
Date of treatment plan is included.
Indication if it is an *initial* or an *updated* treatment plan.
The treatment plan is updated whenever goals are achieved or new problems are identified.
Progress on all goals are included in the update.
Treatment plan is based on and consistent with the assessment (initial or updated).
Treatment plan has individualized long-term goals.
Treatment plan has individualized short-term goals/objectives that are specific.
Treatment plan has individualized short-term goals/objectives that are measurable.
Treatment plan has individualized short-term goals/objectives that are action-oriented.
Treatment plan has individualized short-term goals/objectives that are realistic.
Treatment plan has individualized short-term goals/objectives that are time-limited.
Treatment plan reflects service locations for each intervention.
Treatment plan reflects staff providing the intervention.
Treatment plan reflects services to be provided in the duration.
Treatment plan reflects services to be provided in the frequency.
Individualized Crisis Plan is in the record.
Crisis plan signed by member and/or member's authorized representative as proof of participation in the development of crisis plan.
PSS: Peer support services are person-centered.
PSS: Peer support services are recovery focused.
PSS: Recovery planning assists members to set goals related to home.
PSS: Recovery planning assists members to set goals related to work.
PSS: Recovery planning assists members to set goals related to community.
PSS: Recovery planning assists members to set goals related to health.
PSS: Recovery planning assists members to accomplish goals related to home.
PSS: Recovery planning assists members to accomplish goals related to work.
PSS: Recovery planning assists members to accomplish goals related to community.
PSS: Recovery planning assists members to accomplish goals related to health.
Progress notes
Service/progress notes are present in the record.
There is evidence in the record that, regardless of the originating site, providers must maintain adequate medical documentation to support reimbursement of the visit.

Service/progress notes document specifically if service was provided through telemedicine/telehealth (outpatient services). ****moved from telemedicine/telehealth**
Service/progress notes reference treatment plan goals.
Service/progress notes include sufficient detail to support the length of the contact
Service/progress notes include service provider contact telephone number
Service/progress notes includes documentation of treatment plan goals/objectives being referenced
Service/progress notes include documentation of specific interventions delivered.
Service/progress notes include documentation of what materials were used when teaching a skill.
Service/progress notes include documentation of observed behaviors.
Service/progress notes include documentation of the member's response to intervention
All service/progress notes include documentation document clearly who is in attendance during each session (outpatient services).
Service/progress notes must include documentation of communication and coordination with the family and/or legal guardian/responsible party for services provided to children and youth.
Service/progress notes describe progress or lack of progress towards treatment plan goals.
Service/progress notes document continuous substance use assessment (if applicable).
Service/progress notes document on-going risk assessments (including but not limited to suicide and homicide).
Service/progress notes document monitoring of any at risk situations (including but not limited to suicide and homicide).
Service/progress notes document compliance or non-compliance with medications (if applicable).
Service/progress notes include date of service noted.
Service/progress notes include begin times of service noted.
Service/progress notes include end times of service noted.
Service/progress notes include signature of the person making the entry. If initials are used, initials of providers must be identified with correlating signatures.
Service/progress notes include the functional title, applicable educational degree, and/or professional license of the person making the entry.
Service/progress notes document the dates or time periods of follow up outpatient providers appointments.
Service/progress notes include when the member misses appointments, if applicable.
Services documented in the service/progress note reflect services billed. BHSP
There is evidence of progress summaries in the record.
There is evidence of progress summaries completed at least every 90 days, or more frequently as needed, if applicable.
Progress summaries document the start and end date for the time period summarized.
Progress summaries indicate who participated.

Progress summaries indicate where contact occurred.
Progress summaries indicate what activities occurred.
Progress summaries indicate how the recipient is progressing or lack of progression toward the personal outcomes in the treatment plan.
Progress summaries document any deviation from the treatment plan, if applicable.
Progress summaries document any changes in the recipient's medical condition, behavior, or home situation that may indicate a need for a reassessment and/or treatment plan change, as applicable.
Progress summaries include signature of the person completing the summary. If initials are used, initials of providers must be identified with correlating signatures.
Progress summaries include the functional title, applicable educational degree, and/or professional license of the person completing the summary.
Progress summaries are dated.
Progress summary is entered in the member's record when a case is transferred or closed.
Progress summaries shall be signed by the person providing the services.
PSS: Peer support services are face-to-face interventions with the member present.
PSS: Peer support services are therapeutic or have programmatic content.
PSS: Peer support services do not contain recreational, social, or leisure activites that do not have therapuetic or programatic content.
PSS: Peer support services documented do not provide transportation.
PSS: Peer support services do not document general office/clerical tasks as part of rendered services.
PSS: Peer support services do not document attendance in meetings or sessions without a documented purpose/benefit from the peer’s presence in that meeting or session.
Continuity and coordination of care
Services provided to children and youth must include communication and/or coordination with the primary care physician (PCP).
All coordination with other providers or agencies involved in the youth’s treatment must be documented within the record.
Release of Information signed or refusal noted for communications with other treating providers must be documented, if applicable.
The record documents that the member was asked whether they have a PCP.
The PCP's name is documented in the record, if applicable.
The PCP's address is documented in the record, if applicable.
The PCP's phone number is documented in the record, if applicable.
If the member has a PCP, there is evidence of provider attempting or successfully communicating with the PCP, or there is documentation that the member/guardian refused consent for the release of information to the PCP.
The record documents that the member was asked whether they are being seen by another behavioral health clinician.
The other behavioral health clinician's name is documented in the record, if applicable.
The other behavioral health clinician's address is documented in the record, if applicable.

The other behavioral health clinician's phone number is documented in the record, if applicable.
If the member is being seen by another behavioral health clinician, there is evidence of provider attempting or successfully communicating with the primary behavioral health clinician, or there is documentation that the member/guardian refused consent for the release of information to the behavioral health clinician.
Provider documents any referrals made to other clinicians, agencies, and/or therapeutic services, if applicable.
Medication management (if applicable)
Each record indicates each medication name. BHSP
Each record indicates each medication type. BHSP
Medication start date is listed.
Each record indicates each medication frequency of administration. BHSP
Each record indicates the dosages of each medication. BHSP
Each record indicates the person who administered each medication. BHSP
Each record indicates each medication route. BHSP
There is evidence that lab work is ordered, if applicable. BHSP
There is evidence ordered lab work has been reviewed by the clinician ordering the lab work, if applicable as evidenced by date and signature of clinician.
Documentation of member education of prescribed medication.
Documentation of the member's guardian and/or legal representative understanding and consenting to the medication used in treatment.
Abnormal Involuntary Movement Scale (AIMS) performed when appropriate (for example, the member is being treated with antipsychotic medication).
Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs, and chronic conditions to document ongoing monitoring. (*Reference list labeled *common antipsychotics* on later tab)
There is evidence of medication monitoring in the treatment record, documenting adherence.
There is evidence of medication monitoring in the treatment record, documenting efficacy.
There is evidence of medication monitoring in the treatment record, documenting adverse effects.
Restraints and seclusion
Documentation of alternatives/other less restrictive interventions were attempted. ***ONLY PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)**
Documentation of restraint/seclusion order. ***only PRTF**
Documentation of physician notification of restraint. ***only PRTF**
Documentation of member face-to-face assessment by a physician or physician extender (for example, PA, NP, APRN) within one hour of restraint initiation/application. ***only PRTF**
Documentation must show evidence of consultation with the physician or physician extender (for example, PA, NP, APRN) within 24 hours of restraint initiation/application. ***only PRTF**
Documentation of member's parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only). ***only PRTF**
Patient safety

If the member was placed on a special watch for harmful behavior, include documentation of the appropriate precautions taken and monitoring occurred. BHSP and Crisis Services
If the member was a victim of abuse or neglect, documentation of report to the appropriate protective agency and Health Standards, as applicable. BHSP and Crisis Services
Adverse incidents
For members 0 to 17, include documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within one business day of discovery. BHSP
Include documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within one business day of discovery. BHSP
Include documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within one business day of discovery. BHSP
Include ocumentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate. BHSP
Cultural competency
There is evidence that services were appropriate for age of the member.
There is evidence that services were appropriate to the developmental abilities of the member.
There is evidence that services were appropriate to the education level of the member.
Primary language spoken by the member is documented.
Any translation needs of the member are documented, if applicable.
Religious/spiritual needs of the member were assessed.
Racial and/or ethnic needs of the member were assessed., if applicable.
There is evidence that services are appropriate to individuals of diverse gender identities.
Identified gender needs of the member were incorporated into treatment, if applicable.
Sexual health related needs were assessed.
Discharge planning
Include documentation of discussion of discharge planning/linkage to next level of care.
A discharge summary is entered in the member's record when a case is transferred or closed.
A discharge summary details the recipient’s progress prior to a transfer or closure when the member is discharged or transitioned to a different level of care.
A discharge summary must be completed within 14 calendar days following a recipient’s discharge or transition to a different level of care.
An appointment date and/or time period of follow up with transitioning behavioral health provider must be documented on the discharge plan. If not, barriers noted, when member is discharged or transitioned to a different level of care.
There is documentation that communication/collaboration occurred with the receiving clinician/program. If not, barriers noted, when member is discharged or transitioned to a different level of care.
PCP appointment date and/or time period of follow up documented if a medical comorbidity is present. If not, barriers noted, when member is discharged or transitioned to a different level of care.

Medication profile provided to an outpatient provider during transition of care. If not, barriers noted, when member is discharged or transitioned to a different level of care.
Medication profile reviewed with the member during transition of care, when member is discharged or transitioned to a different level of care.
The course of treatment (the reason(s) for treatment and the extent to which treatment goals were met) is reflected in the discharge summary, when member is discharged or transitioned to a different level of care.

Major depressive disorder
The provider found sufficient evidence to support the diagnosis of major depressive disorder (MDD) by ruling out medical conditions that might cause depression and/or complicate the treatment.
The provider delivered education about MDD and its treatment to the member, and if appropriate, to the family or support network.
If psychotic features were found, the treatment plan included the use of either antipsychotic medication or electroconvulsive therapy (ECT), or clear documentation of why not implemented.
If MDD was of moderate severity or above, the treatment plan used a combination of psychotherapy and antidepressant medication, or clear documentation of why not.
The psychiatrist or prescriber delivered education about the medication including signs of new or worsening suicidality and the high risk times for this side effect.
If the provider was not a prescriber, there was documentation of a referral for a medical/psychiatric evaluation if any of the following are present: psychotic features, complicating medical/psychiatric conditions, severity level of moderate or above.
Documented use of a validated evidence-based screening tool (PHQ-9, PHQ-2, CE)
ADHD
Diagnosis was determined based on input/rating scales from family members/caregivers, teachers, and other adults in the member's life.
The record indicated that the medical evaluation was reviewed to rule out the medical causes for the signs and symptoms.
Psychoeducation was delivered to the member, and in the case of a minor, to the parents/caregivers
If the provider is a prescriber, the treatment plan explains the rationale of the selection of pharmacological intervention including risks, benefits, and side effects.

Parents and guardians were educated about follow up within 30 days of the initial prescription and two more times within 270 days (HEDIS®)
Evidence of ongoing/continued assessment of patient response to medication, side effects, adverse effects, and any laboratory monitoring that is necessary
If antidepressants are prescribed, the provider delivered education about a possible increased risk of suicidal behavior, including early warning signs.
If behavior therapy is prescribed, training is provided to parents in specific techniques to improve their abilities to modify and shape their child's behavior while improving the child's ability to regulate their own behavior.
Documented use of a validated evidence-based screening tool (Vanderbilt, Connors, CBCL, SNAP-IV, ADHD Rating Scale IV)
Substance use
Education was delivered about substance use disorders.
A plan for maintaining sobriety, including strategies to address triggers was developed, and the role of substance use in increasing suicide risk was discussed.
The treatment plan included a referral to self-help groups, such as AA, AL-ALNON, and NA.
Evaluation included the consideration of appropriate psychopharmacotherapy.
For MD providers, evidence that medication-assisted treatment (MAT)/abstinence-aiding medications were considered.
If a provider is not an MD, there was evidence a referral for MAT/abstinence-aiding medication or a diagnostic consultation was considered.
Schizophrenia

The member was assessed for other psychiatric and medical disorders (including other schizophrenia spectrum disorders such as schizoaffective disorder) that could account for the symptoms or complicate treatment.
Education was provided regarding schizophrenia and its treatment to the member and, if applicable, family and support network.
If significant risk was found, the provider implemented a plan to manage the risk, including a plan for diminishing access to weapons/lethal means.
If the provider was not an MD, documentation of a referral for a psychiatric evaluation was included in the record.
If a psychiatric referral was made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan.
If provider was a MD, and if there was several unsuccessful medication trials and/or severe suicidality, then the member as considered for ECT and/or Clozapine.
Documented use of a validated evidence-based schizophrenia disorder screening tool (PDSQ, SIPS, BSABS, PANSS, SPQ, SAE)
Generalized anxiety disorder — adult
Diagnosis for generalized anxiety disorder (GAD) based on DSM-5 criteria.
Member received education from physician about GAD, options for treatment, and general prognosis.
Cognitive behavioral therapy (CBT) psychotherapy and/or psychopharmacotherapy considered as first line treatment.
Ongoing monitoring of symptoms that are assessed for severity
Generalized anxiety disorder — children
Diagnosis for GAD based on DSM-5 criteria
Member received education from physician about GAD, options for treatment, and general prognosis.
CBT psychotherapy and/or psychopharmacotherapy considered as first line treatment.
Ongoing monitoring of symptoms that are assessed for severity
Documented use of a validated evidence-based screening tool (Spence Children's Anxiety Scale (SCAS), Self-Report for Childhood Anxiety Related Disorder (SCARED)

Bipolar disorder
Diagnosis is documented by type, (acute manic, hypomania, mixed, or acute depressive episode).
Completed psychological assessment documented first line treatment is psychotherapy using trauma-focused therapy or stress management and/or pharmacotherapy.
Psychoeducation, psychotherapy, and family/support network intervention provided as indicated.
Evidence of medication monitoring and managing adverse side effects.
Documented use of a validated evidence based bipolar screening tool (The Mood Questionnaire, PGH 9, MDQ, Mania Rating Scale, Young Mania Rating Scale, Child Mania Rating Scale)
Suicide risk
High to intermediate level of acute risk for suicide and risk assessment documented.
Psychosocial evaluation completed.
Assessment of lethal means and limited access to lethal means if needed.
Assessment for indications for inpatient admission.
Safety plan development if risk is not imminent including social support.
Continued monitoring of patient status and reassessment of risk in follow-up contacts.
Documented use of a validated evidence based screening tool
(Columbia, Self-Harm Behavior Questionnaire (SHBQ), Reasons for Living Inventory, Suicide Cognitions Scale- Revised, Beck Scale for Suicide Ideation)
Oppositional defiant disorder
Screened for co-occurring disorders to include ADHD, conduct disorders, mood disorders, learning and developmental disabilities, adjustment disorders, relational disorders, depression, anxiety, and substance abuse (particularly in adolescents).
Screened for symptom frequency: Oppositional defiant disorder (ODD) consists of recurring patterns of negativistic, hostile, or defiant behaviors lasting at least six months. The presentation also refers to angry and vindictive behavior and problems with control of temper.
If needed, referral for a cognitive evaluation to rule out learning disability
Screened for or coordinated care with a PCP to rule out chronic pediatric illness, significant head trauma, or lead toxicity.
Provided education and established therapeutic alliance with child and family. The LMHP should obtain information, clarify roles, raising issues and promoting solutions with parent's assistance.
Incorporated non-drug therapies into treatment plan as applicable and appropriate.

Documented use of a validated evidence-based screening tool (CBCL Vanderbilt, Pediatric Symptom checklist).
Post-traumatic stress disorder
History and symptom presence and duration meeting DSM-V criteria for post-traumatic stress disorder (PTSD)
Safety assessment
Screening for a comorbid substance use disorder
Trauma history and duration
Mental status exam
Current medications including over-the-counter drugs and herbals
If the provider is a non-MD, there is documentation of a referral for amedical/psychiatric evaluation if any of the following are present: need for medication initiation or adjustment, signs of physical trauma, or stabilization required.

Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Scoring Grid
General
There is evidence within the record that the member is receiving permanent supportive housing. This only applies if the member is receiving services from more than one mental health rehabilitation (MHR) provider.
If a member is receiving services from more than one MHR, there is evidence within the record the providers have documented coordination of care.
When an MHR member is being transferred, there is evidence within the record that the two agencies coordinated care prior to the transfer.
When an MHR member is being transferred, there is evidence within the record that the member has prescription refills if needed.
Member Choice form
There is evidence that a *Member Choice* form is part of the member's clinical record.
There is evidence that the *Member Choice* form is signed prior to the start of MHR services and when transferring from one MHR provider to another.
There is evidence that the *Member Choice* form must be fully completed.
There is evidence that the *Member Choice* form is signed by all parties.
CPST/PSR: initial evaluation
There is evidence within the record that the Level of Care Utilization System (LOCUS)/Child and Adolescent Level of Care Utilization System (CALOCUS) is performed by an LMHP.
There is evidence within the record that assessments were performed prior to receiving Community Psychiatric Supportive Treatment (CPST) and Psychosocial Rehabilitation (PSR) for Adults.
There is evidence within the record that re-assessments occur at least once every 365 days until discharge for adults.
For youth, assessments must also be performed at least once every 180 days until discharge and/or any time there is a significant change to the member's circumstances.
There is evidence within the record that an assessment is performed any time there is a significant change to the member's circumstances for adults.

Children and adolescents assessments shall be completed with the involvement of the primary caregiver.
Services provided to children and adolescents must include communication with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child.
Services provided to children and adolescents must include coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child.
For members 18 years of age and over, has at least a score of three on the LOCUS
For members 18 years of age and over, member must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain on the LOCUS rating. *Dimension 2
There is evidence of medical necessity, If applicable, for members 18 years of age and over with longstanding deficits, who do not experience any acute changes in their status and have previously met the criteria stated above regarding LOCUS scores, but who now meet a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR.
CPST/PSR: treatment plan
Treatment plans developed by an LMHP or physician.
There is evidence within the record that the member has received a signed copy of the treatment plan upon completion and after each revision.
There is evidence within the record that the member’s parent/caregiver and/or family are involved in the member's treatment plan.

There is evidence that the treatment plan and approach are updated if member is not progressing.
There is evidence that the treatment plan and approach are updated if the family is not engaged to assure family involvement before reauthorization is considered.
There is evidence within the record that all team members have signed the treatment plan.
Specific interventions based on the assessed needs that must include reference to training material when delivering skills training **PSR**
Treatment plan include services and interventions to support independent community living for transitioning adolescents in the setting of their own choice (ages 15 to 21).
Treatment plan include services and interventions to support independent community living for adults in the setting of their own choice.
Treatment plan includes services and interventions that must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and **improve functional skills at school, home, or community**.
Treatment plan include member's capacities.
Treatment plan include member's preferences.
Treatment plan includes crisis avoidance interventions including the identification of risk factors, including individualized back-up plans.
Treatment plan includes crisis avoidance interventions including barriers with strategies to overcome them, including individualized back-up plans.
Evidence that the member record includes documentation of the treatment plan review at least once every 180 days or more often if indicated
CPST/PSR: progress notes
There is evidence within the record that CPST services were provided telephonically, by telehealth, and/or face-to-face. *CMS has approved telehealth for CPST effective May 1, 2023.
There is evidence within the record that PSR services were provided face to face.
MHR services provided in school
There is evidence within the record that the assessments indicate school related needs.
There is evidence that the assessment includes a review of school records.
There is evidence that the assessment includes interviews with school personnel.
There is evidence within the record that reassessment of need shall be conducted to be determined if services shall continue with school as a place of service.
There is evidence within the record that MHR providers shall collaborate with school personnel to collect data to monitor a member's progress.

The member must not be removed from a core class such as math, science, or English, without written permission from the parent and school personnel. A rationale must be documented in the member's record.
If allowed by the member's school, direct interventions may be delivered in the classroom if medically necessary and on the member's treatment plan.
There is evidence within the record of the written approval from the member's school prior to delivering services in a school setting.
There is evidence within the record that providers are actively communicating with school personnel to avoid services duplication.
There is evidence within the record that providers are actively coordinating services with school personnel to avoid services duplication.
Services in locations without the caregiver in attendance, such as school or community settings, shall have written approval by the parent/caregiver filed in each member's record.

Therapeutic Group Home (TGH): initial evaluation
The supervising practitioner (psychologist and/or psychiatrist) must complete an initial diagnostic assessment at admission or within 72 of admission and prior to service delivery.
The supervising practitioner (psychologist and/or psychiatrist) must complete an initial diagnostic assessment prior to service delivery.
The supervising practitioner (psychologist and/or psychiatrist) must provide face-to-face assessment of the member at least every 28 days or more often as necessary per *LAC I:42* , chapter 62.
Discharge planning within the first week of admission with clear action steps
Assessments shall be completed with the involvement of the child or adolescent to the extent possible.
The assessment protocol documents less intensive levels of treatment have been determined to be unsafe, unsuccessful, or unavailable.
There is evidence of a standardized assessment tool such as the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment.
The assessment protocol must differentiate across life domains.
The assessment protocol must differentiate between risk factors.
The assessment protocol must differentiate between protective factors.
The assessment protocol must track progress over time.
TGH: treatment plan
There is evidence of a treatment planning tool such as the CALOCUS/CANS being utilized for treatment
Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the member.
The individualized, strengths-based services are based on both clinical and functional assessments.
Assist with the development of skills for daily living
Recreational activities are provided for all enrolled members.
Focus on reducing the behavior and/or symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation.
The treatment plan must be implemented with oversight from a licensed mental health professional
Transition the child or adolescent from TGH to home- or community-based living, with outpatient
Care coordination is provided to arrange and/or plan for access of educational services.
Care coordination is provided to arrange and/or plan for access of therapeutic services.
The treatment plan must include behaviorally measurable discharge goals.
Discharge planning with target dates outlined in the treatment plan
Additional TGH
Members attend community-based school, work, and/or training.
The psychologist or psychiatrist must prescribe the type of care provided.

Psychiatric Residential Treatment Facility (PRTF) Scoring Grid

PRTF: initial evaluation
A diagnostic evaluation must be conducted within the first 24 hours of admission in consultation with the youth. Pg. 43
A diagnostic evaluation must be conducted within the first 24 hours of admission in consultation with the parents/legal guardian.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the medical aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the psychological aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the social aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the behavioral aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the developmental aspects of the recipient's situation.
A diagnostic evaluation must be conducted within the first 24 hours of admission that reflects the need for inpatient psychiatric care.
PRTF: treatment plan
The plan must be developed no later than 72 hours after admission.
The plan must be implemented no later than 72 hours after admission.
The plan must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to determine that services being provided are or were required on an inpatient basis
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of therapies designed to meet the objectives.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of activities designed to meet the objectives.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of experiences designed to meet the objectives.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to include, at an appropriate time, post-discharge plans.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to include, at an appropriate time, coordination of inpatient services, with partial discharge plans.

The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to include, at an appropriate time, related community services to ensure continuity of care with the member's family upon discharge.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to include, at an appropriate time, related community services to ensure continuity of care with the member's school upon discharge.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to include, at an appropriate time, related community services to ensure continuity of care with the member's community upon discharge.
Additional PRTF
The member must have access to education services, including supports to attend public school if possible, or in-house educational components, or vocational components if serving adolescents
The member’s health is maintained (such as dental hygiene for a child expected to reside in the facility for 12 months). Pg. 51

ASAM Level 1

These services include, but are not limited to, individual, group, family counseling and psychoeducation on recovery and wellness. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but are fewer than nine contact hours per week for adults and fewer than six hours a week for adolescents .

Substance Use Disorder (SUD) Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care.
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
A comprehensive bio-psychosocial evaluation which substantiates appropriate member placement must be completed prior to admission,
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.
The comprehensive bio-psychosocial evaluation must contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.

The comprehensive bio-psychosocial evaluation must contain employment history.
The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment, or screening process
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must be made.
Evaluations must include the consideration of appropriate psychopharmacotherapy.
SUD Core Requirements: progress notes
The treatment plan must identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual.
The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan specifies the amount.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
Treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative, and providers.
Re-evaluations of the treatment plan must determine if services have contributed to meeting the stated goals.

If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
ASAM Level 1 requirements: The treatment plan is reviewed/updated in collaboration with the member, as needed, at a minimum of every 90 days or more frequently if indicated by the member's needs and documented accordingly.
SUD Core Requirements: progress notes
Treatment services at all levels of care of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication and/or coordiination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music, or vocational education as evidenced by their signature on relevant documentation.
SUD Core Requirements: medication management
There must be evidence that the member was assessed to determine if medication assisted treatment (MAT) was a viable option of care based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.
SUD Core Requirements: discharge planning
Documentation of discharge/transfer planning beginning at admission
Documentation of referrals made as needed
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attends and participates in discharge planning as evidenced by their signature on relevant documentation.

ASAM Level 2.1

These services include, but are not limited to, individual, group, family counseling and psychoeducation on recovery, as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis intervention coverage and orientation to community-based support groups. Intensive outpatient program services must include evidence-informed practices. These programs offer comprehensive, coordinated and defined services and must have a minimum of three (3) hour groups three (3) days per week (nine (9) contact hours) for adults and a minimum of three (3) hour groups two (2) days per week (six (6) contact hours) for adolescents.

SUD Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care.
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.

The comprehensive bio-psychosocial evaluation must contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.
The comprehensive bio-psychosocial evaluation must contain employment history.
The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment, or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must be made.
Evaluations must include the consideration of appropriate psychopharmacotherapy.
SUD Core Requirements: treatment plan
The treatment plan must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual.

The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan specifies the amount.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
The treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative, and providers.
Re-evaluations of the treatment plan must determine if services have contributed to meeting the stated goals.
If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
ASAM Level 2.1 Requirements: The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every 30 days, or more frequently if indicated by the member's needs and documented accordingly.
SUD Core Requirements: progress notes
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music, or vocational education as evidenced by their signature on relevant documentation.
Treatment services at all levels of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.

Documentation of services provided to children and youth must include communication and/or coordiination with the family and/or legal guardian.
ASAM Level 2.1 Requirements: Progress notes include documentation of evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing, and/or multidimensional family therapy.
SUD Core Requirements: medication management
There must be evidence that the member was assessed to determine if medication-assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.
SUD Core Requirements: discharge planning
Documentation of discharge/transfer planning beginning at admission
Documentation of referrals made as needed
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attends and participates in discharge planning as evidenced by their signature on relevant documentation.

ASAM Level 2-WM

This level of care is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, withdrawal management and referral services.

SUD Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care.
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
ASAM LEVEL 2-WM: Urine drug screens are required upon admission.
ASAM LEVEL 2-WM: Evidence of physicians' orders for medical management.
ASAM LEVEL 2-WM: Evidence of physicians' orders for psychiatric management.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.

The comprehensive bio-psychosocial evaluation must contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.
The comprehensive bio-psychosocial evaluation must contain employment history.
The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must be made.
Evaluations must include the consideration of appropriate psychopharmacotherapy.
SUD Core Requirements: treatment plan
The treatment plan must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual.

The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan specifies the amount.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
Treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative, and providers.
Re-evaluations of the treatment plan must determine if services have contributed to meeting the stated goals.
If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
ASAM LEVEL 2-WM REQUIREMENTS: The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every 30 days or more frequently if indicated by the member's needs and documented accordingly.
ASAM Level 2-WM: The treatment plan must be reviewed and signed by the **physician** and must be filed in the individual's record within 24 hours of admission with updates, as needed.
ASAM Level 2-WM: The treatment plan must be reviewed and signed by the **individual** and must be filed in the individual's record within 24 hours of admission with updates, as needed.
ASAM Level 2-WM: Urine drug screens are required as directed by the treatment plan.
SUD Core Requirements: progress notes
Treatment services at all levels of care of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.

Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication and/or coordiination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.
ASAM Level 2-WM: Progress notes document the implementation of the stabilization/treatment plan.
ASAM Level 2-WM: Progress notes document the individual's response to and/or participation in scheduled activities.
ASAM LEVEL 2-WM: Progress notes must document the individual's physical condition.
ASAM Level 2-WM: Progress notes must document the individual's vital signs.
ASAM Level 2-WM: Progress notes must document The individual's mood.
ASAM Level 2-WM: Progress notes must document the individual's behavior.
SUD Core Requirements: medication management
There must be evidence that the member was assessed to determine if medication-assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.

SUD Core Requirements: discharge planning
Documentation of discharge/transfer planning beginning at admission.
Documentation of referrals made as needed.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.

ASAM Level 3.1

Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on-site. This level of services does not include sober houses, boarding houses or group homes where treatment services are not provided (An example is a halfway house).

SUD Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care.
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.
The comprehensive bio-psychosocial evaluation must contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.
The comprehensive bio-psychosocial evaluation must contain employment history.
The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.

A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment, or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must be made.
Evaluations must include the consideration of appropriate psychopharmacotherapy.
SUD Core Requirements: treatment plan
The treatment plan must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual.
The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan specifies the amount.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
The treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative, and providers.
Re-evaluations of the treatment plan must determine if services have contributed to meeting the stated goals.
If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
LEVEL 3.1 Adult: The individualized, interdisciplinary treatment plan must be developed in collaboration with the member within 72 hours of admission.
LEVEL 3.1 Adult/Adolescent: The treatment plan is reviewed in collaboration with the member every 90 days or more frequently if indicated by member needs and documented accordingly.
SUD Core Requirements: progress notes
Treatment services at all levels of care of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Documentation of services provided to children and youth must include communication and/or coordiination with the family and/or legal guardian.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music, or vocational education as evidenced by their signature on relevant documentation.
SUD Core Requirements: medication management

There must be evidence that the member was assessed to determine if medication-assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.
SUD Core Requirements: discharge planning
Documentation of discharge/transfer planning beginning at admission
Documentation of referrals made as needed
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.

ASAM Level 3.2-WM

Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring, observation, and support in a supervised environment for a person served, to achieve initial recovery from the effects of alcohol and/or other drugs.

SUD Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care.
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.
The comprehensive bio-psychosocial evaluation must contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.
The comprehensive bio-psychosocial evaluation must contain employment history.
The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.

A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must be made.
Evaluations must include the consideration of appropriate psychopharmacotherapy.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Medical clearance and screening is performed upon arrival.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Evidence of toxicology and drug screening — Toxicology and drug screenings are medically monitored.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Evidence of physicians' orders for medical management
ASAM Level 3.2-WM Adult/Adolescent Requirements: Evidence of physicians' orders for psychiatric management
ASAM Level 3.2-WM Adolescent TGH ASAM Requirement (In addition to the staffing required by TGHs): There is a physician on duty as needed for management/review/approval of psychiatric and/or medical needs of the client through course of stay as evidence by signature and/or relevant documentation.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Individuals who require medication management must be transferred to medically monitored or medical withdrawal management program until stabilized.
SUD Core Requirements: treatment plan
The treatment plan must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual.
The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan specifies the amount.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
Treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative, and providers.
Re-evaluations of the treatment plan must determine if services have contributed to meeting the stated goals.
If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
ASAM Level 3.2-WM Adult/Adolescent Requirements: The individualized, interdisciplinary treatment plan must be developed in collaboration with the member within 24 hours [of admission].

ASAM Level 3.2-WM Adult/Adolescent Requirements: The stabilization/treatment plan must be reviewed and signed by the member within 24 hours of admission.
ASAM Level 3.2-WM Adult/Adolescent Requirements: The signed stabilization/treatment plan must be filed in the member's record within 24 hours of admission.
SUD Core Requirements: progress notes
Treatment services at all levels of care of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Documentation of services provided to children and youth must include communication and/or coordiination with the family and/or legal guardian.
ASAM Level 3.2-WM Adult/Adolescent Requirements: The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Daily assessment of progress through withdrawal management must be documented in a manner that is person-centered and individualized.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes document the implementation of the stabilization/treatment plan.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes must document the individual's response to and/or participation in scheduled activities.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes include the individual's physical condition.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes include the individual's vital signs.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes include the individual's mood.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes include the individual's behavior.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes include individual statements about the individual's condition.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes include individual statements about the individual's needs.
ASAM Level 3.2-WM Adult/Adolescent Requirements: Progress notes include Information about the individual's progress or lack of progress in relation to stabilization/treatment goals.
SUD Core Requirements: medication management

There must be evidence that the member was assessed to determine if medication-assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.
SUD Core Requirements: discharge planning
Documentation of discharge/transfer planning beginning at admission
Documentation of referrals made as needed
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.

ASAM Level 3.3

Frequently referred to as extended or long-term care, Level 3.3 programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery from substance-related disorders **.**

SUD Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care.
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.
The comprehensive bio-psychosocial evaluation must contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.
The comprehensive bio-psychosocial evaluation must contain employment history.
The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment, or screening process.

A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must be made.
Evaluations must include the consideration of appropriate psychopharmacotherapy.
SUD Core Requirements: treatment plan
The treatment plan must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual.
The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan specifies the amount.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
The treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative, and providers.
Re-evaluations of the treatment plan must determine if services have contributed to meeting the stated goals.
If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
ASAM Level 3.3 Requirements: An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed in collaboration with the member.
ASAM Level 3.3 Requirements: An individualized, interdisciplinary treatment plan must be developed in collaboration with the member.
ASAM Level 3.3 Requirements: The treatment plan is reviewed in collaboration with the member, as needed, or at a minimum of every 90 days or more frequently if indicated by member needs and documented accordingly.
SUD Core Requirements: progress notes
Treatment services at all levels of care of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
SUD Core Requirements: medication management

There must be evidence that the member was assessed to determine if medication-assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.
SUD Core Requirements: discharge planning
Documentation of discharge/transfer planning beginning at admission
Documentation of referrals made as needed
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.
Women with Dependent Children Program: **In addition to the requirement for ASAM Level 3.3 facilities, Mothers with Dependent Children Programs must follow additional guidelines and meet specific requirements (Reference: LAC 48:I Ch. 57, §5705C).**
ASAM Level 3.3 Requirements: Providers must offer weekly parenting classes in which attendance is required.
ASAM Level 3.3 Requirements: Providers must address the specialized needs of the parent.
ASAM Level 3.3 Requirements: Providers must offer education for its parent members that further addresses effects of chemical dependency on a women's health and/or pregnancy.
ASAM Level 3.3 Requirements: Providers must offer counseling for its parent members that further addresses effects of chemical dependency on a women's health and/or pregnancy.
ASAM Level 3.3 Requirements: Providers must offer rehabilitation services for its parent members that further addresses effects of chemical dependency on a women's health and/or pregnancy.
ASAM Level 3.3 Requirements: Providers must offer education for its parent members that further address parenting skills.
ASAM Level 3.3 Requirements: Providers must offer counseling for its parent members that further address parenting skills.
ASAM Level 3.3 Requirements: Providers must offer rehabilitation services for its parent members that further address parenting skills.
ASAM Level 3.3 Requirements: Providers must offer education for its parent members that further address health and/or nutrition.
ASAM Level 3.3 Requirements: Providers must offer counseling for its parent members that further address health and/or nutrition.
ASAM Level 3.3 Requirements: Providers must offer rehabilitation services for its parent members that further address health and/or nutrition.
ASAM Level 3.3 Requirements: Providers must regularly assess parent-child interactions.

ASAM Level 3.3 Requirements: Providers must address any identified needs in treatment.
ASAM Level 3.3 requirements: Providers must provide access to family planning services.
ASAM Level 3.3 Requirements: The provider must address the specialized and therapeutic needs and care for the dependent children.
ASAM Level 3.3 Requirements: The provider must develop an individualized plan of care to address those [specialized and therapeutic] needs, to include goals, objectives, and target dates.
ASAM Level 3.3 Requirements: The provider must provide age-appropriate education for children.
ASAM Level 3.3 Requirements: The provider must provide age-appropriate counseling for children.
ASAM Level 3.3 Requirements: The provider must provide age-appropriate rehabilitation services for children.

ASAM Level 3.5 *These programs are designed to treat persons who have significant social and psychological problems and are characterized by their reliance on the treatment community as a therapeutic agent.*
SUD Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.
The comprehensive bio-psychosocial evaluation must contain relationships with family of origin,
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or
The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.
The comprehensive bio-psychosocial evaluation must contain employment history.
The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must
Evaluations must include the consideration of appropriate psychopharmacotherapy.
SUD Core Requirements: treatment plan
The treatment plan must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual.

The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan specifies the amount.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
The treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative,
Re-evaluations of the treatment plan must determine if services have contributed to meeting the
If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
LEVEL 3.5 adult/adolescent requirements: An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed.
LEVEL 3.5 adult/adolescent requirements: An individualized, interdisciplinary treatment plan must be developed in collaboration with the member.
LEVEL 3.5 adult/adolescent requirements: The treatment plan is reviewed in collaboration with the member, as needed, or at a minimum of every 30 days or more frequently if indicated by member
LEVEL 3.5 adult/adolescent requirements: The program must include an in-house education/vocational component if serving adolescents.
SUD Core Requirements: progress notes
Treatment services at all levels of care of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
SUD Core Requirements: medication management
There must be evidence that the member was assessed to determine if medication-assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.
SUD Core Requirements: discharge planning
Documentation of discharge/transfer planning beginning at admission
Documentation of referrals made as needed.
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant

ASAM Level 3.7 Adult

**An adult is defined as anyone 21 years of age and over.*

Facilities that provide ASAM level 3.7 medically monitored intensive residential treatment services provide care for individuals who may have co-occurring addiction and mental health disorders that meet the eligibility criteria for placement in a co-occurring disorder-capable program or difficulties with mood, behavior or cognition related to a substance use or mental disorder or emotional behavioral or cognitive symptoms that are troublesome, but do not meet the Diagnostic and Statistical Manual for Mental Disorders (DSM) criteria for mental disorder.

SUD Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care.
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.
The comprehensive bio-psychosocial evaluation must contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or significant others.

The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.
The comprehensive bio-psychosocial evaluation must contain employment history.
The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain legal history, if applicable.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must be made.
Diagnostic laboratory tests or appropriate referral must be made as required to prevent spread of contagious/communicable disease, or as indicated by physical examination or nursing assessment.
Evaluations must include the consideration of appropriate psychopharmacotherapy.
SUD Core Requirements: treatment plan
The treatment plan must be developed within 72 hours.
The treatment plan must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual.

The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan must specify the amount of services.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
The treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative, and providers.
Re-evaluations of the treatment plan must determine if services have contributed to meeting the stated goals.
If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
LEVEL 3.7 adult requirements: An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed.
LEVEL 3.7 adult requirements: An individualized, interdisciplinary treatment plan must be developed in collaboration with the member.
LEVEL 3.7 adult requirements: The treatment plan is reviewed in collaboration with the member, as needed, or at a minimum of every 30 days or more frequently if indicated by member needs and documented accordingly.
SUD Core Requirements: progress notes
Treatment services at all levels of care of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
SUD Core Requirements: medication management
There must be evidence that the member was assessed to determine if medication-assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.

SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.
SUD Core Requirements: discharge planning
Documentation of discharge/transfer planning beginning at admission
Documentation of referrals made as needed
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.

ASAM Level 3.7-WM

Medically monitored inpatient withdrawal management is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. It

SUD Core Requirements: initial evaluation
Triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral.
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.
ASAM 6 Dimensional risk evaluation substantiates member placement at the appropriate ASAM level of care.
The [ASAM 6 Dimensional risk] evaluation must be reviewed and signed by an LMHP.
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement.
The comprehensive bio-psychosocial evaluation must contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation must contain past addictive disorders treatment, if applicable.
The comprehensive bio-psychosocial evaluation must contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation must contain current health status.
The comprehensive bio-psychosocial evaluation must contain social history.
The comprehensive bio-psychosocial evaluation must contain current living situation.
The comprehensive bio-psychosocial evaluation must contain relationships with family of origin, nuclear.
The comprehensive bio-psychosocial evaluation must contain relationships with family and/or significant others.
The comprehensive bio-psychosocial evaluation must contain education.
The comprehensive bio-psychosocial evaluation must contain vocational training.
The comprehensive bio-psychosocial evaluation must contain employment history.

The comprehensive bio-psychosocial evaluation must contain employment current status.
The comprehensive bio-psychosocial evaluation must contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation must contain military service current status.
The comprehensive bio-psychosocial evaluation must contain past emotional state.
The comprehensive bio-psychosocial evaluation must contain legal history, if applicable.
The comprehensive bio-psychosocial evaluation must contain present emotional state.
The comprehensive bio-psychosocial evaluation must contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation must contain weaknesses.
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.
A drug screening is conducted when the member's history is inconclusive or unreliable.
An appropriate assignment to level of care with referral to other appropriate services as indicated must be made.
Diagnostic laboratory tests or appropriate referral must be made as required to prevent spread of contagious/communicable disease, or as indicated by physical examination or nursing assessment.
Evaluations must include the consideration of appropriate psychopharmacotherapy.
Level 3.7-WM Requirements**:** A physical examination must be performed by a physician, PA, or APRN.
LEVEL 3.7-WM REQUIREMENTS: A physical examination must be performed by a physician, PA, or APRN within 24 hours of admission.
Level 3.7-WM Requirements**:** evidence of physicians' orders for psychiatric management
Level 3.7-WM Requirements**:** evidence of physicians' orders for medical management

Level 3.7-WM Requirements**:** Appropriate toxicology tests must be ordered by a physician, PA, or APRN within 24 hours of admission.
Level 3.7-WM Requirements**:** Appropriate laboratory tests must be ordered by a physician, PA, or APRN within 24 hours of admission.
Level 3.7-WM Requirements: Evidence that toxicology and drug screenings are medically monitored. A physician may waive drug screening if and when individual signs list of drugs being used and understands that his/her dishonesty could result in severe medical reactions during withdrawal management process.
SUD Core Requirements: treatment plan
The treatment plan must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual.
The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
The treatment plan must specify the amount of services.
Treatment plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.
The re-evaluation of the treatment plan must involve the individual, family and/or legal representative, and providers.
Re-evaluations of the treatment plan must determine if services have contributed to meeting the stated goals.
If there is no measureable reduction of disability or restoration of functional level, a new treatment plan must be developed and identify a different rehabilitation strategy with revised goals and services.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must either be on the Child and Family Team (CFT) or working closely with the CFT.
Level 3.7-WM Requirements: A qualified professional must identify the individual's short-term needs based on the withdrawal management history, the medical history and the physical examination, if available, and prepare a plan of action until individual becomes physically stable.
Level 3.7-WM Requirements: An individualized, interdisciplinary stabilization/treatment plan must be developed in collaboration with the member, including problem identification in ASAM Dimensions 2-6 [Recovery Environment].
Level 3.7-WM Requirements: The treatment plan is reviewed and signed by physician within 24 hours of admission as evidenced by date and signature.

Level 3.7-WM Requirements: The treatment plan is reviewed and signed by the individual within 24 hours of admission as evidenced by date and signature.
SUD Core Requirements: progress notes
Treatment services at all levels of care of care shall offer a family component.
Adolescent substance use programs shall include family involvement as evidenced by parent education.
Adolescent substance use programs shall include family involvement as evidenced by family therapy.
Level 3.7-WM Requirements: Daily assessment of member's progress must be documented accordingly.
Level 3.7-WM Requirements: Progress notes must document the individual's response to and/or participation in scheduled activities.
Level 3.7-WM Requirements: Progress notes must document the individual's physical condition.
Level 3.7-WM Requirements: Progress notes must document the individual's vital signs.
Level 3.7-WM Requirements: Progress notes must document The individual's mood.
Level 3.7-WM Requirements: Progress notes must document the individual's behavior.
Level 3.7-WM Requirements: Progress notes must document statements about the individual's condition.
Level 3.7-WM Requirements: Progress notes must document statements about the individual's needs.
Level 3.7-WM Requirements: Progress notes must document Information about the individual's progress or lack of progress in relation to stabilization/treatment goals.
SUD Core Requirements: medication management
There must be evidence that the member was assessed to determine if medication-assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, must educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, must provide on-site MAT or refer to MAT offsite.
SUD Core Requirements: discharge planning

Documentation of discharge/transfer planning beginning at admission
Documentation of referrals made as needed
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.

Opiod treatment program (OTP) requirements
Screening
A screening is conducted to determine eligibility for admission.
A screening is conducted to determine eligibility for referral.
A screening is conducted to determine appropriateness for admission.
A screening is conducted to determine appropriateness for referral.
A complete physical examination by the OTP's physician must be conducted before admission to the OTP.
Members who meet clinical criteria must be at least 18 years old unless the member has consent from a parent or legal guardian, if applicable, and the State Opioid Treatment Authority.
Physical examination
A drug screening test by the OTP's physician must be conducted before admission to the OTP.
A full medical exam, including results of serology and other tests, must be completed within 14 days of admission.
The physician shall ensure members have a substance use or opioid use disorder (OUD).
An OUD must be present for at least one year before admission for treatment, or meet exception criteria, as set in federal regulations.
Alcohol and drug assessment and referrals
The American Society of Addiction Medicine (ASAM) OTP requirement: Comprehensive bio-psychosocial assessment must be completed within the first seven days of admission, which substantiates treatment.
For new admissions, the ASAM 6 Dimensional risk evaluation must be included in the assessment.
The assessment must be reviewed by a licensed mental health professional (LMHP).
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns.
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment.
The comprehensive bio-psychosocial evaluation shall contain past addictive disorders treatment, if applicable.

The comprehensive bio-psychosocial evaluation shall contain present addictive disorders treatment.
The comprehensive bio-psychosocial evaluation shall contain significant medical history.
The comprehensive bio-psychosocial evaluation shall contain current health status.
The comprehensive bio-psychosocial evaluation shall contain family history.
The comprehensive bio-psychosocial evaluation shall contain social history.
The comprehensive bio-psychosocial evaluation shall contain current living situation.
The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin (nuclear), family, and/or significant others.
The comprehensive bio-psychosocial evaluation shall contain education.
The comprehensive bio-psychosocial evaluation shall contain vocational training.
The comprehensive bio-psychosocial evaluation shall contain employment history.
The comprehensive bio-psychosocial evaluation shall contain employment current status.
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain military service current status.
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.
The comprehensive bio-psychosocial evaluation shall contain current legal status.
The comprehensive bio-psychosocial evaluation shall contain past emotional state.
The comprehensive bio-psychosocial evaluation shall contain present emotional state.
The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.
The comprehensive bio-psychosocial evaluation shall contain strengths.
The comprehensive bio-psychosocial evaluation shall contain weaknesses.

The comprehensive bio-psychosocial evaluation shall contain needs.
Assessments shall include the consideration of appropriate psychopharmacotherapy.
Medication management
There is evidence that the member was assessed to determine if medication assisted treatment (MAT) was a viable option of care, based on the substance use disorder (SUD) diagnosis. *OUD or AUD are appropriate for MAT.
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.
SUD providers, when clinically appropriate, shall provide on-site MAT or refer to MAT offsite.
SUD providers, when clinically appropriate, shall document member education in the progress notes.
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.
SUD providers, when clinically appropriate, shall document member response in the progress notes.
Treatment planning process
The treatment plan must be developed within seven days of admission by the treatment team.
The treatment plan must be based on the assessments.
The treatment plan must include person-centered goals.
The treatment plan must include person-centered objectives.
The treatment plan must Identify the services intended to reduce the identified condition.
The treatment plan must include anticipated outcomes of the individual.
The treatment plan must include a referral to self-help groups (AA/NA, Al-Anon).
The treatment plan must specify the amount of services.
The treatment plan must be signed by the LMHP or physician responsible for developing the plan.
The treatment plan must specify a timeline for re-evaluation of that plan that is, at least, an annual redetermination.
The re-evaluation must involve the family and/or responsible party.

Re-evaluations must determine if services have contributed to meeting the stated goals.
The treatment plan shall be updated and revised if there is no measureable reduction of disability or restoration of functional level.
If a new treatment plan is developed it includes a different rehabilitation strategy.
If a new treatment plan is developed it includes revised goals.
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.
Treatment services
During the initial treatment phase the provider conducts orientation. ***Initial treatment phase lasts from three to seven days.**
During the initial treatment phase the provider conducts counseling.***Initial treatment phase lasts from three to seven days.**
During the initial treatment phase the provider develops the initial treatment plan for treatment of critical health or social issues. ***Initial treatment phase lasts from three to seven days.**
During early stabilization, the provider conducts weekly monitoring of the member's response to medication. ***Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.**
During early stabilization, the provider provides at least four individual counseling sessions. *Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.
During early stabilization, the provider revises the treatment plan within 30 days to include input by all disciplines. *Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.
During early stabilization, the provider revises the treatment plan within 30 days to include input by the member. *Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.
During early stabilization, the provider revises the treatment plan within 30 days to include input by significant others. *Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.
During early stabilization, the provider conducts random monthly drug screen tests. ***Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration.**

During maintenance treatment, the provider performs random monthly drug screen tests until the member has negative drug screen tests for 90 consecutive days as well as random testing for alcohol when indicated. ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**
During maintenance treatment, after the member has obtained a negative drug screen for 90 consecutive days, monthly testing to members who are allowed six days of take home doses, as well as random testing for alcohol when indicated ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**
During maintenance treatment, after the member has obtained a negative drug screen for 90 consecutive days, random testing for alcohol when indicated ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**
During maintenance treatment, continuous evaluation by the nurse of the member's use of treatment from the program. *Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.
During maintenance treatment, the provider shall documented reviews of the treatment plan every 90 days in the first two years of treatment by the treatment team. *Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.
During maintenance treatment, the provider shall documentation of response to treatment in a progress note at least every 30 days. ***Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time.**
During medically supervised withdrawal from synthetic narcotic with continuing care, the provider shall decrease the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, as medically tolerated by member. ***Medically supervised withdrawal from synthetic narcotic occurs only when withdrawal is requested by the member.**
During medically supervised withdrawal from synthetic narcotic with continuing care, the provider shall provide counseling of the type based on medical necessity. ***Medically supervised withdrawal from synthetic narcotic occurs only when withdrawal is requested by the member.**
During medically supervised withdrawal from synthetic narcotic with continuing care, the provider shall conduct discharge planning as appropriate. ***Medically supervised withdrawal from synthetic narcotic occurs only when withdrawal is requested by the member.**

Evidence that those with take-home medication privilege have absence of criminal activity during treatment
Evidence that those with take-home medication privilege the member must have negative drug/alcohol screen for at least 30 days
Evidence that those with take-home medication privilege the member must have regular clinic attendance
Evidence that those with take-home medication privilege the member must have absence of serious behavioral problems during treatment
Evidence that those with take-home medication privilege the member must have stability of home environment
Evidence that those with take-home medication privilege the member must have stability of social relationships
Evidence that take-home medication can be safely stored (lock boxes provided by member).
Evidence that after the first 30 days and during the remainder of the first 90 days in treatment, one therapeutic dose per week was given to the member to self-administer at home. ***Treatment days 30 to 90 = one dose per week.**
Evidence that in the second 90 days, two therapeutic doses per week were given to the member to self-administer at home. Add for reviewer clarity: ***Treatment days 91 to 180 = two dose per week.**
Evidence that in the third 90 days of treatment, three therapeutic doses per week were given to the member to self-administer at home. ***Treatment days 181 to 270 = three dose per week.**
Evidence that in the final 90 days of treatment of the first year, four therapeutic doses per week were given to the member to self-administer at home. ***Treatment days 271 to 360 = four dose per week.**
Evidence the treatment team and medical director determined that the therapeutic privilege doses are appropriate that after one year in treatment, a six-day dose supply, consisting of take home doses and therapeutic doses may be allowed once a week. *Treatment days 365 to 729 = six-day dose supply once per week.
Evidence the treatment team and medical director determined that the therapeutic privilege doses are appropriate that after two years in treatment, a 13-day dose supply, consisting of take home doses and therapeutic doses may be allowed once every two weeks. *Treatment day 730/2 year mark = 13/day dose supply once every two weeks.
Exceptions — take-home meds
Evidence of a new determination made by the treatment team regarding take-home privileges due to positive drug screens at any time for any drug other than prescribed.

Evidence of take-home privileges being revoked due to the patient having a urine drug screen with any substances other than Methadone, Methadone Metabolites, or a medication for which the patient does not have a valid prescription.
Care coordination
Communication with the other health care providers as it relates to the member's OUD treatment in the member's treatment record.
Coordination with other health care systems shall occur, as needed, to achieve the treatment goals in the member's treatment record.
Member record
Recording of dispensing in accordance with federal and state requirements
Results of five most recent drug screen tests with action taken for positive results
Documentation of physical status and use of additional prescription medication
Contact notes and/or progress notes (monthly, or more frequently, as indicated by needs of client) must include employment/vocational needs.
Contact notes and/or progress notes (monthly, or more frequently, as indicated by needs of client) must include legal status.
Contact notes and/or progress notes (monthly, or more frequently, as indicated by needs of client) must include social status.
Contact notes and/or progress notes (monthly, or more frequently, as indicated by needs of client) must include overall individual stability.
Documentation and confirmation of the factors to be considered in determining whether a take-home dose is appropriate, if necessary.
Documentation of approval of any exception to the standard schedule of take-home doses.
Documentation of physician's justification for approval of any exception to the standard schedule of take-home doses.

Mobile Crisis Response (MCR) Specific Requirements
Preliminary Screening — determination of risk
There is evidence in the record that crisis services were not used as step-down services.
There is evidence in the record of a new or unforeseen documented crisis not otherwise addressed in the member's existing crisis plan.
There is evidence that the case records include preliminary screening.
There is evidence that the preliminary screening included the reason for presentation for services and/or the nature of the member's crisis.
There is evidence that the preliminary screening included the grave disability.
There is evidence that the preliminary screening included the risks of suicidality.
There is evidence that the preliminary screening included the risk of self-harm.
There is evidence that the preliminary screening included the risk of danger to others.
There is evidence that the brief preliminary person-centered screening of risk includes contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.
There is evidence that the brief preliminary mental status includes the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.
There is evidence that a brief preliminary medical stability screening was conducted which includes contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.

There is evidence that further evaluation for other mental health services include contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or coordination in with other alternative behavioral health services at an appropriate level.
When the member is referred from another crisis provider, there is evidence that the provider requested records from the previous crisis service providers.
Assessment
If further evaluation is needed, there is evidence that the assessment was conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service.
There is evidence, if a member is referred from another crisis provider and further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.
Documentation — involvement of family/natural supports
There is evidence that support, education, and/or consultation was provided to the member, family, and collateral supports.
If further evaluation is needed, there is evidence that the assessment included contact with the member, family members, or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level.
Interventions
There is evidence that the case records includes notes on the interventions delivered after every encounter.
There is evidence that the case records include documentatio,,,n of successful and/or failed encounters and/or attempts.
There is evidence that intervention strategies are built upon and/or updated by the MCR or BHCC service providers.
There is evidence that the interventions are driven by the member.
There is evidence that the intervention includes resolution-focused treatment designed to de-escalate the crisis.
There is evidence that the Interventions include resolution-focused peer support designed to de-escalate the crisis.

There is evidence that the interventions include rresolution-focused safety planning designed to de-escalate the crisis.
There is evidence that the interventions include resolution-focused service planning designed to de-escalate the crisis.
There is evidence that the interventions include resolution-focused care coordination designed to de-escalate the crisis.
There is evidence that the strategies are developed for the member to use post current crisis.
There is evidence that the strategies are developed to mitigate risk of future incidents until the member engages in alternative services.
There is evidence that the short-term goals were set to stabilization.
There is evidence that the short-term goals were set to ensure symptom reduction.
There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning.
There is evidence that the interventions include using person-centered approaches, such as resolution of the crisis and problem solving of the crisis.
Coordination and continuity of care
The member's treatment record must reflect relief, resolution, and problem solving of the identified crisis or referral to an alternate provider.
There is evidence that all levels of crisis providers coordinated the transfer to alternate levels of care within 24 hours when warranted.
There is evidence that providers coordinated the transfer to primary medical care when the member requires primary medical care with an existing provider.
There is evidence that providers coordinated the transfer to a community-based behavioral health provider when the member requires ongoing support at a lower level of care with the member's existing behavioral health provider.
There is evidence that providers coordinated the transfer to another crisis provider when the member requires ongoing support, if applicable.

There is evidence that providers coordinated the transfer to Inpatient treatment when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent, if applicable.
There is evidence that providers coordinated the transfer to residential substance use treatment when the member requires ongoing support and treatment outside of the home for a substance use disorder, if applicable.
There is evidence that there was coordinated contact through a warm handoff with the member's MCO to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated.
There is evidence that any member records were provided to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral.
Follow-up requirements
There is evidence that follow up with the member and/or authorized member's caretaker/family were completed within 24 to 72 hours either telephonically or face to face post crisis to ensure stability for those not accessing higher levels of care or another crisis service.
There is evidence that follow up with the member and/or authorized member's caretaker/family were continued beyond 15 days post discharge from MCR and/or BHCC provider to ensure stability for those not accessing higher levels of care or another crisis service.
There is evidence that the member and/or authorized member's caretaker/family desired no further communication post crisis within the record, if applicable.
There is evidence the discharge summary included communications with family.
There is evidence the discharge summary included communications with treating providers.

Community Brief	Comments general 65, LOC specific p
Met	
There is evidence in the record that crisis services were not used as step-own services.	
There is evidence in the record of a new or unforeseen documented crisis not otherwise addressed in the member's existing crisis plan.	
There is evidence that the case records include preliminary screening.	
There is evidence that the preliminary screening included the reason for presentation for services and/or the nature of the member's crisis.	
There is evidence that the preliminary screening included the grave disability.	
There is evidence that the preliminary screening included the risks of suicidality.	
There is evidence that the preliminary screening included the risk of self-harm.	
There is evidence that the preliminary screening included the risk of danger to others.	
There is evidence that the brief preliminary person-centered screening of risk includes contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.	
There is evidence that the brief preliminary mental status includes the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.	
There is evidence that a brief preliminary medical stability screening was conducted which includes contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.	

There is evidence that the further evaluation for other mental health services include contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or coordination in with other alternative behavioral health services at an appropriate level.	
When the member is referred from another crisis provider, there is evidence that the provider requested records from the previous crisis service providers.	
Assessment	
If further evaluation is needed, there is evidence that the assessment was conducted by an licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service.	
There is evidence, if a member is referred from another crisis provider and further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.	
Documentation — involvement of family/natural supports	
There is evidence that support, education, and/or consultation was provided to the member, family, and collateral supports.	combined 30-32
If further evaluation is needed, there is evidence that the assessment included contact with the member, family members, or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level.	
Interventions	
There is evidence that the case records include notes on the interventions delivered after every encounter.	
There is evidence that the case records include documentation of successful and/or failed encounters and/or attempts.	
There is evidence that the interventions are driven by the member.	
There is evidence that the intervention includes resolution-focused treatment designed to de-escalate the crisis.	
There is evidence that the interventions include resolution-focused peer support designed to de-escalate the crisis.	
There is evidence that the interventions include resolution-focused safety planning designed to de-escalate the crisis.	
There is evidence that the interventions include resolution-focused service planning designed to de-escalate the crisis.	

There is evidence that the interventions include resolution-focused care coordination designed to de-escalate the crisis.	
There is evidence that the strategies are developed for the member to use post current crisis.	
There is evidence that the strategies are developed to mitigate risk of future incidents until the member engages in alternative services.	
There is evidence that the short-term goals were set to stabilization.	
There is evidence that the short-term goals were set to ensure symptom reduction.	
There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning.	
There is evidence that the interventions include using person-centered approaches, such as resolution of the crisis and problem solving of the crisis.	
Coordination and continuity of care	
The member's treatment record must reflect relief, resolution, and problem solving of the identified crisis or referral to an alternate provider.	
There is evidence that all levels of crisis providers coordinated the transfer to alternate levels of ca,re within 24 hours when warranted.	
There is evidence that providers coordinated the transfer to primary medical care when the member requires primary medical care with an existing provider.	
There is evidence that providers coordinated the transfer to a community-based behavioral health provider when the member requires ongoing support at a lower level of care with the member's existing behavioral health provider.	
There is evidence that providers coordinated the transfer to another crisis provider when the member requires ongoing support, if applicable.	
There is evidence that providers coordinated the transfer to inpatient treatment when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent, if applicable.	
There is evidence that providers coordinated the transfer to residential substance use treatment when the member requires ongoing support and treatment outside of the home for a substance use disorder, if applicable.	
There is evidence that there was coordinated contact through a warm handoff with the member's MCO to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated.	

There is evidence that any member records were provided to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral.	
Follow-up requirements	
There is evidence that follow up with the member and/or the authorized member's caretaker/family were completed either telephonically or face to face within 24 hours to 15 days following the initial contact with the CBCS provider once discharged from the MCR and/or BHCC provider to ensure continued stability post crisis for those not accessing higher levels of care.	
There is evidence that follow up with the member and/or authorized member's caretaker/family were continued beyond 15 days post discharge from the MCR and/or BHCC provider to ensure stability for those not accessing higher levels of care or another crisis service.	
There is evidence that the member and/or authorized member's caretaker/family desired no further communication post crisis within the record, if applicable.	
There is evidence the discharge summary included communications with family.	
There is evidence the discharge summary included communications with treating providers.	

Behavioral Health Crisis Care (BHCC) specific requirements
Preliminary screening — determination of risk
There is evidence that the case records include preliminary screening
There is evidence that the preliminary screening included the reason for presentation for services and/or the nature of the member's crisis.
There is evidence that the preliminary screening included the grave disability.
There is evidence that the preliminary screening included the risks of suicidality.
There is evidence that the preliminary screening included the risk of self-harm.
There is evidence that the preliminary screening included the risk of danger to others.
There is evidence that the brief preliminary person-centered screening of risk includes contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.
There is evidence that the brief preliminary mental status includes the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.
There is evidence that a brief preliminary medical stability was conducted includes contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or in coordination with other alternative behavioral health services at an appropriate level.
There is evidence that the further evaluation for other mental health services include contact with the member, family members, or other collateral sources with pertinent information for the purpose of the screening and/or referral to and/or coordination in with other alternative behavioral health services at an appropriate level.
When the member is referred from another crisis provider, there is evidence that the provider requested records from the previous crisis service providers.
Medical screen
There is evidence a registered nurse or licensed practical nurse practicing within the scope of their license performed a medical screen to evaluate for medical stability.
Assessment

If further evaluation is needed, there is evidence that the assessment was conducted by an licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service.
If further evaluation is needed, there is evidence that the assessment included contact with the member, family members, or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level.
There is evidence, if a member is referred from another crisis provider and further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.
Documentation — involvment of family/natural supports
There is evidence that support, education, and/or consultation was provided to the member, family, and collateral supports.
Interventions
There is evidence that the case records include notes on the interventions delivered after every encounter.
There is evidence that the case records include documentation of successful and/or failed encounters and/or attempts.
There is evidence that intervention strategies are built upon and/or updated by the MCR or BHCC service providers.
There is evidence that the interventions are driven by the member.
There is evidence that the intervention includes resolution focused treatment designed to de-escalate the crisis.
There is evidence that the interventions include resolution-focused peer support designed to de-escalate the crisis.
There is evidence that the interventions include resolution-focused safety planning designed to de-escalate the crisis.
There is evidence that the interventions include resolution-focused service planning designed to de-escalate the crisis,
There is evidence that the interventions include resolution-focused care coordination designed to de-escalate the crisis.
There is evidence that the strategies are developed for the member to use post current crisis.
There is evidence that the strategies are developed to mitigate risk of future incidents until the member engages in alternative services.
There is evidence that the short-term goals were set to stabilization.
There is evidence that the short-term goals were set to ensure symptom reduction.
There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning

There is evidence that the interventions include using person-centered approache, such as resolution of the crisis and problem solving of the crisis.
Coordination and continuity of care
The member's treatment record must reflect relief, resolution, and problem solving of the identified crisis or referral to an alternate provider.
There is evidence that all levels of crisis providers coordinated the transfer to alternate levels of care within 24 hours when warranted.
There is evidence that providers coordinated the transfer to primary medical care when the member requires primary medical care with an existing provider.
There is evidence that providers coordinated the transfer to a community-based behavioral health provider when the member requires ongoing support at a lower level of care with the member's existing behavioral health provider.
There is evidence that providers coordinated the transfer to another crisis provider when the member requires ongoing support, if applicable.
There is evidence that providers coordinated the transfer to inpatient treatment when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent, if applicable.
There is evidence that providers coordinated the transfer to residential substance use treatment when the member requires ongoing support and treatment outside of the home for a substance use disorder, if applicable.
There is evidence that there was coordinated contact through a warm handoff with the member's MCO to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated.
There is evidence that any member records were provided to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral.
Follow-up requirements
There is evidence that follow up with the member and/or authorized member's caretaker/family were completed within 24 to 72 hours either telephonically or face to face post crisis to ensure stability for those not accessing higher levels of care or another crisis service.

There is evidence that telephonic follow up with the member and/or authorized member's caretaker/family were continued beyond 72 hours post crisis to ensure stability for those not accessing higher levels of care or another crisis service when applicable.
There is evidence that the member and/or authorized member's caretaker/family desired no further communication post crisis within the record, if applicable.
There is evidence the discharge summary included communications with the family.
There is evidence the discharge summary included communications with treating providers.

Crisis stabilization (CS) specific requirements
Assessment
There is evidence that a referral is completed by Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), Community Brief Crisis Support providers, or ACT Teams.
There is evidence that the member is in psychiatric crisis and in need of temporary 24 hours a day, seven days a week support to provide crisis relief, resolution, and intensive supportive resources.
There is evidence that the psychiatric diagnostic evaluation was completed.
There is evidence that if a psychiatric diagnostic evaluation was completed within 30 days **by previous provider**, an update to capture the member's current status must be added to the previous evaluation.
There is evidence that the psychiatric diagnostic evaluation of risk included a **mental status exam** conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service and practicing within the scope of their professional license.
There is evidence of initial assessment of CS needs, including crisis resolution and debriefing. (Youth CS section)
There is evidence of **ongoing assessment** of CS needs, including crisis resolution and debriefing. (Youth CS section)
Medical screen
There is evidence that the preliminary assessment of a youth's medical stability includes contact with the member, family members, or other collateral sources (for example, caregiver, school personnel) with pertinent information. (Youth CS section)
There is evidence a registered nurse or licensed practical nurse practicing within the scope of their license performed a **medical screen to evaluate for medical stability**.
There is evidence that the **psychiatric diagnosis evaluation of risk** included **medical stability** conducted by an LMHP or psychiatrist with experience regarding this specialized mental health service and practicing within the scope otheir professional license.

There is evidence that assessment is built upon what is learned by previous crisis response providers or the assertive community treatment (ACT) provider.
Involvement of family/natural supports
There is evidence of regular contact with family to prepare for the **youth**'s return and their ongoing needs as part of the family. (**Youth CS Section**)
There is evidence of follow up with the individual and the individual's caretaker and/or family members. (**Youth CS Section**)
There is evidence that the assessment included contact with the member, family members, or other collateral sources (for example, caregiver, school personnel) with pertinent information for the purpose of the evaluation and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level.
There is evidence that support was provided to the member, family, and/or collateral supports.
There is evidence that education was provided to the member, family, and/or collateral supports.
There is evidence that consultation was provided to the member, family, and/or collateral supports.
Interventions
There is evidence of documentation that supports the need for short-term and intensive supportive resources for the youth and their family **(Youth CS Section)**
There is evidence that the interventions are driven by the member.
There is evidence that interventions are developed by the LMHP, psychiatrist, or non-licensed staff in collaboration with the LMHP or the psychiatrist.
There is evidence the interventions are built on the strategies developed by the mobile crisis response (MCR), Behavioral Health Crisis Care (BHCC), and/or community brief support service (CBCS) service providers.
There is evidence that the short-term goals are developed to ensure stabilization.
There is evidence that the short-term goals were set to ensure symptom reduction.
There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning.

There is evidence that the interventions were developed with input from the member, family, and/or other collateral sources.
There is evidence that the interventions are developed for the member to use post crisis to mitigate risk of future incidents until the member engages in alternative services, if appropriate.
There is evidence that the brief interventions include using person-centered approaches.
There is evidence that substance use was recognized and addressed in an integrated fashion and assessing the need for engagement in care, if applicable.
Care coordination
There is evidence that providers coordinated the transfer to primary medical care within 24 hours.
There is evidence that providers coordinated the transfer to community-based behavioral health provider within 24 hours.
There is evidence that providers coordinated the transfer to Community Brief Crisis Support (CBCS) within 24 hours.
There is evidence that providers coordinated the transfer to CS within 24 hours.
There is evidence that providers coordinated the transfer to inpatient treatment within 24 hours.
There is evidence that providers coordinated the transfer to residential substance use treatment within 24 hours.
There is evidence that readiness for discharge is evaluated daily.
There is evidence that a warm handoff with the member's MCO to link member with no current behavorial health (BH) provider and/or primary medical care provider to outpatient services as indicated.
There is evidence of a warm handoff with member's existing or new BH provider.
There is evidence that member records were provided to the existing or new BH provider or to another crisis service to assist with continuing care upon referral.
There is evidence that there was member involvement throughout the planning of services.
There is evidence that there was member involvement throughout the delivery of services.

There is evidence of consultation with the physician and/or with other qualified providers to assist with youth's specific crisis. **(Youth CS Section)**
Follow-up
There is evidence that telephonic follow up to the member and/or authorized member's caretaker and/or family up to 72 hours to ensure continued stability post crisis for those not accessing CBCS or higher levels of care.
There is evidence of additional calls/visits to the member following the crisis unless the member indicates no further communication is desired as documented in the member's record.

Personal care agencies ASR
There is evidence of services provided on an individual level.
There is documentation that any changes in the member's behavior that impact the member's health and/or safety was reported to the **appropriate MCO**.
There is documentation that any changes in the member's behavior that impact the member's health and/or safety were reported to the **community case manager**, if applicable.
There is evidence of provider participation in team meetings, as requested by case manager, if applicable.
Provider responsibilities — discharge
If the provider proposes involuntary transfer, discharge of a member, and/or if a provider closes in accordance with licensing standards, there is evidence that the provider gave written notice to the **member, a family member, and/or the authorized representative**, if known, at least 30 calendar days prior to the transfer or the discharge.
If the provider proposes involuntary transfer, discharge of a member, and/or if a provider closes in accordance with licensing standards, there is evidence that the provider gave written notice to the **case manager**, if applicable, at least 30 calendar days prior to the transfer or the discharge
If the provider proposes involuntary transfer, discharge of a member, and/or if a provider closes in accordance with licensing standards, there is evidence that **written notice was made via certified mail**, return receipt requested.
If the provider proposes involuntary transfer, discharge of a member, and/or if a provider closes in accordance with licensing standards, there is **evidence that written notice was in a language and manner that the member understands.**
If the provider proposes involuntary transfer, discharge of a member, and/or if aprovider closes in accordance with licensing standards, there is evidence **that a copy of the written discharge/transfer notice was placed in the member's record.**
There is evidence that the written discharge/transfer notice includes documentation **of the reason for transfer or discharge**.
There is evidence that the written discharge/transfer notice includes documentation of **the effective date of transfer or discharge**.
There is evidence that the written discharge/transfer notice includes documentation of **the explanation of a member's right** to personal and/or third parties' representation at all stages of the transfer or discharge.
There is evidence that the written discharge/transfer notice includes documentation of the **contact information for the Advocacy Center**.
There is evidence that the written discharge/transfer notice includes documentation of the names of provider personnel available to assit the member and family in **decision making**.
There is evidence that the written discharge/transfer notice includes documentation of the names of provider personnel available to assit the member and family in **transfer arrangements**.
There is a copy of the written discharge/transfer notice in the member's record that includes **time** for the discharge planning conference.

There is a copy of the written discharge/transfer notice in the member's record that includes **place** for the discharge planning conference.
There is a copy of the written discharge/transfer notice in the member's record that includes **date** for the discharge planning conference.
There is a copy of the written discharge/transfer notice in the member's record that includes a statement regarding the member's appeal rights.
There is a copy of the written discharge/transfer notice in the member's record that includes the **name** of the director of the Division of Administrative Law.
There is a copy of the written discharge/transfer notice in the member's record that includes the **current address** of the Division of Administrative Law
There is a copy of the written discharge/transfer notice in the member's record that includes the **telephone** number of the Division of Administrative Law.
There is a copy of the written discharge/transfer notice in the member's record that includes a statement regarding the member's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.
There is evidence of transfer or discharge planning conference with the **member**.
There is evidence of transfer or discharge planning conference with family (if applicable).
There is evidence of transfer or discharge planning conference with the **case manager** (if applicable).
There is evidence of transfer or discharge planning conference with the **legal representative**, if applicable.
There is evidence of transfer or discharge planning conference with the **advocate**, if such is known.
There is evidence of developing discharge options that will provide reasonable assurance that the member will be transferred or discharge to a setting that can be expected to meet their needs.
There is evidence of preparing an updated service plan, as applicable.
There is evidence of preparing an updated written discharge summary that includes a summary of the **health** of the member.
There is evidence of preparing an updated written discharge summary that includes a summary of the **behavioral issues** of the member.
There is evidence of preparing an updated written discharge summary that includes a summary of the **social issues** of the member.
There is evidence of preparing an updated written discharge summary that includes a summary of the **nutritional status** of the member.
There is evidence of providing all services required prior to discharge that are contained in the final update of the service plan, as applicable.
There is evidence of providing all services required prior to discharge that are contained in the transfer or discharge plan.
Service plan
There is evidence of a service plan in the record.
There is evidence that the service plan was developled prior to delivery of services.

There is evidence that the service plan is updated at least every six months or more frequently based on changes to the member's needs or preferences.
There is evidence that the service plan was developed in collaboration with the member/member's family to include the **frequency** of each activity.
There is evidence that the service plan was developed in collaboration with the member/member's family to include the **duration** of each activity.
There is evidence that the service plan was developed in collaboration with the member/member's family based on the **member's goals**.
There is evidence that the service plan was developed in collaboration with the member/member's family based on **member preferences**.
There is evidence that the service plan was developed in collaboration with the member/member's family based on **assessed needs**.
There is evidence that the service plan was followed.
There is evidence that the personal care service (PCS) provider provided the plan to the member prior to service delivery.
There is evidence that the PCS provider provided the plan to the member when the plan is updated.
Service logs
There is evidence that service logs document the PCS provided and billed.
There is evidence that service logs document any variation from the approved service plan with reason for variation.
There is evidence that service logs document the member's name.
There is evidence that service logs document the name of the direct service worker who provided the service
There is evidence that service logs document assistance provided to the member.
There is evidence that service logs document the date of service.
There is evidence that service logs document the place of services.
There is evidence that service logs are completed daily, as tasks are provided (may not be completed prior to services).
There is evidence that service logs are signed by the direct service worker after the work has been completed at the end of the week.
There is evidence that service logs are dated by the direct service worker after the work has been completed at the end of the week
There is evidence that service logs are signed by the member or responsible representative after the work has been completed at the end of the week.
There is evidence that service logs are dated by the member or responsible representative after the work has been completed at the end of the week.
There is evidence that service logs are specific to only **one** member.
Back-up staffing
There is evidence of a back-up staffing plan in the event the assigned direct service worker is unable to provide support due to unplanned circumstances or emergencies that may arise during the direct service worker's shift.

There is evidence that available options for back-up coverage were discussed with the member or their authorized representative and complete the required staffing plan.
There is evidence that the back-up plan includes person or persons responsible for back up coverage (including names, relationships, and contact phone numbers).
There is evidence that the back-up plan includes a toll-free telephone number with 24-hour availability that allows the recipient to contact the provider if the worker fails to show up for work.
There is evidence that the back-up plan includes member signature.
There is evidence that the back-up plan includes provider signature.
There is evidence that the back-up plan includes date.
There is evidence that the direct care worker contacted the provider when not able to provide services.
There is evidence that the direct care worker contacted the family/member immediately when not able to provide services.
There is evidence that the back-up plan is current.
There is evidence that the back-up plan is being followed according to the plan.
Emergency evacuation plans
There is evidence of an individualized emergency plan in preparation for emergencies and disasters that may arise.
There is evidence of an individualized emergency plan responses to emergencies and disasters that may arise.
There is evidence of an individualized emergency plan that documents specific resources available through the provider, natural resources, and the community.
There is evidence that the emergency plan is assesd on an ongoing basis whether the emergency plan is current and being followed according to the plan.
There is evidence that the emergency plan is signed by the member.
There is evidence that the emergency plan is signed by authorized representative.
There is evidence that the emergency plan is signed by the provider.
There is evidence that the emergency plan is dated by the member.
There is evidence that the emergency plan is dated by the authorized representative .
There is evidence that the emergency plan is dated by the provider.
Limitations and exclusions
There is evidence that personal care service (PCS) does not include administration of medication.
There is evidence that PCS does not include insertion and sterile irrigation of catheters.
There is evidence that PCS does not include irrigation of any body cavities which require sterile procedures.
There is evidence that PCS does not include complex wound care.
There is evidence that PCS does not include skilled nursing services as defined in the State Nurse Practice Act.
There is evidence that services are provided in home- and/or community-based settings.

There is evidence that PCS are not billed during the time the member has been admitted to a hospital, nursing home, or residential facility. Services may be provided and billed on the day the member is admitted to the hospital and following the member's discharge.
There is evidence that PCS is not provided outside the state of Louisiana unless a temporary exception has been approved by the Medicaid managed care entity.

The following is a list of the *HIPAA* -compliant forms of video communication technology:
1. Apple FaceTime 2. Facebook Messenger video chat 3. Google Hangouts video 4. Zoom 5. Skype
6. Simple practice
The following is a list of Business Associate Agreements (BAAs) (I am not sure that this needs to be included):
1. Skype for business/Microsoft Teams 2. Updox 3. VSee 4. Zoom for Healthcare 5. Doxy.me [doxy.me] 6. Google G Suite Hangouts Meet 7. Cisco Webex Meetings/Webex Teams 8. Amazon Chime 9. Go To Meeting 10. Spruce Health Care Messenger
This information is found in Informational Bulletin 20-5 (Revised November 24, 2020)

Louisiana Department of Health
Informational Bulletin 20-6
Revised May 17, 2022
https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2020/IB20-6_rev_5.17.22

IB 20-6: LMHP Telemedicine/Telehealth IB 20-4: MHR Telemedicine/Telehealth IB 20-7: SUD Teler

rev_5.17.22.pdf

nedicine/Telehealth

The DEA uses drug scheduling as a rating system to determine which drugs have a higher potential for abuse. The agency also uses scheduling to determine the charges brought upon those in possession of drugs.

Schedule I Controlled Substances: These substances have no defined medicinal purposes, have a lack of accepted safety for use under medical supervision, and have the highest potential for abuse.

Schedule I drugs include:

Heroin
Hallucinogens
Marijuana (This drug is scheduled differently in some states but is still a Schedule I federally.)
Ecstasy

an accepted medical purpose in some circumstances. Most of these drugs have strict guidelines regarding their medicinal purposes.

Schedule II drugs include:

Cocaine (when used as an anesthetic)
Methamphetamine
Methadone
Morphine
Dilaudid
Demerol
Oxycodone
Hydrocodone
Fentanyl
Adderall
Ritalin
Dexedrine

Schedule III Controlled Substances: Drugs under this schedule are those with a moderate to low abuse potential (lower than Schedule I and II), a currently accepted medical use, and a low to moderate potential for physical or
Schedule III drugs can include:

Anabolic steroids
Testosterone
Codeine is one of the most commonly abused Schedule III drugs with addictive and intoxicating qualities.
Buprenorphine
Ketamine

Schedule IV Controlled Substances: These drugs are considered by the DEA to have an accepted medical use and a lower potential of abuse compared to Schedule III substances.

Schedule IV drugs include:

Xanax
Darvon/Darvocet
Valium
Ativan
Librium
Klonopin
Ambien
Sonata
Lunesta
Tramadol

Schedule V Controlled Substances: These substances have the lowest potential for abuse according to the DEA.
Schedule V Controlled Substances can include:

Prescriptions to control conditions like irritable bowel syndrome and fibromyalgia
Robitussin AC, a cough suppressant with very low amounts of codeine

List of Common Controlled Substances (Narcotics):

Actiq®
Dexedrine®
Levorphanol ProSom®
Adderall®
Dextroamphetamine Librium®
Resoxyn®
Alfenta®
Dextrostat®
Lorax®
Restoril®
Alfentanil Diazepam Lorazepam Ritalin®
Alprazolam Diazepam®
Lorcet®
Ritalina®
Alzapam®
Dilaudid®
Lortab®
Ritaline®
Ambien®
Dilaudid-HP®
Lunesta®
RMS®
Anexsia®
Dolacet®
Mepergan®
Rohypnol®

Anodynos-DHC®
Dolophine®
Meperidine Roxanol®
Astramorph®
Dover's Powder®
Metadate®
Roxanol-SR®
Ativan®
Duadyne DHC®
Methadone Roxicet®
Attenta®
Duocet®
Methamphetamine Roxicodone®
Azdone®
Duragesic®
Methylin®
Roxilox®
Benzedrine Duramorph®
Methylphenidate Roxiprin®
Beta-phenyl-isopropylamine E-Lor®
Methylphenidate Rubifen®
Buprenex®
Empirin® with Codeine Morphine Secobarbital Buprenorphine Endocet®
Morphine Sulfate®
Seconal®
Butorphanol Epimorph®
MS Contin®
Serax®
Carisoprodol Equasym®
MSIR®
Soma®
Chlorazepate Estazolam Noctec®
Stadol®
Chlordiazepoxide Fentanyl Norcet®
Statex®
Choral Hydrate Fentanyl®
Norco®
Sublimaze®
Clonazepam Ferndex®
Novosecobarb®
Temazepam Cocaine Fiorinal® with Codeine Opium Tranxene®
Cocaine®
Topical Solution Flunitrazepam Opium Tincture®
Triazolam Codeine Flurazepam Oralet®
Tylenol® with Codeine Codoxyn®
Focalin®
Oramorph SR®

Tylox®
Co-Gesic®
Genagesic®
Oxazepam Uniserts®
Concerta®
Halcion®
Oxycet®
Valium®
Dalmane®
Hydrocet®
Oxycodone Valrelease®
Damason-P®
Hydrocodone OxyContin®
Vicodin®
Darvocet-N®
Hydromorphone OxyFAST®
Vicoprofen®
Darvon®
Hydrostat IR®
OxyIR®
Wygesic®
Darvon-N®
Hy-Phen®
Percocet®
Xanax®
Daytrana®
Infumorph®
Percodan-Demi®
Zetran®
Demerol®
Klonopin®
Propacet®
Zydone®
Desoxyephedrine Levo-Dromoran®
Propoxyphene

Some of the common atypical antipsychotics include:

Risperidone
Olanzapine
Quetiapine
Ziprasidone
Aripiprazole
Paliperidone
Lurasidone