Medicaid Services Manual
Transmittal Letter

March 25, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 4100—Substance Use Disorder Treatment Services and Coverage

Background And Explanation

Revisions are being proposed to Medicaid Service Manual (MSM) Chapter 4100-Substance Use Disorder (SUD) Treatment Services and Coverage to require that a provider who wishes to enroll into more than group enrollment needs to have a distinct National Provider Identifier number (NPI) for each. Clarification is being provided for the service description of residential substance use treatment services 3.1, 3.5, and 3.7WM by adding language to clarify service hours, clarify that requirements to be reimbursed for the residential daily rate, and clarify that the program must comply with criteria set by the Division of Public and Behavioral Health (DPBH). Additional language was added to clarify that a psychiatric evaluation is to be completed when clinically indicated. Finally, language was added to clarify that the lead clinician is required to cosign all progress notes for structured non-clinical activities that are performed within a residential SUD treatment setting.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: These proposed changes affect all Medicaid-enrolled providers delivering SUD treatment. Those provider types (PT) include, but are not limited to: Physician, M.D., Osteopath, D.O., (PT 20), Advance Practice Registered Nurse, (PT 24), Nurse Midwife, Psychologist (PT 26), (PT 74), Physician's Assistant, (PT 77), Pharmacist (PT 91), Licensed Clinical Social Worker (PT 14, Specialty 305), Licensed Marriage and Family Therapist (PT 14, Specialty 306), Licensed Clinical Professional Counselor (PT 14, Specialty 307), Methadone Clinic, (PT 17, Specialty 171), Substance Use Agency Model (PT 17, Specialty 215), newly created PTs Certified Alcohol and Drug Counselor (PT 93, Specialty 701), Certified Alcohol and Drug Counselor Intern (PT 93, Specialty 703), Licensed Alcohol and Drug Counselor (PT 93, Specialty 702), Licensed Clinical Alcohol and Drug Counselor (PT 93, Specialty 709), Licensed Clinical Alcohol and Drug Counselor Intern (PT 93, Specialty 705), Peer Recovery Support Specialist (PT 93, Specialty 706), Behavioral Health Outpatient Treatment (PT 14, Specialty 300), and Behavioral Health Rehabilitative Treatment (PT 82, Specialty 300).

Financial Impact on Local Government: The financial impact of the proposed regulation on local government is unknown at this time.

These changes are effective March 26, 2025.

Material Transmitted		Material Superseded
MTL OL		MTL 17/24, 18/24
MSM Chapter 4100—Substance Use Disorder Treatment Services and Coverage		MSM Chapter 4100—Substance Use Disorder Treatment Services and Coverage

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4103(I)	**Coverage and Limitations**	Added language to require providers who wish to enroll in more than one specialty to obtain a distinct NPI for each specialty.
4106(C)(1)(a)(4)	**Utilization of American Society of Addiction Medicine (ASAM)**	Clarified requirements to be reimbursed the daily bundled rate.
4106(C)(1)(b)(5)		Clarified service description for ASAM level of care (LOC) for residential 3.5 services.
4106(C)(1)(c)(3)		Clarified requirements to be reimbursed the daily bundled rate.
4107(A)(5)(b)(4)	**Inpatient Alcohol/Substance Use Policy Withdrawal Management and Treatment Services**	Clarified that a psychiatric evaluation is required when clinically indicated.
4115(B)2	**Documentation Requirements**	Language was added to clarify that the lead clinician is required to cosign all progress notes for structured non-clinical activities that are performed within a residential SUD treatment setting.

4103 COVERAGE AND LIMITATIONS

A. DHCFP covers medically necessary and clinically appropriate services as defined in MSM Chapter 100 for Medicaid recipients who have been diagnosed with or at risk of a SUD(s). The substance use policy is under the rehabilitative authority of the State Plan for behavioral health services.

B. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, and be prescribed on an individualized treatment plan, to achieve maximum reduction of substance use and to restore the recipient to their optimal level of functioning.

C. DHCFP reimburses for interventions in a substance use treatment clinic medical delivery model provided by qualified Medicaid providers. Recipients are screened and assessed as meeting diagnostic criteria for SUD, substance use related disorder, substance-induced disorders, co-occurring disorders, and/or mental health disorders as defined in the current International Classification of Diseases (ICD).

D. DHCFP covers screenings that are validated, standardized, and evidence based.

E. DHCFP covers a comprehensive assessment, an individualized examination which establishes the presence or absence of mental health and SUD, determines the recipient's readiness for change, and identifies the strengths and barriers that may affect the recipient's treatment and recovery.

1. The comprehensive assessment process includes an extensive recipient history which should include current medical conditions, past medical history, labs and diagnostics, medication history, substance use history, legal history, family educational and social history, employment history, trauma history, developmental history, mental health history, a differential DSM 5TR diagnosis, an ASAM initial assessment, and risk assessment.

2. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

3. For adolescents, information for assessment and treatment planning may be obtained from a parent, guardian, or other important resources (such as a teacher or probation officer).

F. DHCFP covers drug screening and testing for outpatient mental health and ASAM Level 1 services as a part of treatment for substance use disorders.

For coverage, limitations, non-covered services, and prior authorization requirements for drug testing, please reference MSM Chapter 800 - Laboratory Services. Authorization for drug screening and testing shall be requested using prior authorization Form FA-6 for Outpatient Medical/Surgical Services. A separate prior authorization request for drug testing in PHP, IOP, or residential substance use treatment settings is not required.

G. For pharmaceutical coverage, limitations, and prior authorization requirements of Narcotic Withdrawal Therapy Agents (Opioid Dependent Drugs) refer to MSM Chapter 1200 – Prescribed Drugs.

H. DHCFP requires that agencies providing any type of substance use treatment be certified by the certification body through the Division of Public Behavioral Health (formerly known as Substance Abuse Prevention and Treatment Agency (SAPTA)).

I. DHCFP requires that if a substance use treatment provider group qualifies to enroll in more than one substance use treatment provider group specialty, the group must do so with unique National Provider Identification (NPI) numbers.

4106 UTILIZATION OF AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

DHCFP utilizes the ASAM multidimensional assessment, for individuals presenting with SUD(s) to determine appropriate placement into a level of care along the continuum of care for substance use treatment. Services must meet medical necessity and clinical appropriateness as defined in MSM Chapter 100 – Medicaid Program.

The components of ASAM outpatient and residential care include harm reduction interventions, counseling, and psychotherapy to address a beneficiary's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the achievement of treatment and recovery goals.

DHCFP will reimburse for services provided appropriate to the corresponding ASAM Level, as indicated below, of which the provider shall be certified by the certifying body through the Division of Public and Behavioral Health (DPBH) (formerly known as SAPTA) and enrolled with Medicaid:

A. ASAM LEVEL 1

A clinic model that meets the certification requirement NAC 458.103 for alcohol and substance use programs. The provider will perform medical, psychiatric, and psychological services, focused on harm reduction principles and recovery, which are available onsite or through consultation or referral. Outpatient services are provided and intended for recipients with mild SUD and those in early remission. Programming consists of less than nine structured clinical hours per week. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. Emergency services are available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu. All other services are individually billed. Long term remission monitoring is necessary within ASAM level 1.

1. 1.0 Outpatient Services

   a. Level 1 Covered Services:

      1. Medication management

      2. 24-hour crisis intervention services face-to-face or telephonically available seven days per week

      3. Mental Health/Substance Use Covered Screens

      4. Comprehensive assessment

5. Individual and group counseling

6. Individual, group, and family psychotherapy

7. Peer Support Services

b. Level 1 Prior Authorization:

1. Prior authorization is required for services after service limitations have been exceeded.

2. Post authorization is not required for intervention during a substance use crisis episode lasting 72 hours or less.

3. Individual, group, family psychotherapy, and counseling services can be utilized for up to 26 total sessions for children and adolescents and up to 18 total sessions for adults before prior authorization is required.

4. Peer Support Services can be utilized for up to 18 hours/72 units annually before prior authorization is required.

5. Provider needs to complete and submit the request for FA 11D for authorization to the QIO-like vendor.

6. Authorization is valid for up to 90 days.

B. ASAM LEVEL 2

Requires a comprehensive interdisciplinary program team approach of appropriately credentialed and supervised addiction treatment professionals, including physicians, acting within their scope of practice who assess and treat co-occurring substance-related disorders. Some staff are cross-trained to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and interactions with substance-related disorders.

1. 2.1 Intensive Outpatient Program (IOP)

a. IOP that consists of 9 to 19 hours per week for adults and a minimum of six hours per week for adolescents of structured clinical services provided at least three days per week.

b. Services should be clearly defined, scheduled, and clinically structured and provided to recipients diagnosed with SUD or co-occurring disorders when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment and recovery are focused on harm reduction, major lifestyle, attitudinal, and behavior issues which impair the individual's ability to cope with major life tasks without use of substances.

c. Services are provided in a certified, non-residential, non-hospital treatment setting typically during the day, before or after work or school, in the evening, and/or on the weekends to allow recipients to apply their skills in a "real world" environment.

d. Frequencies and intensity are appropriate to the objectives of the treatment plan.

e. Active affiliations with other levels of addiction care, ideally integrated, to help recipients access recovery support services.

f. Clinical services provided by formally affiliated external addiction treatment providers and programs (i.e., OTPs) may count toward the total hours of weekly clinical services if care and billing are coordinated and documented.

2. 2.5 Partial Hospitalization Program (PHP)

a. PHP programs provide at least 20 hours per week and five days a week of clinically structured high-intensity outpatient services for recipients with SUD or co-occurring disorders for adults and adolescents.

b. Service is specifically designed for the diagnosis and active treatment and recovery of a SUD when there is a reasonable expectation for improvement or when it is necessary to maintain the person's functional level and prevent relapse or inpatient hospitalization.

c. Services within the PHP are more clinically intense than IOP and, in addition to addressing major lifestyle, attitudinal, and behavior issues which impair the individual's ability to cope with major life tasks without the addictive use of alcohol and/or other drugs, have the capacity to treat individuals with substantial medical and co-occurring psychiatric problems.

d. For adolescents, information for assessment and treatment planning may be obtained from a parent, guardian, or other important resources (such as a teacher or probation officer) and should include:

1. An initial withdrawal assessment, including a medical evaluation at admission (or medical review of an evaluation performed withing 48 hours preceding admission, or within seven days preceding admission for a patient who is stepping down from a residential setting).

2. Ongoing withdrawal monitoring assessment performed several times a week.

3. Ongoing screening for medical and nursing needs, with medical and nursing evaluation available through consultation or referral.

e. For adolescents, partial hospital often occurs during school hours; such programs typically have access to educational services for their adolescent recipients. Programs that do not provide educational services should coordinate with a school system in order to assess and meet their adolescent recipients' educational needs. Educational services provided are designed to maintain the educational and intellectual development of the recipient and, when indicated, to provide opportunities to remedy deficits in the adolescent's education.

f. Support systems in PHPs for adolescents include:

1. Medical, psychological, psychiatric, laboratory, toxicology, educational, occupational, and other services needed by adolescents are available through consultation or referral. Medical and psychiatric consultation is available within eight hours by telephone and within 48 hours face-to-face (depending on the urgency of the situation) through on-site services, referral to off-site services, or transfer to another level of care.

2. Emergency services, which are available by telephone 24 hours a day, seven days a week when the program is not in session.

3. Direct affiliation with more and less intensive levels of care.

4. The adolescent’s formal and informal support systems.

3. ASAM Level 2 Covered services:

a. Medical and Psychiatric consultation

b. Psychopharmacological consultation

c. Medication management

d. 24-hour crisis intervention services face-to-face or telephonically available seven days per week

e. Comprehensive biopsychosocial assessment

f. Behavioral Health/Substance Use covered screens

g. Individual and group counseling

h. Individual, group, and family psychotherapy

i. Self-help/recovery groups

j. Drug testing

k. Psychosocial Rehabilitation

l. Basic Skills Training

m. Peer Support Services

4. ASAM Level 2.5 covered services:

All services in ASAM Level 2.1 and additionally access to psychiatric, medical and/or laboratory services.

5. ASAM Level 2 Prior Authorization:

a. All initial IOP and PHP services require prior authorization to establish medical necessity.

b. The intensity of the services will be driven by medical necessity.

c. Prior authorization is not required for services of substance use screening and 24-hour crisis intervention.

d. Post authorization is not required for 24-hour crisis intervention.

e. Provider needs to complete and submit request for FA 11D for authorization to the QIO-like vendor.

f. Authorization for 2.1 is valid for up to 90 days.

g. Authorization for 2.5 is valid for up to three weeks.

C. ASAM LEVEL 3

Residential SUD programs provide individuals in recovery from SUD and co-occurring disorders a safe and stable 24-hour live-in setting staffed by designated addiction treatment personnel who provide a planned and structured regimen of care in order to recover skills, utilizing harm reduction principles, where skill restoration and counseling services are provided on-site to the residents as a condition of tenancy. The type and intensity of services is determined by the recipient's need and must be clinically appropriate and medically necessary.

Residential SUD is a clinic model that meets the certification requirement NAC 458.103 for alcohol and substance use programs and is made up of two distinct components: clinical services and therapeutic milieu.

Medical, psychiatric, and psychological services are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation.

Room and board are not reimbursable services through DHCFP.

1. The following ASAM residential levels are covered by Nevada Medicaid:

a. 3.1 Clinically Managed Low-Intensity Residential Services:

1. Treatment services facilitate the application of recovery, relapse prevention and coping skills, and strategies. Services also promote prosocial skills, skills of daily living, personal responsibility, and reintegration of the recipient into network systems of work, education, and family life.

2. Services are focused on improving the recipient's functioning and coping skills to enable them to safely engage in treatment at a less intensive level of care and address readiness to change and other challenges that impact the recipient's ability to successfully engage in recovery.

3. Appropriate for individuals who require time and structure to further develop, practice, and integrate their recovery and coping skills in a clinically managed and supportive residential environment.

4. Provides 9 to 19 hours of clinical services per week with primary focus on the skills needed for safe reintegration in the community and address intrapersonal determinants such as self-efficacy, outcome expectancies, motivation, coping, emotional states, cravings, and social and personal supports. To be reimbursed for the daily bundled rate, daily activity must be provided that aligns with the individual's treatment plan goals and as certified by the certification body through the DPBH Agency (formerly known as SAPTA).

b. 3.5 Clinically Managed High Intensity Residential Services:

1. Treatment is delivered by a multidisciplinary treatment team under the oversight of a medical director.

2. Treatment is focused on harm reduction principles and stabilization of risky substance use and SUD related behaviors, initiation or restoration of a recovery process, and preparation for ongoing recovery with support at less intensive levels of care.

3. Designed to serve individuals who have specific limitations in the skills needed to avoid substance use in a manner that poses significant risk for serious harm or destabilizing loss in a less intensive level of care.

4. Requires clinical-led habilitative and rehabilitative services to develop and or demonstrate sufficient recovery skills to safely transition to a level of care that does not provide 24-hour supervision and a high-intensity therapeutic milieu.

5. Provides no less than ~~at least~~ 25 hours per week of structured activity~~clinical services~~ designed to support recovery from SUD and co-occurring conditions and includes daily activities that allows recipients to learn and practice prosocial behaviors, 10 of which must be group or individual counseling.~~that~~ To be reimbursed for the daily bundled rate, daily activity must be provided that aligns with the individual's treatment plan goals and as certified by the certification body through DPBH (formerly known as SAPTA).~~address low frustration tolerance, impulsivity, emotional dysregulation, interpersonal instability, and reliance of substances to cope with stressors, at least seven hours of structured activity per day, and a minimum of 10 hours of clinical counseling services must be provided each week for adults and adolescents.~~

6. Has capacity to provide social model withdrawal management.

c. 3.7WM Medically Monitored Inpatient Withdrawal Management:

1. Organized service delivered by medical professionals who provide 24-hour evaluation and management of intoxication, withdrawal, biomedical concerns, and common low complexity psychiatric concerns in a permanent residential facility.

2. Services are delivered under a defined set of physician-approved policies and physician-managed procedures and medical protocols.

3. Recipients at this level of care receive 24-hour observation, monitoring, and treatment; however, they do not require the full resources of an acute care hospital. To be reimbursed for the daily bundled rate, daily activity must be provided that aligns with the individual's treatment plan goals and as certified by the certification body through DPBH (formerly known as SAPTA).

2. ASAM Level 3 covered services:

a. 24-hour crisis intervention services face-to-face or telephonically available seven days per week

b. Medication management

c. Mental Health/Substance Use Covered Screens

d. Comprehensive biopsychosocial assessment

e. Individual and group counseling

f. Individual, group, and family psychotherapy

h. Peer Support Services

i. Psychosocial education groups

j. Drug testing and screening

3. ASAM Level 3 Prior Authorization:

4107 INPATIENT ALCOHOL/SUBSTANCE USE POLICY WITHDRAWAL MANAGEMENT AND TREATMENT SERVICES

Inpatient substance use services are those services delivered in freestanding substance use treatment hospitals or general hospitals with a specialized substance use treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance use professionals and a structured multidisciplinary clinical approach to treatment and recovery. These hospitals provide medical withdrawal management and treatment services for individuals suffering from acute alcohol and substance use conditions.

A. COVERAGE AND LIMITATIONS

1. Hospital inpatient days may be considered a Medicaid benefit when withdrawal management and treatment for acute alcohol and/or other substance use necessitates intervention through the constant availability of physicians and/or medical services found in the acute hospital setting.

2. Medicaid reimburses for admission to substance use units of general hospitals regardless of age.

3. Medicaid reimburses admission to freestanding psychiatric and substance use hospitals for recipients age 65 and older, or those 21 and under.

4. For recipients ages 21 to 64, "Nevada's Treatment of OUDs and SUDs Transformation Project" (1115 SUD Waiver) allows for reimbursement of residential substance use and withdrawal management services within an IMD setting through December 31, 2027.

5. Medicaid reimburses only for the following SUD withdrawal management and treatment:

   a. Withdrawal Management

      1. Medicaid reimburses for up to five hospital inpatient withdrawal management days with unlimited lifetime admission (Medicaid covers stays beyond five days only if additional withdrawal management services are deemed medically necessary by the QIO-like vendor).

      2. Results of a urine drug screen or blood alcohol test must be provided at the time of the initial request for authorization.

b. Treatment

1. Medicaid reimburses for up to 21 hospital inpatient treatment days with unlimited lifetime admissions as determined medically necessary by the physician (stays beyond 21 days are covered only if additional treatment services are deemed medically necessary by the QIO- like vendor).

2. Prior to inpatient admission, the referring or admitting physician must document a discussion for a plan of after care to include referrals to counseling, therapy, and peer support services within the substance use treatment continuum of care. Aftercare recommendations and the recipient's response must be documented and included as a part of the recipient's inpatient hospital record.

3. It is the hospital's responsibility to assist the recipient during hospitalization to ensure the above-mentioned post discharge resources will be utilized.

4. A psychiatric evaluation must be completed within 72 hours of any inpatient withdrawal management or treatment admission when clinically indicated.

6. Nevada Medicaid reimburses for SUD services to recipients diagnosed with an alcohol/SUD when admitted to a general hospital without a specialized alcohol/substance use unit only under one of the following conditions:

a. The admission is an emergency and is approved by the QIO-like vendor.

1. QIO-like vendor must be contacted for authorization purposes within five business days of the emergency admission; and

2. The hospital, as determined by the QIO-like vendor, makes all efforts to stabilize the recipient's condition and discharge the recipient to a substance use/psychiatric hospital or general hospital with a substance use/psychiatric unit as expeditiously as possible; or

3. The admission is approved by the QIO-like vendor for medical withdrawal management only.

b. All transfers from withdrawal management to treatment require prior authorization. This applies to all Medicaid recipients, regardless of age.

4115 DOCUMENTATION REQUIREMENTS

All programs require documentation in the recipient's medical record that consists of an individualized treatment plan, progress notes, a discharge plan, and a discharge summary. Documentation should clearly reflect implementation of the treatment plan and the recipient's response to the therapeutic interventions for all disorders being treated, as well as subsequent amendments to the plan and treatment plan reviews conducted at specified times as documented on the treatment plan. Providers will consider how to incorporate harm reduction strategies into the recipient's treatment and recovery and make recommendations to the prescribing provider. Refusal of services by recipient must be documented in progress notes.

A. TREATMENT PLAN

A written individualized plan, referred to as treatment plan, is a person centered, comprehensive treatment guide developed jointly with the recipient, their family (in the case of legal minors) and/or their legal representative and the licensed SUD professional within the scope of their practice under state law, and adds recipient-provider "shared decision making" considerations.

A Treatment Plan is rehabilitative and recovery oriented and addresses individualized goals and objectives. Goals are developed to reduce the duration and intensity of symptoms to the least intrusive service level possible while integrating care to address overall health. The Treatment Plan must consist of services designed to achieve goals to help restore the recipient to a functional level of independence. The services on a treatment plan must be medically necessary and clinically appropriate and must utilize evidence-based practices.

1. The treatment plan is based on a comprehensive assessment and includes:

   a. The strengths and needs of the recipient;

   b. Documentation supporting ASAM levels of care;

   c. Person centered goals and objectives that are specific, measurable, attainable, realistic, and time sensitive (SMART);

   d. Incorporates harm reduction principles;

   e. Continue service, transfer, and discharge criteria per ASAM; and

   f. Upon discharge, a continuing care plan.

2. The recipient, or their legal representative, and family or natural support systems in the event of minors, must be involved in development of the treatment plan, be

given a choice of providers, indicate an understanding of the need for services and the elements of the treatment plan. Recipient's, family's (when appropriate), and/or representative's participation in treatment planning must be documented on the treatment plan.

a. Temporary, but clinically necessary, services do not require an alteration of the treatment plan, however, must be identified in a progress note. The note must indicate the necessity, amount scope, duration, and provider of the service.

b. Required signatures for treatment plan:

1. Recipient and their family/legal guardian (in the case of legal minors); and

2. The individual responsible for developing the plan, and;

3. The clinical supervisor should cosign assessments and treatment plans completed by an intern as indicated by the appropriate licensing board.

3. All SUD services requested must ensure the goal of restoring a recipient's functional levels is consistent with the therapeutic design of the services to be provided under the Treatment Plan

4. All requested SUD services must ensure all involved health professionals incorporate a coherent and cohesive developed treatment plan that best serves the recipient's needs.

5. Services should be developed with a goal that promotes collaboration between other health providers of the recipient, community supports including, but not limited to, community resources, friends, family, or other supporters of the recipient and recipient identified stakeholders to ensure the recipient can receive care coordination and continuity of care.

6. The requested services are to be specific, measurable, and relevant in meeting the goals and objectives identified in the Treatment Plan. The SUD licensed professional responsible for treatment plan development must identify within the Treatment Plan the scope of services to be delivered and are not duplicative or redundant of other prescribed behavioral health services.

7. The treatment plan is required to include, but not be limited to the following information:

a. Recipient's full legal name;

b. Recipient's Medicaid/Nevada Check Up billing number;

c. Intensity of Needs determination;

d. Documentation of SUD, co-occurring disorder, or mental health diagnosis;

e. Date of determination for diagnosis;

f. The name and credentials of the provider who completed the determination.

B. PROGRESS NOTE

A progress note is the written documentation of treatment services provided to the recipient which describes the progress, or lack thereof, towards the goals and objectives on the written treatment plan.

1. All progress notes documented with the intent of submitting a billable Medicaid SUD claim must be documented as the following:

a. In a manner that is sufficient to support the claim and billing of the services provided and;

b. Must include the amount, scope, and duration of the service(s) provided as well as identify the provider of the service(s) and;

c. Is required for each day the service was delivered, and;

d. Must be legible and must include the following information:

1. The name of the individual receiving the service(s).

2. If the services are in a group setting, it must be indicated;

3. The place of service;

4. The date the service was delivered;

5. The actual beginning and ending times the service was delivered;

6. The name of the provider who delivered the service;

7. The credentials of the person who delivered the service;

8. The signature of the provider who delivered the service;

9. The goals and objectives that were discussed and provided during the time the services were provided; and

10. A statement assessing the recipient's progress, or not, towards attaining the identified treatment and recovery goals and objectives.

2. On a monthly basis, the lead clinician is required to review a sample of progress notes for all structured activities, as required by the certifying body (formerly known as SAPTA) through DPBH. If deficiencies are discovered in the services provided or the documentation of those services, corrective education must be provided to staff and documented in the employee file.

C. DISCHARGE PLAN

The discharge plan must be included in the treatment plan and identifies:

1. The planned duration of the overall services to be provided under the Treatment Plan;

2. Discharge Criteria, including ASAM discharge criteria as clinically appropriate;

3. Recommended aftercare services for goals that were both achieved and not achieved during duration of the Treatment Plan;

4. Identify available agency(ies) and independent provider(s) to provide aftercare services (i.e. community-based services, community organizations, nonprofit agencies, county organization(s) and other institutions) and the purpose of each for the recipient's identified needs under the Treatment Plan to ensure the recipient has access to supportive aftercare.

D. DISCHARGE SUMMARY

A discharge summary is written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement describing the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives as documented in the treatment plan. The discharge summary documentation must include the reason for discharge, current intensity of needs level and recommendations for further treatment. ASAM discharge criteria is met unless the recipient left prior to treatment being completed.

1. Discharge summaries are to be completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.