Administering Agency: Nevada County Behavioral Health Department, Health and Human Services Agency

Contract No. _____

Contract Description: Provision of Drug Medi-Cal (DMC) outpatient Narcotic Treatment Program (NTP) for referred clients of the Nevada County Behavioral Health Department.

PROFESSIONAL SERVICES CONTRACT
FOR HEALTH AND HUMAN SERVICES AGENCY

THIS PROFESSIONAL SERVICES CONTRACT ("Contract") is made at Nevada City, California, as of August 8, 2023 by and between the County of Nevada, ("County"), and Aegis Treatment Centers, LLC. ("Contractor") (together "Parties", individual "Party"), who agree as follows:

1. **Services** Subject to the terms and conditions set forth in this Contract, Contractor shall provide the services described in Exhibit A. Contractor shall provide said services at the time, place, and in the manner specified in Exhibit A.

2. **Payment** County shall pay Contractor for services rendered pursuant to this Contract at the time and in the amount set forth in Exhibit B. The payments specified in Exhibit B shall be the only payment made to Contractor for services rendered pursuant to this Contract. Contractor shall submit all billings for said services to County in the manner specified in Exhibit B; or, if no manner be specified in Exhibit B, then according to the usual and customary procedures which Contractor uses for billing clients similar to County. **The amount of the contract shall not exceed Eight Hundred Six Thousand Dollars ($806,000).**

3. **Term** This Contract shall commence on July 1, 2023 All services required to be provided by this Contract shall be completed and ready for acceptance no later than the **Contract Termination Date** of: June 30, 2024.

4. **Facilities, Equipment and Other Materials** Contractor shall, at its sole cost and expense, furnish all facilities, equipment, and other materials which may be required for furnishing services pursuant to this Contract.

5. **Exhibits** All exhibits referred to herein and attached hereto are incorporated herein by this reference.

6. **Electronic Signatures** The Parties acknowledge and agree that this Contract may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature. Without limitation, "electronic signature" shall include faxed or emailed versions of an original signature or electronically scanned and transmitted versions (e.g., via pdf) of an original signature.

7. **Time for Performance** Time is of the essence. Failure of Contractor to perform any services within the time limits set forth in Exhibit A or elsewhere in this Contract shall constitute material breach of this contract. Contractor shall devote such time to the performance of services pursuant to this Contract as may be reasonably necessary for the satisfactory performance of Contractor's obligations pursuant to this Contract. Neither Party shall be considered in default of this Contract to the extent performance is prevented or delayed by any cause, present or future, which is beyond the reasonable control of the Party.

8. **Liquidated Damages**
Liquidated Damages are presented as an estimate of an intangible loss to the County. It is a provision that allows for the payment of a specified sum should Contractor be in breach of contract. Liquidated

Damages ☐**shall apply** ☒**shall not apply** to this contract. Liquidated Damages applicable to this contract are incorporated in Exhibit F, attached hereto.

9. **Relationship of Parties**

9.1. **Independent Contractor**
In providing services herein, Contractor, and the agents and employees thereof, shall work in an independent capacity and as an independent contractor and not as agents or employees of County. Contractor acknowledges that it customarily engages independently in the trade, occupation, or business as that involved in the work required herein. Further the Parties agree that Contractor shall perform the work required herein free from the control and direction of County, and that the nature of the work is outside the usual course of County's business. In performing the work required herein, Contractor shall not be entitled to any employment benefits, Workers' Compensation, or other programs afforded to County employees. Contractor shall hold County harmless and indemnify County against such claim by its agents or employees. County makes no representation as to the effect of this independent contractor relationship on Contractor's previously earned California Public Employees Retirement System ("CalPERS") retirement benefits, if any, and Contractor specifically assumes the responsibility for making such determination. Contractor shall be responsible for all reports and obligations including but not limited to: social security taxes, income tax withholding, unemployment insurance, disability insurance, workers' compensation and other applicable federal and state taxes.

9.2. **No Agent Authority** Contractor shall have no power to incur any debt, obligation, or liability on behalf of County or otherwise to act on behalf of County as an agent. Neither County nor any of its agents shall have control over the conduct of Contractor or any of Contractor's employees, except as set forth in this Contract. Contractor shall not represent that it is, or that any of its agents or employees are, in any manner employees of County.

9.3. **Indemnification of CalPERS Determination** In the event that Contractor or any employee, agent, or subcontractor of Contractor providing service under this Contract is determined by a court of competent jurisdiction or CalPERS to be eligible for enrollment in CalPERS as an employee of County, Contractor shall indemnify, defend and hold harmless County for all payments on behalf of Contractor or its employees, agents, or subcontractors, as well as for the payment of any penalties and interest on such contributions, which would otherwise be the responsibility of County.

10. **Assignment and Subcontracting** Except as specifically provided herein, the rights, responsibilities, duties and services to be performed under this Contract are personal to Contractor and may not be transferred, subcontracted, or assigned without the prior written consent of County. Contractor shall not substitute or replace any personnel for those specifically named herein or in its proposal without the prior written consent of County.

Contractor shall cause and require each transferee, subcontractor, and assignee to comply with the insurance provisions set forth herein, to the extent such insurance provisions are required of Contractor under this Contract. Failure of Contractor to so cause and require such compliance by each transferee, subcontractor, and assignee shall constitute a material breach of this Contract, and, in addition to any other remedy available at law or otherwise, shall serve as a basis upon which County may elect to suspend payments hereunder, or terminate this Contract, or both.

11. **Licenses, Permits, Etc.** Contractor represents and warrants to County that Contractor shall, at its sole cost and expense, obtain or keep in effect at all times during the term of this Contract, any licenses, permits, and approvals which are legally required for Contractor to practice its profession at the time the services are performed.

12. **Hold Harmless and Indemnification Contract** To the fullest extent permitted by law, each Party (the "Indemnifying Party") hereby agrees to protect, defend, indemnify, and hold the other Party (the "Indemnified Party"), its officers, agents, employees, and volunteers, free and harmless from any and all losses, claims, liens, demands, and causes of action of every kind and character resulting from the Indemnifying Party's negligent act, willful misconduct, or error or omission, including, but not limited to, the amounts of judgments, penalties, interest, court costs, legal fees, and all other expenses incurred by the Indemnified Party arising in favor of any party, including claims, liens, debts, personal injuries, death, or damages to property (including employees or property of the Indemnified Party) and without limitation, all other claims or demands of every character occurring or in any way incident to, in connection with or arising directly or indirectly out of, the Contract. The Indemnifying Party agrees to investigate, handle, respond to, provide defense for, and defend any such claims, demand, or suit at the sole expense of the Indemnifying Party, using legal counsel approved in writing by Indemnified Party. Indemnifying Party also agrees to bear all other costs and expenses related thereto, even if the claim or claims alleged are groundless, false, or fraudulent. This provision is not intended to create any cause of action in favor of any third party against either Party or to enlarge in any way either Party's liability but is intended solely to provide for indemnification of the Indemnified Party from liability for damages, or injuries to third persons or property, arising from or in connection with Indemnifying Party's performance pursuant to this Contract. This obligation is independent of, and shall not in any way be limited by, the minimum insurance obligations contained in this Contract.

13. **Certificate of Good Standing** Contractors who are registered corporations, including those corporations that are registered non-profits, shall possess a Certificate of Good Standing also known as Certificate of Existence or Certificate of Authorization from the California Secretary of State, and shall keep its status in good standing and effect during the term of this Contract.

14. **Standard of Performance** Contractor shall perform all services required pursuant to this Contract in the manner and according to the standards observed by a competent practitioner of the profession in which Contractor is engaged in the geographical area in which Contractor practices its profession. All products of whatsoever nature which Contractor delivers to County pursuant to this Contract shall be prepared in a substantial first class and workmanlike manner and conform to the standards or quality normally observed by a person practicing in Contractor's profession.

15. **Contractor without additional compensation** Contractor's personnel, when on County's premises and when accessing County's network remotely, shall comply with County's regulations regarding security, remote access, safety and professional conduct, including but not limited to Nevada County Security Policy NCSP-102 Nevada County External User Policy and Account Application regarding data and access security. Contractor personnel will solely utilize County's privileged access management platform for all remote access support functions, unless other methods are granted in writing by County's Chief Information Officer or their designee.

16. **Prevailing Wage and Apprentices** To the extent made applicable by law, performance of this Contract shall be in conformity with the provisions of California Labor Code, Division 2, Part 7, Chapter 1, commencing with section 1720 relating to prevailing wages which must be paid to workers employed on a public work as defined in Labor Code section 1720, et seq., and shall be in conformity with Title 8 of the California Code of Regulations section 200 et seq., relating to apprenticeship. Where applicable:
    - Contractor shall comply with the provisions thereof at the commencement of Services to be provided herein, and thereafter during the term of this Contract. A breach of the requirements of this section shall be deemed a material breach of this contract. Applicable prevailing wage determinations are available on the California Department of Industrial Relations website at http://www.dir.ca.gov/OPRL/PWD.
    - Contractor and all subcontractors must comply with the requirements of Labor Code section 1771.1(a) pertaining to registration of contractors pursuant to section 1725.5. Registration and all related requirements of those sections must be maintained throughout the performance of the Contract.

- Contracts to which prevailing wage requirements apply are subject to compliance monitoring and enforcement by the Department of Industrial Relations. Each Contractor and each subcontractor must furnish certified payroll records to the Labor Commissioner at least monthly.
- The County is required to provide notice to the Department of Industrial Relations of any public work contract subject to prevailing wages within five (5) days of award.

17. **Accessibility** It is the policy of County that all County services, programs, meetings, activities and facilities shall be accessible to all persons, and shall be comply with the provisions of the Americans With Disabilities Act and Title 24, California Code of Regulations. To the extent this Contract shall call for Contractor to provide County contracted services directly to the public, Contractor shall certify that said direct services are and shall be accessible to all persons.

18. **Nondiscriminatory Employment** Contractor shall not discriminate in its employment practices because of race, religious creed, color, national origin, ancestry, physical handicap, medical condition, marital status, sex or sexual orientation, or any other legally protected category, in contravention of the California Fair Employment and Housing Act, Government Code section 12900 et seq.

19. **Drug-Free Workplace** Senate Bill 1120, (Chapter 1170, Statutes of 1990), requires recipients of State grants to maintain a "drug-free workplace". Every person or organization awarded a contract for the procurement of any property or services shall certify as required under Government Code Section 8355-8357 that it will provide a drug-free workplace.

20. **Political Activities** Contractor shall in no instance expend funds or use resources derived from this Contract on any political activities.

21. **Financial, Statistical and Contract-Related Records:**

21.1. **Books and Records** Contractor shall maintain statistical records and submit reports as required by County. Contractor shall also maintain accounting and administrative books and records, program procedures and documentation relating to licensure and accreditation as they pertain to this Contract. All such financial, statistical and contract-related records shall be retained for five (5) years or until program review findings and/or audit findings are resolved, whichever is later. Such records shall include but not be limited to bids and all supporting documents, original entry books, canceled checks, receipts, invoices, payroll records, including subsistence, travel and field expenses, together with a general ledger itemizing all debits and credits.

21.2. **Inspection** Upon reasonable advance notice and during normal business hours or at such other times as may be agreed upon, Contractor shall make all of its books and records, including general business records, available for inspection, examination or copying, to County, or to the State Department of Health Care Services, the Federal Department of Health and Human Services, the Controller General of the United States and to all other authorized federal and state agencies, or their duly authorized representatives.

21.3. **Audit** Contractor shall permit the aforesaid agencies or their duly authorized representatives to audit all books, accounts or records relating to this Contract, and all books, accounts or records of any business entities controlled by Contractor who participated in this Contract in any way. All such records shall be available for inspection by auditors designated by County or State, at reasonable times during normal business hours. Any audit may be conducted on Contractor's premises or, at County's option, Contractor shall provide all books and records within fifteen (15) days upon delivery of written notice from County. Contractor shall promptly refund any moneys erroneously charged and shall be liable for the costs of audit if the audit establishes an over-charge of five percent (5%) or more of the correct amount owed during the audit period.

22. **Cost Disclosure:** In accordance with Government Code Section 7550, should a written report be prepared under or required by the provisions of this Contract, Contractor agrees to state in a separate section of said

report the numbers and dollar amounts of all contracts and subcontracts relating to the preparation of said report.

23. **Termination**.

A. A material breach , as defined pursuant to the terms of this Contract or otherwise, in addition to any other remedy available at law or otherwise, shall serve as a basis upon which County may elect to immediately suspend payments hereunder, or terminate this Contract, or both, without notice.

B. If Contractor fails to timely provide in any manner the services materials and products required under this Contract, or otherwise fails to promptly comply with the terms of this Contract, or violates any ordinance, regulation or other law which applies to its performance herein, County may terminate this Contract by giving **five (5) calendar days written notice to Contractor.**

C. Either Party may terminate this Contract for any reason, or without cause, by giving **thirty (30) calendar days written notice** to the other, which notice shall be sent by registered mail in conformity with the notice provisions, below. In the event of termination not the fault of Contractor, Contractor shall be paid for services performed to the date of termination in accordance with the terms of this Contract. Contractor shall be excused for failure to perform services herein if such performance is prevented by acts of God, strikes, labor disputes or other forces over which Contractor has no control.

D. County, upon giving **thirty (30) calendar days written notice** to Contractor, shall have the right to terminate its obligations under this Contract at the end of any fiscal year if County or the State of California, as the case may be, does not appropriate funds sufficient to discharge County's obligations coming due under this contract.

E. Any notice to be provided under this section may be given by the Agency Director.

F. Suspension: County, upon giving seven (7) calendar days written notice to Contractor, shall have the right to suspend this Contract, in whole or in part, for any time period as County deems necessary due to delays in Federal, State or County appropriation of funds, lack of demand for services to be provided under this contract, or other good cause. Upon receipt of a notice of suspension from County, Contractor shall immediately suspend or stop work as directed by County and shall not resume work until and unless County gives Contractor a written notice to resume work. In the event of a suspension not the fault of the Contractor, Contractor shall be paid for services performed to the date of the notice of suspension in accordance with the terms of this Contract.

In the event this Contract is terminated:

1) Contractor shall deliver copies of all writings prepared by it pursuant to this Contract. The term "writings" shall be construed to mean and include handwriting, typewriting, printing, Photostatting, photographing, and every other means of recording upon any tangible thing any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof.
2) County shall have full ownership and control of all such writings delivered by Contractor pursuant to this Contract.
3) County shall pay Contractor the reasonable value of services rendered by Contractor to the date of termination pursuant to this Contract not to exceed the amount documented by Contractor and approved by County as work accomplished to date; provided, however, that in no event shall any payment hereunder exceed the amount of the Contract specified in Exhibit B, and further provided, however, County shall not in any manner be liable for lost profits which might have been made by Contractor had Contractor completed the services required by this Contract. In this regard, Contractor shall furnish to County such financial information as in the judgment of County is necessary to determine the reasonable value of the services rendered by Contractor. The foregoing is cumulative and does not affect any right or remedy, which County may have in law or equity.

24. **Intellectual Property** Contractor will not publish or transfer any materials produced or resulting from activities supported by this Contract without the express written consent of County. All reports, original drawings, graphics, plans, studies and other data and documents, in whatever form or format, assembled

or prepared by Contactor or Contractor's subcontractors, consultants, and other agents in connection with this Contract are "works made for hire" (as defined in the Copyright Act, 17 U.S.C. Section 101 et seq., as amended) for County, and Contractor unconditionally and irrevocably transfers and assigns to County all right, title, and interest, including all copyrights and other intellectual property rights, in or to the 'works made for hire." Unless required by law, Contractor shall not publish, transfer, discuss, or disclose any of the above-described works made for hire or any information gathered, discovered, or generated in any way through this Contract, without County's prior express written consent. To the extent County provides any of its own original photographs, diagrams, plans, documents, information, reports, computer code and all recordable media together with all copyright interests thereto, to Contractor during this Contract, such information shall remain the property of County, and upon fifteen (15) days demand therefor, shall be promptly delivered to County without exception.

25. **Waiver** One or more waivers by one Party of any major or minor breach or default of any provision, term, condition, or covenant of this Contract shall not operate as a waiver of any subsequent breach or default by the other Party.

26. **Conflict of Interest** Contractor certifies that no official or employee of County, nor any business entity in which an official of County has an interest, has been employed or retained to solicit or aid in the procuring of this Contract. In addition, Contractor agrees that no such person will be employed in the performance of this Contract unless first agreed to in writing by County. This includes prior Nevada County employment in accordance with County's Personnel Code

27. **Entirety of Contract** This Contract contains the entire Contract of County and Contractor with respect to the subject matter hereof, and no other contract, statement, or promise made by any Party, or to any employee, officer or agent of any Party, which is not contained in this Contract, shall be binding or valid.

28. **Alteration** No waiver, alteration, modification, or termination of this Contract shall be valid unless made in writing and signed by all Parties, except as expressly provided in Section 23, Termination.

29. **Governing Law and Venue** This Contract is executed and intended to be performed in the State of California, and the laws of that State shall govern its interpretation and effect. The venue for any legal proceedings regarding this Contract shall be the County of Nevada, State of California. Each Party waives any federal court removal and/or original jurisdiction rights it may have.

30. **Compliance with Applicable Laws** Contractor and any subcontractors shall comply with any and all federal, state and local laws, codes, ordinances, rules and regulations which relate to, concern of affect the services or type of services to be provided by this Contract.

31. **Confidentiality** Contractor, its employees, agents and or subcontractors may come in contact with documents that contain information regarding matters that must be kept confidential by County, including personally identifiable patient or client information. Even information that might not be considered confidential for the usual reasons of protecting non-public records should be considered by Contractor to be confidential.

    Contractor agrees to maintain confidentiality of information and records as required by applicable federal, state, and local laws, regulations and rules and recognized standards of professional practice.

    Notwithstanding any other provision of this Contract, Contractor agrees to protect the confidentiality of any confidential information with which Contractor may come into contact in the process of performing its contracted services. This information includes but is not limited to all written, oral, visual and printed patient or client information, including but not limited to: names, addresses, social security numbers, date of birth, driver's license number, case numbers, services provided, social and economic conditions or circumstances, agency evaluation of personal information, and medical data.

Contractor shall not retain, copy, use, or disclose this information in any manner for any purpose that is not specifically permitted by this Contract. Violation of the confidentiality of patient or client information may, at the option of County, be considered a material breach of this Contract.

32. **Additional Contractor Responsibilities**

A. To the extent Contractor is a mandated reporter of suspected child and/or dependent adult abuse and neglect, it shall ensure that its employees, agents, volunteers, subcontractors, and independent contractors are made aware of, understand, and comply with all reporting requirements. Contractor shall immediately notify County of any incident or condition resulting in injury, harm, or risk of harm to any child or dependent adult served under this Contract.

B. Contractor will immediately notify County of any active complaints, lawsuits, licensing or regulatory investigations, reports of fraud or malfeasance, or criminal investigations regarding its operations. Contractor agrees to work cooperatively with County in response to any investigation commenced by County with regard to this Contract or the clients served herein, including providing any/all records requested by County related thereto.

C. Contractor shall employ reasonable background check procedures on all employees, prospective employees, volunteers and consultants performing work involving direct contact with minor children or dependent adults under this Contract, including fingerprinting and criminal records checks, sexual offender registry checks, and reference checks, including both personal and professional references.

33. **Notification** Any notice or demand desired or required to be given hereunder shall be in writing and deemed given when personally delivered or deposited in the mail, postage prepaid, and addressed to the Parties as follows:

COUNTY OF NEVADA:		**CONTRACTOR:**	
Nevada County Behavioral Health Department		Aegis Treatment Centers, LLC.	
Address:	950 Maidu Ave	Address	1317 Route 73 North, Suite 200
City, St, Zip	Nevada City, CA 95959	City, St, Zip	Mount Laurel, NJ 08054
Attn:	Kelly Miner-Gann	Attn:	Contracting
Email:	kelly.miner-gann@nevadacountyca.gov	Email:	contracting@pinnacletreatment.com
Phone:	(530) 470-2522	Phone:	484-888-8867

Any notice so delivered personally shall be deemed to be received on the date of delivery, and any notice mailed shall be deemed to be received five (5) days after the date on which it was mailed.

Authority: All individuals executing this Contract on behalf of Contractor represent and warrant that they are authorized to execute and deliver this Contract on behalf of Contractor.

IN WITNESS WHEREOF, the Parties have executed this Contract to begin on the Effective Date.

COUNTY OF NEVADA:

By: _____ Date: _____

Printed Name/Title: Honorable Edward Scofield, Chair, of the Board of Supervisors

By: _____
Attest: Julie Patterson Hunter, Clerk of the Board of Supervisors

CONTRACTOR: Aegis Treatment Centers, LLC.

By: _____ Date: _____

Name: _____

* Title: _____

If Contractor is a corporation, this Contract must be signed by two corporate officers; one of which must be the secretary of the corporation, and the other may be either the President or Vice President, unless an authenticated corporate resolution is attached delegating authority to a single officer to bind the corporation (California Corporations Code Sec. 313).

Exhibits

Exhibit A: Schedule of Services
Exhibit B: Schedule of Charges and Payments
Exhibit C: Insurance Requirements
Exhibit D: Behavioral Health Provisions
Exhibit E: Schedule of HIPAA Provisions
Summary Page

EXHIBIT "A"
SCHEDULE OF SERVICES
AEGIS TREATMENT CENTERS, LLC.

Aegis Treatment Centers, LLC., hereinafter referred to as "Contractor", shall provide Drug Medi-Cal (DMC) outpatient Narcotic Treatment Program (NTP) for referred clients of the Nevada County Behavioral Health Department, hereinafter referred to as "County". Opioid (Narcotic) Treatment Program (ASAM OTP Level 1) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed provider and approved and authorized according to the State of California requirements. NTPs/OTPs are required to offer methadone, buprenorphine, naloxone, and disulfiram.

Medi-Cal beneficiaries whose county of responsibility is Nevada County are able to receive covered and clinically appropriate DMC ODS services consistent with the following assessment, access, and level of care determination criteria.

Narcotic Treatment Program (This section supersedes MHSUDS IN 16-048)

1. Narcotic Treatment Program (NTP), also described in the ASAM Criteria© as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).
2. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary including:
    a. Methadone
    b. Buprenorphine (transmucosal and long-acting injectable)
    c. Naltrexone (oral and long-acting injectable)
    d. Disulfiram
    e. Naloxone
    f. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication.
    g. Service components:
        i. Intake: The history and physical exam conducted by the LPHA at admission qualifies as the medical necessity determination for NTP/OTP program services pursuant to state and federal regulations
        ii. Initial Assessment
        iii. Care Coordination
        iv. Counseling (individual and group)

a. The NTP shall offer the beneficiary a minimum of fifty (50) minutes of counseling services per calendar month
b. Counseling services may be provided in-person, by telehealth, or by telephone

v. Family Therapy (referral to family therapy if indicated)
vi. Medical Psychotherapy
vii. Medication Services
viii. MAT for OUD
ix. MAT for AUD and other non-opioid SUDs
x. Patient Education
xi. Recovery Services
xii. SUD Crisis Intervention Services
xiii. Medical evaluation for methadone treatment
a. Medical history
b. Laboratory tests
c. Physical exam
d. Medical evaluation must be conducted in-person

DEFINITIONS

Adolescent: Refers to beneficiaries under age 21.

Assessment: Consists of activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards.[1] Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the "Other laboratory and X-ray services" benefit of the California Medicaid State Plan).

Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level. **Family**

Therapy: A rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their

[1] As described above, NTPs conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies the purpose of determining medical necessity under the DMC-ODS

loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

Group Counseling: Consists of contacts with multiple beneficiaries at the same time. Group Counseling focuses on the needs of the participants. Group counseling shall be provided to a group that includes 2-12 individuals.

Individual Counseling: Consists of contacts with a beneficiary. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

Medical Psychotherapy: A counseling service to treat SUDs other than OUD conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.

Medication Services: Includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other Non-Opioid Substance Use Disorders. Medication Services includes prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or WM not included in the definitions of MAT for OUD or MAT for AUD services.

Medications for Addiction Treatment (also known as Medication Assisted Treatment (MAT)) for Opioid Use Disorders (OUD): Includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders.

MAT for OUD may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the "Levels of Care" section.

- "Patient Education", which is education for the beneficiary on addiction, treatment, recovery, and associated health risks.
- Prescribing and monitoring for MAT for OUD, which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD.

SUD Crisis Intervention Services: Consists of contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation, and be provided in the least intensive level of care that is medically necessary to treat their condition.

Withdrawal Management Services (WM): Provided to beneficiaries when medically necessary for maximum reduction of the SUD symptoms and restoration of the beneficiary to their best possible functional level.

- Observation, which is the process of monitoring the beneficiary's course of withdrawal. Observation is conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

Practice Requirements: Contractor must implement at least two evidenced based practices in its treatment modalities. The acceptable evidenced based practices for the treatment of SUDs should be from the following list:

a. Motivational Interviewing- A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on beneficiaries' past successes.
b. Cognitive-Behavioral Therapy- Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
c. Relapse Prevention- A behavioral self-control program that teaches individuals with SUD how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial SUD treatment.
d. Trauma-Informed Treatment- Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
e. Psychoeducation- Psychoeducational groups are designed to educate beneficiaries about substance abuse and related behaviors and consequences. Psychoeducational groups provide information designed to have a direct application to beneficiaries' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

1. Data Collection, Reports, and Ancillary Services:

1.1 Contractor agrees to abide by the provisions of Attachment 1 hereto attached and incorporated herein as required of "contractors" and "subcontractors" under the State Department of Health Care Services (DHCS) Standard Agreement Number by and between DHCS and the County.

1.2 Contractor shall cooperate with the County in the implementation, monitoring and evaluation of the Contract and comply with any and all reporting requirements established by the County. Payment of invoices may be held until Contractor is in compliance with reporting requirements. County shall not be responsible for reimbursement of invoices submitted by Contractor that do not have proper authorizations in place. Contractor shall participate in Risk Needs Responsivity practices as determined by County.

1.3 Contractor agrees to provide the following data quarterly to the Nevada County Quality Assurance Manager:

1.3.1 Number of new clients

1.3.2 Number of clients discharged successfully or unsuccessfully

1.3.3 Percentage of clients who are illicit opiate free within 90 days of admission

1.4 Contractor shall make referrals as permissible and in accordance to HIPAA and 42 CFR Part 2, or assist County case managers in the identification of and referral to ancillary services needed by individual clients, including literacy enhancement, family counseling, and vocational training.

2. Case Referrals:

2.1 Contractor agrees to accept new County case referrals as having been appropriately assessed if such referrals are deemed by Contractor's physician to meet admission criteria as set by Title 9 and 22 of the California Code of Regulations.

3. Maintenance of Effort:

3.1 Contractor agrees to provide County ***upon request***:

3.1.1 Number of full time equivalent (FTE) staff assigned to this program

3.1.2 Staffing profile by license, education, certification, or training

3.1.3 Staff development and training plan

3.1.4 Quarterly program reports (in writing or in person), including expected outcomes, results, and performance measurements

3.1.5 Reports on and participation in any quality assurance or quality improvement processes

3.1.6 Participation in distribution of client satisfaction surveys

4. Performance Measurement:

4.1 Client progress, while in treatment, shall be evaluated using the ASAM assessment and placement instrument at intervals as required by Title 9 and 22 of the California Code of Regulations.

4.1.1 Client satisfaction surveys shall be collected (as available) at discharge, and again at 90 days post discharge.

4.1.2 CalOMS data on number of intakes, versus number of successful discharges shall be reported.

4.1.3 Contractor shall supply any other relevant outcome data they have available.

5. Workforce Development:

Contractor shall provide training for staff to develop competence in current and evidence-based practices. In addition, for each special population served (e.g. women, adolescents), Contractor shall require staff to participate in training relevant to that population.

6. Written Policies

Contractor shall have written policies that:

a) Buprenorphine/naloxone (e.g. Suboxone) is prescribed whenever buprenorphine-containing medication is indicated for opioid medication-assisted treatment (MAT) (with the rare exception of a medical provider-documented contraindication to naloxone, e.g. anaphylactic allergy to naloxone);

b) Contractor medical staff will check CA Department of Justice's CURES prescription drug monitoring program for each client at intake and regularly thereafter, at least monthly, to detect multiple opioid (or benzodiazepine) prescriptions, especially from multiple prescribers and /or pharmacies;

c) Provide services to each client referred to provider within 3 days of referral date

Diversity, Equity, Inclusion

Despite progress in addressing explicit discrimination, racial inequities continue to be deep, pervasive, and persistent across the country. Though we have made many strides toward racial equity, policies, practices, and implicit bias have created and still create disparate results. Through partnerships with the community, Nevada County Behavioral Health strives to address these inequities and continue progress in moving forward.

Contractor is encouraged to have a diverse and inclusive workforce that includes representation from the disparate communities served by our county. Contractor will be expected to think holistically about creating services, program sites and an employee culture that is welcoming and inclusive. Contractor should track metrics on Diversity, Equity, and Inclusion outcomes within their service delivery. Additional efforts should be made to identify and highlight growth opportunities for equitable outcomes, access to services, and other opportunities. Contractor is to contact County contract manager about proposed metrics to track.

7. Confidentiality

Contractor shall ensure the confidentiality of participants and their records, including but not limited to substance abuse treatment records, medical records, and behavioral health records, in accordance with federal and state law. Further, Contractor shall comply with the provisions of HIPAA and the HiTECH Act, as more fully set forth in Exhibit D, which is attached hereto and incorporate herein by reference.

8. DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM:

I. Contractor will track Timely access data, including date of initial contact, date of first offered appointment and date of scheduled assessment. Contractor will also track ASAM data. Contractor shall also track no show data. The percentage of no shows for medication appointments as well as counseling appointments shall be reported monthly. Timely access data, ASAM data, and no-show data should be submitted to the Nevada County Quality Assurance Manager or designee by the 10th of each month for the previous month. Contractor will be provided an Excel Spreadsheet to track timeliness data, ASAM level of care data, and no-show data. No show data is an important performance metric that the contractor can monitor to analyze trends and implement appropriate changes to services as indicated.

Performance Standard:

a) First face-to-face appointment shall occur no later than 3 days of initial contact/request for service.
b) First face-to-face appointment Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders shall occur no later than 3 days.
c) Contractor will track No Show data for MAT/NTP appointments and for counseling appointments. Contractor will track the number of MAT appointments per month and the number of no shows for MAT/NTP appointments per month; the number counseling appointments per month and the number of no show to counseling appointment per month. This data will be reported to the County on a quarterly basis.
d) At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location and time of services

II. Transitions between Levels of Care

Appropriate care coordinators/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in the client's medical record. The Contractor shall refer the beneficiary to the County when the ASAM assessment indicate levels of care other than NTP (for example residential treatment and/or outpatient treatment. The Contractor shall also refer the client to the County for Recovery Services upon discharge from the program.

Performance Standard:

a) Transitions between levels of care shall occur within five (5) and no later than 10 business days from the time of re-assessment indicating the need for a different level of care.

IV. Delivery of Individualized and Quality Care

a) Beneficiary Satisfaction: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, Contractor shall select a minimum of one quality improvement initiative to implement annually.
b) Evidence-Based Practices (EBPs): Contractors will implement, and assess fidelity to, at least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psychoeducation.
c) ASAM Level of Care: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in the client's medical record.

Performance Standards:

1. At least 80% of beneficiaries will report an overall satisfaction score of at least 3.5 or higher on the Treatment Perceptions Survey
2. At least 80% of beneficiaries completing the Treatment Perceptions Survey reported that they were involved in choosing their own treatment goals (overall score of 3.5+ out of 5.0)
3. Contractor will implement with fidelity at least two approved EBPs
4. 100% of beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care
5. At least 80% of beneficiaries are re-assessed within 90 days of the initial assessment

The Parties hereby acknowledge and agree that in the event of changes to the Drug Medi-Cal Organized Delivery System which County determines will constitute a material change to rights and obligations set forth in this Agreement, the County has, at its option, the right to re-open and renegotiate this Agreement upon thirty (30) days written notice to Contractor

EXHIBIT "B"
SCHEDULE OF CHARGES AND PAYMENTS
AEGIS TREATMENT CENTERS, LLC.

Subject to the satisfactory performance of services required of Contractor pursuant to this Contract, and the terms and conditions set forth, the maximum obligation of this Agreement shall not exceed $806,000 for the contract term. Only services for Nevada County Medi-Cal beneficiaries who maintain residency in Nevada County shall be billed through this Agreement.

Medication	Non-Peri	Peri
Methadone	$ 19.19	$ 29.47
Buprenorphine-Naloxone Combo Film	$ 28.68	$ 39.89
Buprenorphine-Naloxone Combo Tablets	$ 32.55	$ 43.86
Buprenorphine Mono	$ 32.06	$ 43.38
Disulfiram	$ 11.45	$ 11.62
Buprenorphine Injectable (Sublocade)	$ 1,996.21	$ 1,996.21
Naltrexone Injectable (Vivitrol)	$ 2,180.41	$ 2,180.41
Naloxone HCL- 2 pack (Generic)	$ 106.07	$ 106.07
Naloxone HCL- 2 pack (Narcan)	$ 144.96	$ 144.96

Direct Service Staff By Discipline	**Hourly Rate**
Physicians Assistant	$ 415.69
Nurse Practitioner	$ 460.90
RN	$ 376.48
MD (typically in SUD system of Care)	$ 926.86
LPHA/Intern or Waivered LPHA (MFT, LCSW, LPCC)	$ 241.22
Alcohol and Drug Counselor	$ 200.08
Peer Recovery Specialist	$ 190.55

FINANCIAL TERMS

1. CLAIMING

2. Contractor shall submit to County, for services rendered in the prior month, and in accordance with CPT format requirements, a statement of services rendered to County that includes documentation to support all fees claimed by the 10th of each month. County shall review the billing and notify the Contractor within fifteen (15) working days if an individual item or group of services is being questioned. Contractor has the option of delaying the entire claim pending resolution of the service(s).
   A. Claims shall be complete and accurate and must include all required information regarding the claimed services.
   B. Contractor shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services and correcting denied services for resubmission in a timely manner as needed.
3. INVOICING
   A. Contractor shall invoice County for services monthly, in arrears, in the format directed by County. Invoices shall be based on claims entered into the County's billing and transactional database system for the prior month.
   B. Invoices shall be provided to County after the close of the month in which services were rendered. Following receipt and provisional approval of a monthly invoice, County shall make payment within 30 days.
      a. If County is unable to make timely payment due to SmartCare Electronic Health Record (her) software conversion/go live, County will issue interim payment(s) at the average of May and June, 2023 services or $1/12^{th}$ of the contract amount, whichever is lower. A true up will be completed on the first invoice once services and reports are available in the EHR.
   C. Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the County's billing and transactional database multiplied by the service rates in Exhibit B-2.
   D. County's payments to Contractor for performance of claimed services are provisional and subject to adjustment until the completion of all settlement activities. County's adjustments to provisional payments for claimed services shall be based on the terms, conditions, and limitations of this Agreement or the reasons for recoupment set forth in Article 5, Section 6.
   E. Contractor shall submit invoices to:

      Nevada County Behavioral Health Department

      Attn: Fiscal Staff

      500 Crown Point Circle, Suite 120

      Grass Valley, CA 95945

4. ADDITIONAL FINANCIAL REQUIREMENTS
   A. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.
   B. Contractor must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the US DHHS may specify.
   C. Contractor agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at https://www.opm.gov/ (U.S. Office of Personnel Management), as from time to time amended.
   D. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud (42 U.S.C. § 1396b(i)(2)).
   E. Contractor shall cooperate with the County in the implementation, monitoring and evaluation of the Contract and comply with any and all reporting requirements established by the County. Payment of invoices may be held until Contractor is in compliance with reporting requirements. County shall not be responsible for reimbursement of invoices submitted by Contractor that do not have proper authorizations in place.
5. FINANCIAL AUDIT REPORT REQUIREMENTS FOR PASS-THROUGH ENTITIES
   A. If County determines that Contractor is a "subrecipient" (also known as a "pass-through entity") as defined in 2 C.F.R. § 200 et seq., Contractor represents that it will comply with the applicable cost principles and administrative requirements including claims for payment or reimbursement by County as set forth in 2 C.F.R. § 200 et seq., as may be amended from time to time. Contractor shall observe and comply with all applicable financial audit report requirements and standards.
   B. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the County. County programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.
   C. Contractor will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year

to the Director. The Director is responsible for providing the audit report to the County Auditor.

D. Contractor must submit any required corrective action plan to the County simultaneously with the audit report or as soon thereafter as it is available. The County shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.

EXHIBIT "B-2"

SCHEDULE OF ODS DRUG MEDI-CAL RATES

Full List of Rates by CPT Code and Discipline. Actual billable CPT codes may be limited based on Nevada County Electronic Health Record/Billing and Transactional Database capabilities. The final list of billable codes will be provided to Contractor by Nevada County Behavioral Health.

ASAM / Service Level	Discipline	CPT Code Name	CPT Code	Hourly Rate
Medication Assisted Treatment (MAT)	Certified Peer Support Specialist	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$190.55
	Certified Peer Support Specialist	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$190.55
	Certified/registered AOD Counselor	Interactive Complexity	90785	$200.08
	Certified/registered AOD Counselor	Psychosocial Rehabilitation, per 15 Minutes	H2017	$200.08
	Certified/registered AOD Counselor	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$200.08
	Certified/registered AOD Counselor	Targeted Case Management, Each 15 Minutes	T1017	$200.08
	Certified/registered AOD Counselor	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$200.08
	Certified/registered AOD Counselor	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$200.08
	Certified/registered AOD Counselor	Behavioral health counseling and therapy, 15 minutes.	H0004	$200.08
	Certified/registered AOD Counselor	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$200.08
	Certified/registered AOD Counselor	Alcohol and/or drug screening	H0049	$200.08
	Certified/registered AOD Counselor	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$200.08
	Certified/registered AOD Counselor	Prenatal Care, at risk assessment.	H1000	$200.08
	Certified/registered AOD Counselor	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$200.08
	Certified/registered AOD Counselor	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	$200.08
	Certified/registered AOD Counselor	Comprehensive community support services, per 15 minutes	H2015	$200.08
	Certified/registered AOD Counselor	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$200.08

	Certified/registered AOD Counselor	Psychoeducational Service, per 15 minutes	H2027	$200.08
	Certified/registered AOD Counselor	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance abuse services, family/couple counseling	T1006	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$200.08
	Licensed Physician	Interactive Complexity	90785	$926.86

Medication Assisted Treatment (MAT)	Licensed Physician	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$926.86
	Licensed Physician	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician. Patient and/or Family not Present. 30 Minutes or More	99367	$926.86
	Licensed Physician	Medication Training and Support, per 15 Minutes	H0034	$926.86
	Licensed Physician	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$926.86
	Licensed Physician	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	99203	$926.86
	Licensed Physician	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	99204	$926.86
	Licensed Physician	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	99205	$926.86
	Licensed Physician	Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	99212	$926.86
	Licensed Physician	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	99213	$926.86
	Licensed Physician	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	99214	$926.86
	Licensed Physician	Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	99215	$926.86
	Licensed Physician	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	99202	$926.86
	Licensed Physician	Oral Medication Administration, Direct Observation, 15 Minutes	H0033	$926.86
	Licensed Physician	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212	$926.86
	Licensed Physician	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	$926.86
	Licensed Physician	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$926.86
	Licensed Physician	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$926.86
	Licensed Physician	Psychological Testing Evaluation, Each Additional Hour	96131	$926.86
	Licensed Physician	Psychological Testing Evaluation, First Hour	96130	$926.86
	Licensed Physician	Psychosocial Rehabilitation, per 15 Minutes	H2017	$926.86
	Licensed Physician	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$926.86
	Licensed Physician	Targeted Case Management, Each 15 Minutes	T1017	$926.86
	Licensed Physician	Telephone Evaluation and Management Service, 11-20 Minutes	99442	$926.86

	Licensed Physician	Telephone Evaluation and Management Service, 21-30 Minutes	99443	$926.86
	Licensed Physician	Telephone Evaluation and Management Service, 5-10 Minutes	99441	$926.86
	Licensed Physician	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$926.86
	Licensed Physician	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$926.86
	Licensed Physician	Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865	$926.86
	Licensed Physician	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882	$926.86
	Licensed Physician	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$926.86
	Licensed Physician	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889	$926.86
	Licensed Physician	Administration of patient-focused health risk assessment instrument.	96160	$926.86
	Licensed Physician	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170	$926.86
Medication Assisted Treatment (MAT)	Licensed Physician	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	$926.86
	Licensed Physician	Telephone Assessment and Management Service, 5-10 Minutes	98966	$926.86
	Licensed Physician	Telephone Assessment and Management Service, 11-20 Minutes	98967	$926.86
	Licensed Physician	Telephone Assessment and Management Service, 21-30 Minutes	98968	$926.86
	Licensed Physician	Observation Care Discharge Day Management, 15 Minutes	99217	$926.86
	Licensed Physician	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 35-44 Minutes	99234	$926.86
	Licensed Physician	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 45-53 minutes	99235	$926.86
	Licensed Physician	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 54-60 Minutes	99236	$926.86
	Licensed Physician	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) requiring Admission are of Low Severity, 16- 29 Minutes	99304	$926.86
	Licensed Physician	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of Moderate Severity, 30-39 Minutes	99305	$926.86
	Licensed Physician	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of High Severity, 40- 60 Minutes	99306	$926.86
	Licensed Physician	Subsequent Nursing Facility Care per Day for the Evaluation and Management of a Patient. Usually, the Patient is Stable, Recovering or Improving, 1-12 Minutes	99307	$926.86

	Licensed Physician	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient is Responding Inadequately to Therapy or Has Developed a Minor Complication, 13- 19 Minutes	99308	$926.86
	Licensed Physician	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient has Developed a Significant Complication or a Significant New Problem, 20-29 Minutes	99309	$926.86
	Licensed Physician	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. The Patient May Be Unstable or May Have Developed a Significant New Problem Requiring Immediate Physician Attention, 30-40 Minutes	99310	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of a New Patient, 15- 25 Minutes	99324	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of a New Patient, 26-35 Minutes	99325	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of a New Patient, 36-50 Minutes	99326	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of a New Patient, 51-65 Minutes	99327	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of a New Patient, 66-80 Minutes	99328	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of an Established Patient, 10-20 Minutes	99334	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of an Established Patient, 21-35 Minutes	99335	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of an Established Patient, 36-50 Minutes	99336	$926.86
	Licensed Physician	Domiciliary or Rest Home Visit of an Established Patient, 51-70 Minutes	99337	$926.86
	Licensed Physician	Individual physician supervisory of a patient (patient not present) in home, 15 – 29 minutes	99339	$926.86
Medication Assisted Treatment (MAT)	Licensed Physician	Individual physician supervisory of a patient (patient not present) in home. Each additional 30 minutes	99340	$926.86
	Licensed Physician	Home Visit of a New Patient, 15-25 Minutes	99341	$926.86
	Licensed Physician	Home Visit of a New Patient, 26-35 Minutes	99342	$926.86
	Licensed Physician	Home Visit of a New Patient, 36-50 Minutes	99343	$926.86
	Licensed Physician	Home Visit of a New Patient, 51-65 Minutes	99344	$926.86
	Licensed Physician	Home Visit of a New Patient, 66-80 Minutes	99345	$926.86
	Licensed Physician	Home Visit of an Established Patient, 10-20 Minutes	99347	$926.86
	Licensed Physician	Home Visit of an Established Patient, 21-35 Minutes	99348	$926.86
	Licensed Physician	Home Visit of an Established Patient, 36-50 Minutes	99349	$926.86
	Licensed Physician	Home Visit of an Established Patient, 51-70 Minutes	99350	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minutes.	99408	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. Greater than 30 minutes.	99409	$926.86
	Licensed Physician	Inter-Professional Telephone/Internet/ Electronic Health Record Assessment Provided by a Consultative Physician, 515 Minutes	99451	$926.86

	Licensed Physician	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495	$926.86
	Licensed Physician	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$926.86
	Licensed Physician	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$926.86
	Licensed Physician	Alcohol and/or drug screening. Laboratory analysis	H0003	$926.86
	Licensed Physician	Behavioral health counseling and therapy, 15 minutes.	H0004	$926.86
	Licensed Physician	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$926.86
	Licensed Physician	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$926.86
	Licensed Physician	Alcohol and/or drug services: (hospital inpatient) Subacute detoxification	H0008	$926.86
	Licensed Physician	Alcohol and/or drug services: (hospital inpatient) Acute detoxification	H0009	$926.86
	Licensed Physician	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	$926.86
	Licensed Physician	Alcohol and/or drug screening	H0049	$926.86
	Licensed Physician	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$926.86
	Licensed Physician	Prenatal Care, at risk assessment.	H1000	$926.86
	Licensed Physician	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$926.86
	Licensed Physician	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	$926.86
Medication Assisted Treatment (MAT)	Licensed Physician	Comprehensive community support services, per 15 minutes	H2015	$926.86
	Licensed Physician	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$926.86
	Licensed Physician	Psychoeducational Service, per 15 minutes	H2027	$926.86
	Licensed Physician	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$926.86
	Licensed Physician	Alcohol and/or substance abuse services, family/couple counseling	T1006	$926.86
	Licensed Physician	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$926.86
	Licensed/Registered Clinical Social Worker	Interactive Complexity	90785	$241.22

	Licensed/Registered Clinical Social Worker	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$241.22
	Licensed/Registered Clinical Social Worker	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$241.22
	Licensed/Registered Clinical Social Worker	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$241.22
	Licensed/Registered Clinical Social Worker	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$241.22
	Licensed/Registered Clinical Social Worker	Psychosocial Rehabilitation, per 15 Minutes	H2017	$241.22
	Licensed/Registered Clinical Social Worker	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$241.22
	Licensed/Registered Clinical Social Worker	Targeted Case Management, Each 15 Minutes	T1017	$241.22
	Licensed/Registered Clinical Social Worker	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$241.22
	Licensed/Registered Clinical Social Worker	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$241.22
	Licensed/Registered Clinical Social Worker	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882	$241.22
	Licensed/Registered Clinical Social Worker	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$241.22
	Licensed/Registered Clinical Social Worker	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889	$241.22
	Licensed/Registered Clinical Social Worker	Administration of patient-focused health risk assessment instrument.	96160	$241.22
	Licensed/Registered Clinical Social Worker	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170	$241.22
	Licensed/Registered Clinical Social Worker	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	$241.22
	Licensed/Registered Clinical Social Worker	Telephone Assessment and Management Service, 5-10 Minutes	98966	$241.22
	Licensed/Registered Clinical Social Worker	Telephone Assessment and Management Service, 11-20 Minutes	98967	$241.22
	Licensed/Registered Clinical Social Worker	Telephone Assessment and Management Service, 21-30 Minutes	98968	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$241.22
Medication Assisted Treatment (MAT)	Licensed/Registered Clinical Social Worker	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$241.22

Licensed/Registered Clinical Social Worker	Behavioral health counseling and therapy, 15 minutes.	H0004	$241.22
Licensed/Registered Clinical Social Worker	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$241.22
Licensed/Registered Clinical Social Worker	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$241.22
Licensed/Registered Clinical Social Worker	Alcohol and/or drug screening	H0049	$241.22
Licensed/Registered Clinical Social Worker	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$241.22
Licensed/Registered Clinical Social Worker	Prenatal Care, at risk assessment.	H1000	$241.22
Licensed/Registered Clinical Social Worker	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$241.22
Licensed/Registered Clinical Social Worker	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	$241.22
Licensed/Registered Clinical Social Worker	Comprehensive community support services, per 15 minutes	H2015	$241.22
Licensed/Registered Clinical Social Worker	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$241.22
Licensed/Registered Clinical Social Worker	Psychoeducational Service, per 15 minutes	H2027	$241.22
Licensed/Registered Clinical Social Worker	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$241.22
Licensed/Registered Clinical Social Worker	Alcohol and/or substance abuse services, family/couple counseling	T1006	$241.22
Licensed/Registered Clinical Social Worker	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$241.22
Licensed/Registered Marriage Family Therapist	Interactive Complexity	90785	$241.22
Licensed/Registered Marriage Family Therapist	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$241.22
Licensed/Registered Marriage Family Therapist	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$241.22
Licensed/Registered Marriage Family Therapist	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$241.22
Licensed/Registered Marriage Family Therapist	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$241.22
Licensed/Registered Marriage Family Therapist	Psychosocial Rehabilitation, per 15 Minutes	H2017	$241.22
Licensed/Registered Marriage Family Therapist	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$241.22
Licensed/Registered Marriage Family Therapist	Targeted Case Management, Each 15 Minutes	T1017	$241.22
Licensed/Registered Marriage Family Therapist	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$241.22
Licensed/Registered Marriage Family Therapist	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$241.22
Licensed/Registered Marriage Family Therapist	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882	$241.22

	Licensed/Registered Marriage Family Therapist	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$241.22

Medication Assisted Treatment (MAT)	Licensed/Registered Marriage Family Therapist	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889	$241.22
	Licensed/Registered Marriage Family Therapist	Administration of patient-focused health risk assessment instrument.	96160	$241.22
	Licensed/Registered Marriage Family Therapist	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170	$241.22
	Licensed/Registered Marriage Family Therapist	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	$241.22
	Licensed/Registered Marriage Family Therapist	Telephone Assessment and Management Service, 5-10 Minutes	98966	$241.22
	Licensed/Registered Marriage Family Therapist	Telephone Assessment and Management Service, 11-20 Minutes	98967	$241.22
	Licensed/Registered Marriage Family Therapist	Telephone Assessment and Management Service, 21-30 Minutes	98968	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$241.22
	Licensed/Registered Marriage Family Therapist	Behavioral health counseling and therapy, 15 minutes.	H0004	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or drug screening	H0049	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$241.22
	Licensed/Registered Marriage Family Therapist	Prenatal Care, at risk assessment.	H1000	$241.22
	Licensed/Registered Marriage Family Therapist	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$241.22
	Licensed/Registered Marriage Family Therapist	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	$241.22
	Licensed/Registered Marriage Family Therapist	Comprehensive community support services, per 15 minutes	H2015	$241.22
	Licensed/Registered Marriage Family Therapist	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$241.22
	Licensed/Registered Marriage Family Therapist	Psychoeducational Service, per 15 minutes	H2027	$241.22

	Licensed/Registered Marriage Family Therapist	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance abuse services, family/couple counseling	T1006	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$241.22
	Licensed/Registered Professional Clinical Counselor	Interactive Complexity	90785	$200.08

Medication Assisted Treatment (MAT)	Licensed/Registered Professional Clinical Counselor	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$200.08
	Licensed/Registered Professional Clinical Counselor	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$200.08
	Licensed/Registered Professional Clinical Counselor	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$200.08
	Licensed/Registered Professional Clinical Counselor	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$200.08
	Licensed/Registered Professional Clinical Counselor	Psychosocial Rehabilitation, per 15 Minutes	H2017	$200.08
	Licensed/Registered Professional Clinical Counselor	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$200.08
	Licensed/Registered Professional Clinical Counselor	Targeted Case Management, Each 15 Minutes	T1017	$200.08
	Licensed/Registered Professional Clinical Counselor	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$200.08
	Licensed/Registered Professional Clinical Counselor	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$200.08
	Licensed/Registered Professional Clinical Counselor	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882	$200.08
	Licensed/Registered Professional Clinical Counselor	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$200.08
	Licensed/Registered Professional Clinical Counselor	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889	$200.08
	Licensed/Registered Professional Clinical Counselor	Administration of patient-focused health risk assessment instrument.	96160	$200.08
	Licensed/Registered Professional Clinical Counselor	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170	$200.08
	Licensed/Registered Professional Clinical Counselor	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	$200.08

	Licensed/Registered Professional Clinical Counselor	Telephone Assessment and Management Service, 5-10 Minutes	98966	$200.08
	Licensed/Registered Professional Clinical Counselor	Telephone Assessment and Management Service, 11-20 Minutes	98967	$200.08
	Licensed/Registered Professional Clinical Counselor	Telephone Assessment and Management Service, 21-30 Minutes	98968	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$200.08
Medication Assisted Treatment (MAT)	Licensed/Registered Professional Clinical Counselor	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$200.08
	Licensed/Registered Professional Clinical Counselor	Behavioral health counseling and therapy, 15 minutes.	H0004	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or drug screening	H0049	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$200.08
	Licensed/Registered Professional Clinical Counselor	Prenatal Care, at risk assessment.	H1000	$200.08
	Licensed/Registered Professional Clinical Counselor	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	$200.08
	Licensed/Registered Professional Clinical Counselor	Comprehensive community support services, per 15 minutes	H2015	$200.08
	Licensed/Registered Professional Clinical Counselor	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$200.08
	Licensed/Registered Professional Clinical Counselor	Psychoeducational Service, per 15 minutes	H2027	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance abuse services, family/couple counseling	T1006	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$200.08

	Nurse Practitioner	Interactive Complexity	90785	$460.90
	Nurse Practitioner	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$460.90
	Nurse Practitioner	Medication Training and Support, per 15 Minutes	H0034	$460.90
	Nurse Practitioner	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$460.90
	Nurse Practitioner	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	99203	$460.90
	Nurse Practitioner	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	99204	$460.90
	Nurse Practitioner	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	99205	$460.90
	Nurse Practitioner	Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	99212	$460.90
	Nurse Practitioner	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	99213	$460.90
	Nurse Practitioner	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	99214	$460.90
	Nurse Practitioner	Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	99215	$460.90
	Nurse Practitioner	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	99202	$460.90
	Nurse Practitioner	Oral Medication Administration, Direct Observation, 15 Minutes	H0033	$460.90
	Nurse Practitioner	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212	$460.90
	Nurse Practitioner	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	$460.90
Medication Assisted Treatment	Nurse Practitioner	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$460.90
	Nurse Practitioner	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$460.90
	Nurse Practitioner	Psychological Testing Evaluation, Each Additional Hour	96131	$460.90
	Nurse Practitioner	Psychological Testing Evaluation, First Hour	96130	$460.90
	Nurse Practitioner	Psychosocial Rehabilitation, per 15 Minutes	H2017	$460.90
	Nurse Practitioner	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$460.90
	Nurse Practitioner	Targeted Case Management, Each 15 Minutes	T1017	$460.90
	Nurse Practitioner	Telephone Evaluation and Management Service, 11-20 Minutes	99442	$460.90
	Nurse Practitioner	Telephone Evaluation and Management Service, 21-30 Minutes	99443	$460.90
	Nurse Practitioner	Telephone Evaluation and Management Service, 5-10 Minutes	99441	$460.90
	Nurse Practitioner	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$460.90
	Nurse Practitioner	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$460.90
	Nurse Practitioner	Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865	$460.90
	Nurse Practitioner	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882	$460.90
	Nurse Practitioner	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$460.90

	Nurse Practitioner	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889	$460.90
	Nurse Practitioner	Administration of patient-focused health risk assessment instrument.	96160	$460.90
	Nurse Practitioner	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170	$460.90
	Nurse Practitioner	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	$460.90
	Nurse Practitioner	Telephone Assessment and Management Service, 5-10 Minutes	98966	$460.90
	Nurse Practitioner	Telephone Assessment and Management Service, 11-20 Minutes	98967	$460.90
	Nurse Practitioner	Telephone Assessment and Management Service, 21-30 Minutes	98968	$460.90
	Nurse Practitioner	Observation Care Discharge Day Management, 15 Minutes	99217	$460.90
	Nurse Practitioner	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 35-44 Minutes	99234	$460.90
	Nurse Practitioner	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 45-53 minutes	99235	$460.90
	Nurse Practitioner	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 54-60 Minutes	99236	$460.90
	Nurse Practitioner	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) requiring Admission are of Low Severity, 16- 29 Minutes	99304	$460.90
	Nurse Practitioner	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of Moderate Severity, 30-39 Minutes	99305	$460.90
	Nurse Practitioner	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of High Severity, 40- 60 Minutes	99306	$460.90
Medication Assisted Treatment (MAT)	Nurse Practitioner	Subsequent Nursing Facility Care per Day for the Evaluation and Management of a Patient. Usually, the Patient is Stable, Recovering or Improving, 1-12 Minutes	99307	$460.90
	Nurse Practitioner	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient is Responding Inadequately to Therapy or Has Developed a Minor Complication, 13- 19 Minutes	99308	$460.90
	Nurse Practitioner	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient has Developed a Significant Complication or a Significant New Problem, 20-29 Minutes	99309	$460.90
	Nurse Practitioner	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. The Patient May Be Unstable or May Have Developed a Significant New Problem Requiring Immediate Physician Attention, 30-40 Minutes	99310	$460.90
	Nurse Practitioner	Domiciliary or Rest Home Visit of a New Patient, 15- 25 Minutes	99324	$460.90

	Nurse Practitioner	Domiciliary or Rest Home Visit of a New Patient, 26-35 Minutes	99325	$460.90
	Nurse Practitioner	Domiciliary or Rest Home Visit of a New Patient, 36-50 Minutes	99326	$460.90
	Nurse Practitioner	Domiciliary or Rest Home Visit of a New Patient, 51-65 Minutes	99327	$460.90
	Nurse Practitioner	Domiciliary or Rest Home Visit of a New Patient, 66-80 Minutes	99328	$460.90
	Nurse Practitioner	Domiciliary or Rest Home Visit of an Established Patient, 10-20 Minutes	99334	$460.90
	Nurse Practitioner	Domiciliary or Rest Home Visit of an Established Patient, 21-35 Minutes	99335	$460.90
	Nurse Practitioner	Domiciliary or Rest Home Visit of an Established Patient, 36-50 Minutes	99336	$460.90
	Nurse Practitioner	Domiciliary or Rest Home Visit of an Established Patient, 51-70 Minutes	99337	$460.90
	Nurse Practitioner	Individual physician supervisory of a patient (patient not present) in home, 15 – 29 minutes	99339	$460.90
	Nurse Practitioner	Individual physician supervisory of a patient (patient not present) in home. Each additional 30 minutes	99340	$460.90
	Nurse Practitioner	Home Visit of a New Patient, 15-25 Minutes	99341	$460.90
	Nurse Practitioner	Home Visit of a New Patient, 26-35 Minutes	99342	$460.90
	Nurse Practitioner	Home Visit of a New Patient, 36-50 Minutes	99343	$460.90
	Nurse Practitioner	Home Visit of a New Patient, 51-65 Minutes	99344	$460.90
	Nurse Practitioner	Home Visit of a New Patient, 66-80 Minutes	99345	$460.90
	Nurse Practitioner	Home Visit of an Established Patient, 10-20 Minutes	99347	$460.90
	Nurse Practitioner	Home Visit of an Established Patient, 21-35 Minutes	99348	$460.90
	Nurse Practitioner	Home Visit of an Established Patient, 36-50 Minutes	99349	$460.90
	Nurse Practitioner	Home Visit of an Established Patient, 51-70 Minutes	99350	$460.90
	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minutes.	99408	$460.90
	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. Greater than 30 minutes.	99409	$460.90
	Nurse Practitioner	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495	$460.90
	Nurse Practitioner	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496	$460.90
Medication Assisted Treatment (MAT)	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$460.90
	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$460.90
	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$460.90

	Nurse Practitioner	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$460.90
	Nurse Practitioner	Alcohol and/or drug screening. Laboratory analysis	H0003	$460.90
	Nurse Practitioner	Behavioral health counseling and therapy, 15 minutes.	H0004	$460.90
	Nurse Practitioner	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$460.90
	Nurse Practitioner	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$460.90
	Nurse Practitioner	Alcohol and/or drug services: (hospital inpatient) Subacute detoxification	H0008	$460.90
	Nurse Practitioner	Alcohol and/or drug services: (hospital inpatient) Acute detoxification	H0009	$460.90
	Nurse Practitioner	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	$460.90
	Nurse Practitioner	Alcohol and/or drug screening	H0049	$460.90
	Nurse Practitioner	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$460.90
	Nurse Practitioner	Prenatal Care, at risk assessment.	H1000	$460.90
	Nurse Practitioner	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$460.90
	Nurse Practitioner	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	$460.90
	Nurse Practitioner	Comprehensive community support services, per 15 minutes	H2015	$460.90
	Nurse Practitioner	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$460.90
	Nurse Practitioner	Psychoeducational Service, per 15 minutes	H2027	$460.90
	Nurse Practitioner	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$460.90
	Nurse Practitioner	Alcohol and/or substance abuse services, family/couple counseling	T1006	$460.90
	Nurse Practitioner	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$460.90
	Physician Assistant	Interactive Complexity	90785	$415.69
	Physician Assistant	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$415.69
	Physician Assistant	Medication Training and Support, per 15 Minutes	H0034	$415.69
	Physician Assistant	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$415.69
	Physician Assistant	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	99203	$415.69
	Physician Assistant	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	99204	$415.69
	Physician Assistant	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	99205	$415.69
	Physician Assistant	Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	99212	$415.69
	Physician Assistant	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	99213	$415.69
	Physician Assistant	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	99214	$415.69

Medication Assisted Treatment (MAT)	Physician Assistant	Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	99215	$415.69
	Physician Assistant	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	99202	$415.69
	Physician Assistant	Oral Medication Administration, Direct Observation, 15 Minutes	H0033	$415.69
	Physician Assistant	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212	$415.69
	Physician Assistant	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	$415.69
	Physician Assistant	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$415.69
	Physician Assistant	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$415.69
	Physician Assistant	Psychological Testing Evaluation, Each Additional Hour	96131	$415.69
	Physician Assistant	Psychological Testing Evaluation, First Hour	96130	$415.69
	Physician Assistant	Psychosocial Rehabilitation, per 15 Minutes	H2017	$415.69
	Physician Assistant	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$415.69
	Physician Assistant	Targeted Case Management, Each 15 Minutes	T1017	$415.69
	Physician Assistant	Telephone Evaluation and Management Service, 11-20 Minutes	99442	$415.69
	Physician Assistant	Telephone Evaluation and Management Service, 21-30 Minutes	99443	$415.69
	Physician Assistant	Telephone Evaluation and Management Service, 5-10 Minutes	99441	$415.69
	Physician Assistant	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$415.69
	Physician Assistant	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$415.69
	Physician Assistant	Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865	$415.69
	Physician Assistant	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882	$415.69
	Physician Assistant	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$415.69
	Physician Assistant	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889	$415.69
	Physician Assistant	Administration of patient-focused health risk assessment instrument.	96160	$415.69
	Physician Assistant	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170	$415.69
	Physician Assistant	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	$415.69
	Physician Assistant	Telephone Assessment and Management Service, 5-10 Minutes	98966	$415.69
	Physician Assistant	Telephone Assessment and Management Service, 11-20 Minutes	98967	$415.69
	Physician Assistant	Telephone Assessment and Management Service, 21-30 Minutes	98968	$415.69
	Physician Assistant	Observation Care Discharge Day Management, 15 Minutes	99217	$415.69

	Physician Assistant	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 35-44 Minutes	99234	$415.69
	Physician Assistant	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 45-53 minutes	99235	$415.69
	Physician Assistant	Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 54-60 Minutes	99236	$415.69
Medication Assisted Treatment (MAT)	Physician Assistant	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) requiring Admission are of Low Severity, 16- 29 Minutes	99304	$415.69
	Physician Assistant	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of Moderate Severity, 30-39 Minutes	99305	$415.69
	Physician Assistant	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of High Severity, 40- 60 Minutes	99306	$415.69
	Physician Assistant	Subsequent Nursing Facility Care per Day for the Evaluation and Management of a Patient. Usually, the Patient is Stable, Recovering or Improving, 1-12 Minutes	99307	$415.69
	Physician Assistant	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient is Responding Inadequately to Therapy or Has Developed a Minor Complication, 13- 19 Minutes	99308	$415.69
	Physician Assistant	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient has Developed a Significant Complication or a Significant New Problem, 20-29 Minutes	99309	$415.69
	Physician Assistant	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. The Patient May Be Unstable or May Have Developed a Significant New Problem Requiring Immediate Physician Attention, 30-40 Minutes	99310	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of a New Patient, 15- 25 Minutes	99324	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of a New Patient, 26-35 Minutes	99325	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of a New Patient, 36-50 Minutes	99326	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of a New Patient, 51-65 Minutes	99327	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of a New Patient, 66-80 Minutes	99328	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of an Established Patient, 10-20 Minutes	99334	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of an Established Patient, 21-35 Minutes	99335	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of an Established Patient, 36-50 Minutes	99336	$415.69
	Physician Assistant	Domiciliary or Rest Home Visit of an Established Patient, 51-70 Minutes	99337	$415.69
	Physician Assistant	Individual physician supervisory of a patient (patient not present) in home, 15 – 29 minutes	99339	$415.69

	Physician Assistant	Individual physician supervisory of a patient (patient not present) in home. Each additional 30 minutes	99340	$415.69
	Physician Assistant	Home Visit of a New Patient, 15-25 Minutes	99341	$415.69
	Physician Assistant	Home Visit of a New Patient, 26-35 Minutes	99342	$415.69
	Physician Assistant	Home Visit of a New Patient, 36-50 Minutes	99343	$415.69
	Physician Assistant	Home Visit of a New Patient, 51-65 Minutes	99344	$415.69
	Physician Assistant	Home Visit of a New Patient, 66-80 Minutes	99345	$415.69
	Physician Assistant	Home Visit of an Established Patient, 10-20 Minutes	99347	$415.69
	Physician Assistant	Home Visit of an Established Patient, 21-35 Minutes	99348	$415.69
	Physician Assistant	Home Visit of an Established Patient, 36-50 Minutes	99349	$415.69
	Physician Assistant	Home Visit of an Established Patient, 51-70 Minutes	99350	$415.69
	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minutes.	99408	$415.69
Medication Assisted Treatment (MAT)	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. Greater than 30 minutes.	99409	$415.69
	Physician Assistant	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495	$415.69
	Physician Assistant	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496	$415.69
	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$415.69
	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$415.69
	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$415.69
	Physician Assistant	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$415.69
	Physician Assistant	Alcohol and/or drug screening. Laboratory analysis	H0003	$415.69
	Physician Assistant	Behavioral health counseling and therapy, 15 minutes.	H0004	$415.69
	Physician Assistant	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$415.69
	Physician Assistant	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$415.69
	Physician Assistant	Alcohol and/or drug services: (hospital inpatient) Subacute detoxification	H0008	$415.69
	Physician Assistant	Alcohol and/or drug services: (hospital inpatient) Acute detoxification	H0009	$415.69
	Physician Assistant	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	$415.69
	Physician Assistant	Alcohol and/or drug screening	H0049	$415.69

	Physician Assistant	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$415.69
	Physician Assistant	Prenatal Care, at risk assessment.	H1000	$415.69
	Physician Assistant	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$415.69
	Physician Assistant	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	$415.69
	Physician Assistant	Comprehensive community support services, per 15 minutes	H2015	$415.69
	Physician Assistant	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$415.69
	Physician Assistant	Psychoeducational Service, per 15 minutes	H2027	$415.69
	Physician Assistant	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$415.69
	Physician Assistant	Alcohol and/or substance abuse services, family/couple counseling	T1006	$415.69
	Physician Assistant	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$415.69
	Registered Nurse	Interactive Complexity	90785	$376.48
	Registered Nurse	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$376.48
	Registered Nurse	Medication Training and Support, per 15 Minutes	H0034	$376.48
	Registered Nurse	Oral Medication Administration, Direct Observation, 15 Minutes	H0033	$376.48
	Registered Nurse	Psychosocial Rehabilitation, per 15 Minutes	H2017	$376.48
Medication Assisted Treatment (MAT)	Registered Nurse	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$376.48
	Registered Nurse	Targeted Case Management, Each 15 Minutes	T1017	$376.48
	Registered Nurse	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882	$376.48
	Registered Nurse	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889	$376.48
	Registered Nurse	Administration of patient-focused health risk assessment instrument.	96160	$376.48
	Registered Nurse	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170	$376.48
	Registered Nurse	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	$376.48
	Registered Nurse	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$376.48
	Registered Nurse	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$376.48

	Registered Nurse	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$376.48
	Registered Nurse	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$376.48
	Registered Nurse	Alcohol and/or drug screening. Laboratory analysis	H0003	$376.48
	Registered Nurse	Behavioral health counseling and therapy, 15 minutes.	H0004	$376.48
	Registered Nurse	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$376.48
	Registered Nurse	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$376.48
	Registered Nurse	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	$376.48
	Registered Nurse	Alcohol and/or drug screening	H0049	$376.48
	Registered Nurse	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$376.48
	Registered Nurse	Prenatal Care, at risk assessment.	H1000	$376.48
	Registered Nurse	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$376.48
	Registered Nurse	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	$376.48
	Registered Nurse	Comprehensive community support services, per 15 minutes	H2015	$376.48
	Registered Nurse	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$376.48
	Registered Nurse	Psychoeducational Service, per 15 minutes	H2027	$376.48
	Registered Nurse	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$376.48
	Registered Nurse	Alcohol and/or substance abuse services, family/couple counseling	T1006	$376.48
	Registered Nurse	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$376.48
Narcotic Treatment Program (NTP)	Certified Peer Support Specialist	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$190.55
	Certified Peer Support Specialist	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$190.55

Narcotic Treatment Program (NTP)	Certified/registered AOD Counselor	Interactive Complexity	90785	$200.08
	Certified/registered AOD Counselor	Psychosocial Rehabilitation, per 15 Minutes	H2017	$200.08
	Certified/registered AOD Counselor	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$200.08

	Certified/registered AOD Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$200.08
	Certified/registered AOD Counselor	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$200.08
	Certified/registered AOD Counselor	Behavioral health counseling and therapy, 15 minutes.	H0004	$200.08
	Certified/registered AOD Counselor	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$200.08
	Certified/registered AOD Counselor	Alcohol and/or drug screening	H0049	$200.08
	Certified/registered AOD Counselor	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$200.08
	Certified/registered AOD Counselor	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$200.08
	Certified/registered AOD Counselor	Comprehensive community support services, per 15 minutes	H2015	$200.08
	Certified/registered AOD Counselor	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$200.08
	Certified/registered AOD Counselor	Psychoeducational Service, per 15 minutes	H2027	$200.08
	Certified/registered AOD Counselor	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance abuse services, family/couple counseling	T1006	$200.08
	Certified/registered AOD Counselor	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$200.08
	Licensed Physician	Interactive Complexity	90785	$926.86
	Licensed Physician	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$926.86
	Licensed Physician	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician. Patient and/or Family not Present. 30 Minutes or More	99367	$926.86
	Licensed Physician	Medication Training and Support, per 15 Minutes	H0034	$926.86
	Licensed Physician	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$926.86
	Licensed Physician	Oral Medication Administration, Direct Observation, 15 Minutes	H0033	$926.86
	Licensed Physician	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212	$926.86
	Licensed Physician	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	$926.86
	Licensed Physician	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$926.86
	Licensed Physician	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$926.86
Narcotic Treatment Program (NTP)	Licensed Physician	Psychological Testing Evaluation, Each Additional Hour	96131	$926.86
	Licensed Physician	Psychological Testing Evaluation, First Hour	96130	$926.86
	Licensed Physician	Psychosocial Rehabilitation, per 15 Minutes	H2017	$926.86

	Licensed Physician	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$926.86
	Licensed Physician	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$926.86
	Licensed Physician	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$926.86
	Licensed Physician	Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865	$926.86
	Licensed Physician	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$926.86
	Licensed Physician	Observation Care Discharge Day Management, 15 Minutes	99217	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minutes.	99408	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. Greater than 30 minutes.	99409	$926.86
	Licensed Physician	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495	$926.86
	Licensed Physician	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$926.86
	Licensed Physician	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$926.86
	Licensed Physician	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$926.86
	Licensed Physician	Alcohol and/or drug screening. Laboratory analysis	H0003	$926.86
	Licensed Physician	Behavioral health counseling and therapy, 15 minutes.	H0004	$926.86
	Licensed Physician	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$926.86
	Licensed Physician	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$926.86
	Licensed Physician	Alcohol and/or drug services: (hospital inpatient) Subacute detoxification	H0008	$926.86
	Licensed Physician	Alcohol and/or drug services: (hospital inpatient) Acute detoxification	H0009	$926.86
	Licensed Physician	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	$926.86
	Licensed Physician	Alcohol and/or drug screening	H0049	$926.86
	Licensed Physician	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$926.86
	Licensed Physician	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$926.86
	Licensed Physician	Comprehensive community support services, per 15 minutes	H2015	$926.86

	Licensed Physician	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$926.86
	Licensed Physician	Psychoeducational Service, per 15 minutes	H2027	$926.86

Narcotic Treatment Program (NTP)	Licensed Physician	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$926.86
	Licensed Physician	Alcohol and/or substance abuse services, family/couple counseling	T1006	$926.86
	Licensed Physician	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$926.86
	Licensed/Registered Clinical Social Worker	Interactive Complexity	90785	$241.22
	Licensed/Registered Clinical Social Worker	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$241.22
	Licensed/Registered Clinical Social Worker	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$241.22
	Licensed/Registered Clinical Social Worker	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$241.22
	Licensed/Registered Clinical Social Worker	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$241.22
	Licensed/Registered Clinical Social Worker	Psychosocial Rehabilitation, per 15 Minutes	H2017	$241.22
	Licensed/Registered Clinical Social Worker	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$241.22
	Licensed/Registered Clinical Social Worker	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$241.22
	Licensed/Registered Clinical Social Worker	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$241.22
	Licensed/Registered Clinical Social Worker	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$241.22
	Licensed/Registered Clinical Social Worker	Behavioral health counseling and therapy, 15 minutes.	H0004	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or drug screening	H0049	$241.22

	Licensed/Registered Clinical Social Worker	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$241.22
	Licensed/Registered Clinical Social Worker	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$241.22
	Licensed/Registered Clinical Social Worker	Comprehensive community support services, per 15 minutes	H2015	$241.22
	Licensed/Registered Clinical Social Worker	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$241.22
	Licensed/Registered Clinical Social Worker	Psychoeducational Service, per 15 minutes	H2027	$241.22
Narcotic Treatment Program (NTP)	Licensed/Registered Clinical Social Worker	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or substance abuse services, family/couple counseling	T1006	$241.22
	Licensed/Registered Clinical Social Worker	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$241.22
	Licensed/Registered Marriage Family Therapist	Interactive Complexity	90785	$241.22
	Licensed/Registered Marriage Family Therapist	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$241.22
	Licensed/Registered Marriage Family Therapist	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$241.22
	Licensed/Registered Marriage Family Therapist	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$241.22
	Licensed/Registered Marriage Family Therapist	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$241.22
	Licensed/Registered Marriage Family Therapist	Psychosocial Rehabilitation, per 15 Minutes	H2017	$241.22
	Licensed/Registered Marriage Family Therapist	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$241.22
	Licensed/Registered Marriage Family Therapist	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$241.22
	Licensed/Registered Marriage Family Therapist	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$241.22
	Licensed/Registered Marriage Family Therapist	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$241.22

	Licensed/Registered Marriage Family Therapist	Behavioral health counseling and therapy, 15 minutes.	H0004	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or drug screening	H0049	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$241.22
	Licensed/Registered Marriage Family Therapist	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$241.22
	Licensed/Registered Marriage Family Therapist	Comprehensive community support services, per 15 minutes	H2015	$241.22
	Licensed/Registered Marriage Family Therapist	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$241.22
	Licensed/Registered Marriage Family Therapist	Psychoeducational Service, per 15 minutes	H2027	$241.22

Narcotic Treatment Program (NTP)	Licensed/Registered Marriage Family Therapist	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance abuse services, family/couple counseling	T1006	$241.22
	Licensed/Registered Marriage Family Therapist	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$241.22
	Licensed/Registered Professional Clinical Counselor	Interactive Complexity	90785	$200.08
	Licensed/Registered Professional Clinical Counselor	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$200.08
	Licensed/Registered Professional Clinical Counselor	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$200.08
	Licensed/Registered Professional Clinical Counselor	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$200.08
	Licensed/Registered Professional Clinical Counselor	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$200.08
	Licensed/Registered Professional Clinical Counselor	Psychosocial Rehabilitation, per 15 Minutes	H2017	$200.08
	Licensed/Registered Professional Clinical Counselor	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$200.08
	Licensed/Registered Professional Clinical Counselor	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$200.08
	Licensed/Registered Professional Clinical Counselor	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$200.08
	Licensed/Registered Professional Clinical Counselor	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$200.08

	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$200.08
	Licensed/Registered Professional Clinical Counselor	Behavioral health counseling and therapy, 15 minutes.	H0004	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or drug screening	H0049	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$200.08
	Licensed/Registered Professional Clinical Counselor	Comprehensive community support services, per 15 minutes	H2015	$200.08
Narcotic Treatment Program (NTP)	Licensed/Registered Professional Clinical Counselor	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$200.08
	Licensed/Registered Professional Clinical Counselor	Psychoeducational Service, per 15 minutes	H2027	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance abuse services, family/couple counseling	T1006	$200.08
	Licensed/Registered Professional Clinical Counselor	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$200.08
	Nurse Practitioner	Interactive Complexity	90785	$460.90
	Nurse Practitioner	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$460.90
	Nurse Practitioner	Medication Training and Support, per 15 Minutes	H0034	$460.90
	Nurse Practitioner	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$460.90
	Nurse Practitioner	Oral Medication Administration, Direct Observation, 15 Minutes	H0033	$460.90
	Nurse Practitioner	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212	$460.90
	Nurse Practitioner	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	$460.90

	Nurse Practitioner	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	$460.90
	Nurse Practitioner	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	$460.90
	Nurse Practitioner	Psychological Testing Evaluation, Each Additional Hour	96131	$460.90
	Nurse Practitioner	Psychological Testing Evaluation, First Hour	96130	$460.90
	Nurse Practitioner	Psychosocial Rehabilitation, per 15 Minutes	H2017	$460.90
	Nurse Practitioner	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$460.90
	Nurse Practitioner	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$460.90
	Nurse Practitioner	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$460.90
	Nurse Practitioner	Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865	$460.90
	Nurse Practitioner	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$460.90
	Nurse Practitioner	Observation Care Discharge Day Management, 15 Minutes	99217	$460.90
	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minutes.	99408	$460.90
	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. Greater than 30 minutes.	99409	$460.90
	Nurse Practitioner	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495	$460.90
	Nurse Practitioner	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496	$460.90
	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$460.90
Narcotic Treatment Program (NTP)	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$460.90
	Nurse Practitioner	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$460.90
	Nurse Practitioner	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$460.90
	Nurse Practitioner	Alcohol and/or drug screening. Laboratory analysis	H0003	$460.90
	Nurse Practitioner	Behavioral health counseling and therapy, 15 minutes.	H0004	$460.90
	Nurse Practitioner	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$460.90
	Nurse Practitioner	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$460.90
	Nurse Practitioner	Alcohol and/or drug services: (hospital inpatient) Subacute detoxification	H0008	$460.90
	Nurse Practitioner	Alcohol and/or drug services: (hospital inpatient) Acute detoxification	H0009	$460.90

	Nurse Practitioner	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	$460.90
	Nurse Practitioner	Alcohol and/or drug screening	H0049	$460.90
	Nurse Practitioner	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$460.90
	Nurse Practitioner	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$460.90
	Nurse Practitioner	Comprehensive community support services, per 15 minutes	H2015	$460.90
	Nurse Practitioner	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$460.90
	Nurse Practitioner	Psychoeducational Service, per 15 minutes	H2027	$460.90
	Nurse Practitioner	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$460.90
	Nurse Practitioner	Alcohol and/or substance abuse services, family/couple counseling	T1006	$460.90
	Nurse Practitioner	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$460.90
	Physician Assistant	Interactive Complexity	90785	$415.69
	Physician Assistant	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$415.69
	Physician Assistant	Medication Training and Support, per 15 Minutes	H0034	$415.69
	Physician Assistant	Multiple-Family Group Psychotherapy, 15 Minutes	90849	$415.69
	Physician Assistant	Oral Medication Administration, Direct Observation, 15 Minutes	H0033	$415.69
	Physician Assistant	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212	$415.69
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	Physician Assistant	Psychosocial Rehabilitation, per 15 Minutes	H2017	$415.69
	Physician Assistant	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$415.69
	Physician Assistant	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	$415.69
Narcotic Treatment Program (NTP)	Physician Assistant	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	$415.69
	Physician Assistant	Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865	$415.69
	Physician Assistant	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	$415.69
	Physician Assistant	Observation Care Discharge Day Management, 15 Minutes	99217	$415.69

	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minutes.	99408	$415.69
	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. Greater than 30 minutes.	99409	$415.69
	Physician Assistant	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495	$415.69
	Physician Assistant	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496	$415.69
	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$415.69
	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$415.69
	Physician Assistant	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$415.69
	Physician Assistant	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$415.69
	Physician Assistant	Alcohol and/or drug screening. Laboratory analysis	H0003	$415.69
	Physician Assistant	Behavioral health counseling and therapy, 15 minutes.	H0004	$415.69
	Physician Assistant	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$415.69
	Physician Assistant	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$415.69
	Physician Assistant	Alcohol and/or drug services: (hospital inpatient) Subacute detoxification	H0008	$415.69
	Physician Assistant	Alcohol and/or drug services: (hospital inpatient) Acute detoxification	H0009	$415.69
	Physician Assistant	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	$415.69
	Physician Assistant	Alcohol and/or drug screening	H0049	$415.69
	Physician Assistant	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$415.69
	Physician Assistant	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$415.69
	Physician Assistant	Comprehensive community support services, per 15 minutes	H2015	$415.69
	Physician Assistant	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$415.69
	Physician Assistant	Psychoeducational Service, per 15 minutes	H2027	$415.69
	Physician Assistant	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$415.69
	Physician Assistant	Alcohol and/or substance abuse services, family/couple counseling	T1006	$415.69
	Physician Assistant	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$415.69
	Registered Nurse	Interactive Complexity	90785	$376.48

Narcotic Treatment Program (NTP)	Registered Nurse	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	$376.48
	Registered Nurse	Medication Training and Support, per 15 Minutes	H0034	$376.48
	Registered Nurse	Oral Medication Administration, Direct Observation, 15 Minutes	H0033	$376.48
	Registered Nurse	Psychosocial Rehabilitation, per 15 Minutes	H2017	$376.48
	Registered Nurse	Sign Language or Oral Interpretive Services, 15 Minutes	T1013	$376.48
	Registered Nurse	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	$376.48
	Registered Nurse	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	$376.48
	Registered Nurse	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011	$376.48
	Registered Nurse	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	$376.48
	Registered Nurse	Alcohol and/or drug screening. Laboratory analysis	H0003	$376.48
	Registered Nurse	Behavioral health counseling and therapy, 15 minutes.	H0004	$376.48
	Registered Nurse	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	$376.48
	Registered Nurse	Alcohol and/or drug services; crisis intervention (outpatient),	H0007	$376.48
	Registered Nurse	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	$376.48
	Registered Nurse	Alcohol and/or drug screening	H0049	$376.48
	Registered Nurse	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	$376.48
	Registered Nurse	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	$376.48
	Registered Nurse	Comprehensive community support services, per 15 minutes	H2015	$376.48
	Registered Nurse	Community-Based Wrap-Around Services, per 15 Minutes	H2021	$376.48
	Registered Nurse	Psychoeducational Service, per 15 minutes	H2027	$376.48
	Registered Nurse	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035	$376.48
	Registered Nurse	Alcohol and/or substance abuse services, family/couple counseling	T1006	$376.48
	Registered Nurse	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007	$376.48

ATTACHMENT 1

Contractor agrees to comply with the requirements of "contractors" and "subcontractors" as listed and required per– Program Specifications of the current Standard Agreement between the County of Nevada and the State Department of Health Care Services entered into by the authority of Chapter 3 of Part 1, Division 10.5 of the Health and Safety Code (HSC) and as approved by County's Board of Supervisors for the purpose of providing alcohol and drug treatment services. The provisions are as follows:

A. Additional Contract Restrictions

This Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this Contract in any manner.

B. Nullification of Drug Medi-Cal (DMC) Treatment Program substance use disorder services (if applicable)

The parties agree that if the Contractor fails to comply with the provisions of Welfare and Institutions Code (W&I) Section 14124.24, all areas related to the DMC Treatment Program substance use disorder services shall be null and void and severed from the remainder of this Contract.

In the event the Drug Medi-Cal Treatment Program Services component of this Contract becomes null and void, an updated Exhibit B, Attachment I will take effect reflecting the removal of federal Medicaid funds and DMC State General Funds from this Contract.

All other requirements and conditions of this Contract will remain in effect until amended or terminated.

C. Hatch Act

Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

D. No Unlawful Use or Unlawful Use Messages Regarding Drugs

Contractor agrees that information produced through these funds, and which pertains to drug and alcohol- related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol- related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999- 11999.3). By signing this Contract, Contractor agrees that it will enforce**,** and will require its Subcontractors to enforce, these requirements.

E. Noncompliance with Reporting Requirements

Contractor agrees that the State has the right to withhold payments until Contractor has submitted any required data and reports to the State, as identified in Exhibit A, Attachment I, Part III – Reporting Requirements, or as identified in Document 1F(a), Reporting Requirements Matrix for Counties.

F. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances

None of the funds made available through this Contract may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

G. Debarment and Suspension

Contractor shall advise all subcontractors of their obligation to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 CFR Part 1001.

H. Restriction on Distribution of Sterile Needles

No funds made available through this Contract shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug unless the State chooses to implement a demonstration syringe services program for injecting drug users with Substance Abuse Prevention and Treatment Block Grant (SABG) funds.

I. Health Insurance Portability and Accountability Act (HIPAA) of 1996

If any of the work performed under this Contract is subject to the HIPAA, then Contractor shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit F, the State and County shall cooperate to assure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit F for additional information.

1. Trading Partner Requirements

(a) No Changes. Contractor hereby agrees that for the personal health information (Information), it will not change any definition, data condition or use of a data element or segment as proscribed in the Federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))

(b) No Additions. Contractor hereby agrees that for the Information, it will not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))

(c) No Unauthorized Uses. Contractor hereby agrees that for the Information, it will not use any code or data elements that either are marked “not used” in the HHS Transaction’s Implementation specification or are not in the HHS Transaction Standard’s implementation specifications. (45 CFR Part 162.915 (c))

(d) No Changes to Meaning or Intent. Contractor hereby agrees that for the Information, it will not change the meaning or intent of any of the HHS Transaction Standard’s implementation specification. (45 CFR Part 162.915 (d))

2. Concurrence for Test Modifications to HHS Transaction Standards

Contractor agrees and understands that there exists the possibility that the State or others may request an extension from the uses of a standard in the HHS Transaction Standards. If this occurs, Contractor agrees that it will participate in such test modifications.

3. Adequate Testing

Contractor is responsible to adequately test all business rules appropriate to their types and specialties. If the Contractor is acting as a clearinghouse for enrolled providers, Contractor has obligations to adequately test all business rules appropriate to each and every provider type and specialty for which they provide clearinghouse services.

4. Deficiencies

Contractor agrees to correct transactions errors or deficiencies identified by the State, and transactions errors or deficiencies identified by an enrolled provider if the Contractor is acting as a clearinghouse for that provider. When County is a clearinghouse, Contractor agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

5. Code Set Retention

Both Parties understand and agree to keep open code sets being processed or used in this Agreement for at least the current billing period or any appeal period, whichever is longer.

6. Data Transmission Log

Both Parties shall establish and maintain a Data Transmission Log, which shall record any and all Data Transmission taking place between the Parties during the term of this Contract. Each Party will take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions between the Parties, and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if it is necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

J. Nondiscrimination and Institutional Safeguards for Religious Providers

Contractor shall establish such processes and procedures as necessary to comply with the provisions of Title 42, USC, Section 300x-65 and Title 42, CFR, Part 54, (Reference Document 1B).

K. Counselor Certification

Any counselor providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be registered or certified as defined in Title 9, CCR, Division 4, Chapter 8. (Document 3H)

L. Cultural and Linguistic Proficiency

To ensure equal access to quality care by diverse populations, each service provider receiving funds from this contract shall adopt the Federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V).

M. Intravenous Drug Use (IVDU) Treatment

Contractor shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo alcohol and other drug (AOD) treatment (42 USC 300x-23(45 CFR 96.126(e)).

N. Tuberculosis Treatment

Contractor shall ensure the following related to Tuberculosis (TB):

1. Routinely make available TB services to each individual receiving treatment for AOD use and/or abuse; Reduce barriers to patients' accepting TB treatment; and,
2. Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance.

O. Trafficking Victims Protection Act of 2000

Contractor and its Subcontractors that provide services covered by this Contract shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 United States Code (USC) 7104(g)) as amended by section 1702. The County is authorized to terminate a contract and/or take other remedial action as deemed necessary, without penalty, if the Contractor or any Subcontractor:

1. Engages in severe forms of trafficking in persons during the period of time that the award is in effect;
2. Procures a commercial sex act during the period of time that the award is in effect;
3. Uses forced labor in the performance of the award or subawards under the award.

For full text of the award term, go to: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=2&SID=30cef173ce45f9ae560f5ba6faf646b4&ty=HTML&h=L&n=pt2.1.175&r=PART

P. Tribal Communities and Organizations

Contractor shall regularly assess (e.g. review population information available through Census, compare to information obtained in the California Outcome Measurement System for Treatment (CalOMS Tx) to determine whether the population is being reached, survey Tribal representatives for insight in potential barriers), the substance use service needs of the American Indian/Alaskan Native (AI/AN) population within the County geographic area, and shall engage in regular and meaningful consultation and collaboration with elected officials of the tribe, Rancheria, or their designee for the purpose of identifying issues/barriers to service delivery and improvement of the

quality, effectiveness and accessibility of services available to AI/NA communities within the County.

Q. Participation of County Alcohol and Drug Program Administrators Association of California.

Pursuant to HSC Section 11801(g), the AOD administrator shall participate and represent the county in meetings of the County Alcohol and Drug Program Administrators Association of California for the purposes of representing the counties in their relationship with the state with respect to policies, standards, and administration for AOD abuse services.

Pursuant to HSC Section 11811.5(c), the county alcohol and drug program administrator shall attend any special meetings called by the Director of DHCS.

R. Youth Treatment Guidelines

Contractor will follow the guidelines in Document 1V, incorporated by this reference, "Youth Treatment Guidelines," in developing and implementing youth treatment programs funded under this Exhibit, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this contract is required for new guidelines to apply.

S. Perinatal Services Network Guidelines

Contractor must comply with the perinatal program requirements as outlined in the Perinatal Services Network Guidelines. The Perinatal Services Network Guidelines are attached to this contract as Document 1G, incorporated by reference. The Contractor must comply with the current version of these guidelines until new Perinatal Services Network Guidelines are established and adopted. The incorporation of any new Perinatal Services Network Guidelines into this contract shall not require a formal amendment.

Contractor receiving SABG funds must adhere to the Perinatal Services Network Guidelines, regardless of whether the Contractor exchanges perinatal funds for additional discretionary funds.

T. Restrictions on Grantee Lobbying – Appropriations Act Section 503

No part of any appropriation contained in this Act shall be sued, other than for formal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature, except in presentation to the Congress or any State legislative body itself.

No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

U. Nondiscrimination in Employment and Services

By signing this Contract, Contractor certifies that under the laws of the United States and the State of California, incorporated into this Contract by reference and made a part hereof as if set forth in full, Contractor will not unlawfully discriminate against any person.

V. Federal Law Requirements:

1. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in Federally-funded programs.
2. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
3. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
4. Age Discrimination in Employment Act (29 CFR Part 1625)
5. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment
6. Title II of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities
7. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
8. Section 504 of the Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of handicap
9. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under Federal contracts and construction contracts greater than $10,000 funded by Federal financial assistance
10. Executive Order 13166 (67 FR 41455) to improve access to Federal services for those with limited English proficiency
11. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse
12. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.
13. Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A – E).

W. State Law Requirements:

1. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).
2. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
3. Title 9, Division 4, Chapter 8 of the CCR, commencing with Section 10800
4. No state or Federal funds shall be used by the Contractor or its Subcontractors for sectarian worship, instruction, or proselytization. No state funds shall be used by the

Contractor or its Subcontractors to provide direct, immediate, or substantial support to any religious activity.

5. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Contract or terminate all, or any type, of funding provided hereunder.

X. This Contract is subject to any additional restrictions, limitations, or conditions enacted by the Federal or state governments that affect the provisions, terms, or funding of this Contract in any manner.

Y. Subcontract Provisions

Contractor shall include all of the foregoing provisions in all of its subcontracts.

Z. Dymally-Alatorre Bilingual Services Act (Government Code sections 7290-7299.8).

Contractor shall comply with the linguistic requirements included in this Section.

Contractor shall have:

1. Oral interpreter services available in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the SUD services or related services through that key point of contact. The threshold languages shall be determined on a countywide basis. Counties may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

   (a) The county has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not; and

   (b) The Contractor provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.

2. Policies and procedures in place to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the SUD services or related services available at the key points of contact.

General program literature used by the Contractor to assist beneficiaries in accessing services available in threshold languages, based on the threshold languages in the county as a whole.

EXHIBIT C
INSURANCE REQUIREMENTS
AEGIS TREATMENT CENTERS, LLC.

Insurance. Contractor shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by Contractor, its agents, representatives, or employees. Coverage shall be at least as broad as:

1. **Commercial General Liability (CGL)**: Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than **$2,000,000** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.
2. **Automobile Liability:** Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Contractor has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than **$1,000,000** per accident for bodily injury and property damage.
3. **Workers' Compensation:** Insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than **$1,000,000** per accident for bodily injury or disease.
4. **Professional Liability (Errors and Omissions)** Insurance covering **medical malpractice and social worker** case management malpractice, also sexual molestation/misconduct/abuse, and information privacy coverage with limit no less than **$1,000,000** per occurrence or claim, **$2,000,000** aggregate.

The insurance obligations under this Contract shall be the greater of 1—all the Insurance coverage and limits carried by or available to Contractor; or 2—the minimum Insurance requirements shown in this Contract. Any insurance proceeds in excess of the specified limits and coverage required, which are applicable to a given loss, shall be available to County. No representation is made that the minimum Insurance requirements of this Contract are sufficient to cover the indemnity or other obligations of Contractor under this Contract.

If Contractor maintains broader coverage and/or higher limits than the minimums shown above, County requires and shall be entitled to the broader coverage and/or the higher limits maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to County.

Other Insurance Provisions:
The insurance policies are to contain, or be endorsed to contain, the following provisions:

1. **Additional Insured Status: County, its officers, employees, agents, and volunteers are to be covered as additional insureds** on the CGL policy with respect to liability arising out of the work or operations performed by or on behalf of Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to Contractor's insurance (at least as broad as ISO Form CG 20 10 11 85 or both CG 20 10, CG 20 25, CG 20 33, or CG 20 38; and CG 20 37 forms if later revisions used.)
2. **Primary Coverage** For any claims related to this contract, **Contractor's insurance shall be primary** insurance primary coverage at least as broad as ISO CG 20 01 04 13 as respects County, its officers, employees, agents, and volunteers. Any insurance or self-insurance

maintained by County, its officers, employees, agents, and volunteers shall be excess of Contractor's insurance and shall not contribute with it.

3. **Notice of Cancellation** This policy shall not be changed without first giving thirty (30) days prior written notice and ten (10) days prior written notice of cancellation for non-payment of premium to County.
4. **Waiver of Subrogation** Contractor hereby grants to County a waiver of any right to subrogation which any insurer or said Contractor may acquire against County by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not County has received a waiver of subrogation endorsement from the insurer.
5. **Deductible and Self-Insured Retentions** Deductible and Self-insured retentions must be declared to and approved by County. County may require Contractor to provide proof of ability to pay losses and related investigations, claims administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or County.
6. **Acceptability of Insurers:** Insurance is to be placed with insurers authorized to conduct business in the State with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to County.
7. **Claims Made Policies** if any of the required policies provide coverage on a claims-made basis:
    a. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.
    b. Insurance must be maintained, and evidence of insurance must be provided for at least five (5) years after completion of the contract of work.
    c. If the coverage is canceled or non-renewed, and not replaced with another **claims-made policy form with a Retroactive Date**, prior to the contract effective date, Contractor must purchase "extended reporting" coverage for a minimum of **five (5)** years after completion of contract work.
8. **Verification of Coverage** Contractor shall furnish County with original Certificates of Insurance including all required amendatory endorsements (or copies of the applicable policy language effecting coverage required by this clause) and a copy of the Declarations and Endorsement Page of the CGL policy listing all policy endorsements to County before work begins. However, failure to obtain and provide verification of the required documents prior to the work beginning shall not waive Contractor's obligation to provide them. County reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.
9. **Subcontractors** Contractor shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and Contractor shall ensure that County is an additional insured on insurance required from subcontractors. For CGL coverage subcontractors shall provide coverage with a format at least as broad as CG 20 38 04 13.
10. **Special Risks or Circumstances** County reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.
11. **Conformity of Coverages** If more than one policy is used to meet the required coverages, such as an umbrella policy or excess policy, such policies shall be following form with all other applicable policies used to meet these minimum requirements. For example, all policies shall be Occurrence Liability policies, or all shall be Claims Made Liability policies, if approved by County as noted above. In no cases shall the types of polices be different.
12. **Premium Payments** The insurance companies shall have no recourse against County and funding agencies, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by a mutual insurance company.

13. **Material Breach** Failure of Contractor to maintain the insurance required by this Contract, or to comply with any of the requirements of this section, shall constitute a material breach of the entire Contract.
14. **Certificate Holder** The Certificate Holder on insurance certificates and related documents should read as follows:

    County of Nevada
    950 Maidu Ave.
    Nevada City, CA 95959

    Upon initial award of a Contract to your firm, you may be instructed to send the actual documents to a County contact person for preliminary compliance review.

    Certificates which amend or alter the coverage during the term of the Contract, including updated certificates due to policy renewal, should be sent directly to Contract Administrator.

EXHIBIT D
BEHAVIORAL HEALTH PROVISIONS

TERMS

Article 1. DEFINITIONS

1. BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN)

"Behavioral Health Information Notice" or "BHIN" means guidance from DHCS to inform counties and contractors of changes in policy or procedures at the federal or state levels. These were previously referred to as a Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN). BHINs and MHSUDS INs are available on the DHCS website.

2. BENEFICIARY OR CLIENT
   "Beneficiary" or "client" means the individual(s) receiving services.
3. DHCS
   "DHCS" means the California Department of Health Care Services.
4. DIRECTOR
   "Director" means the Director of the County Behavioral Health Department, unless otherwise specified.

1. NOTICE TO PARTIES
   A. Contractor shall notify County in writing of any change in organizational name, Head of Service or principal business at least 15 business days in advance of the change. DHCS shall certify Contractor to participate in the DMC-ODS program. Contractor cannot reduce or relocate without first receiving approval by DHCS. A DMC certification application shall be submitted to the DHCS Provider Enrollment Division (PED) 60 days prior to the desired effective date of the reduction of covered services or relocation. Contractor shall be subject to continuing certification requirements at least once every five years. Said notice shall become part of this Agreement upon acknowledgment in writing by the County, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.
   B. Contractor must immediately notify County of a change in ownership, organizational status, licensure, or ability of Contractor to provide the quantity or quality of the contracted services in a timely fashion.

2. ENTIRE AGREEMENT

This Agreement, including all schedules, addenda, exhibits and attachments, contains the entire understanding of the Parties in regard to Contractor's provision of the services specified in Exhibit A ("Schedule of Services") and supersedes all prior representations in regard to the same subject matter, whether written or oral.

3. SEVERABILITY

If any provision of this Agreement, or any portion thereof, is found by any court of competent jurisdiction to be unenforceable or invalid for any reason, such provision shall be severable and shall not in any way impair the enforceability of any other provision of this Agreement.

4. CONFORMITY WITH STATE AND FEDERAL LAWS AND REGULATIONS

A. Contractor shall provide services in conformance with all applicable state and federal statues, regulations and subregulatory guidance, as from time to time amended, including but not limited to:

I. California Code of Regulations, Title 9;

II. California Code of Regulations, Title 22;

III. Contractor agrees to comply with the Bronzan-McCorquodale Act (Welfare and Institutions Code, Division 5, 6, and 9, Section 5600 et seq. and Section 4132.44), Title 9 and Title 22 of the California Code of Regulations, Title XIX of the Social Security Act, State Department of Health Care Services Policy Letters, and Title 42 of the Code of Federal Regulations, Sections 434.6 and 438.608 which relate to, concern or affect the Services to be provided under this Contact.

IV. United States Code of Federal Regulations, Title 42, including but not limited to Parts 2, 438 and 455;

V. United States Code of Federal Regulations, Title 45;

VI. United States Code, Title 42 (The Public Health and Welfare), as applicable;

VII. Balanced Budget Act of 1997;

VIII. Health Insurance Portability and Accountability Act (HIPAA); and

IX. Applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance, such as BHINs, MHSUDS INs, and provisions of County's state or federal contracts governing client services.

X. Clean Air Act and Federal Water Pollution Control: Contractor shall comply with the provisions of the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended, which provides that contracts and subcontracts of amounts in excess of $100,000 shall contain a provision that Contractor and any subcontractor shall comply with all applicable standards, orders or regulations issues pursuant to the Clear Air Act and the Federal Water Pollution Control Act. Violations shall be reported to the Centers for Medicare and Medicaid Services.

XI. For the provision of services as provided herein, Contractor shall not employ or contract with providers or other individuals and entities excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act and shall screen all individuals and entities employed or retained to provide services for eligibility to participate in Federal Health Care programs (see http://oig.hhs.gov/exclusions/index.asp and http://files.medical.ca.gov/pubsdoco/SandILanding.asp). Contractor shall check monthly and immediately report to the department if there is a change of status.

XII. Dymally-Alatorre Bilingual Act: Contractor shall comply with all applicable provisions of the Dymally-Alatorre Bilingual Act which requires that state agencies, their contractors, consultants or services providers that serve a substantial number of non-English-speaking people employ a sufficient number of bilingual persons in order to provide certain information and render certain services in a language other than English.

XIII. Byrd Anti-Lobbying Amendment: Contractor certifies that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by

31 USC 1352. Contractor shall also disclose to Department of Health Care Services ("DHCS") any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.

B. In the event any law, regulation, or guidance referred to in subsection (A), above, is amended during the term of this Agreement, the Parties agree to comply with the amended authority as of the effective date of such amendment without amending this Agreement.

Article 2. SERVICES AND ACCESS PROVISIONS

1. CERTIFICATION OF ELIGIBILITY

Contractor will, in cooperation with County, comply with 42 C.F.R. § 455.1(a)(2) and BHIN 23-001, to obtain a certification of a client's eligibility for SUD services under Medi-Cal.

Share of Cost Medi-Cal Beneficiaries

A. Program complies with participant fair hearings, audit process, and DMC Provider Administrative Appeals.
B. Termination of participant attending DMC services occurs only when the participant:
    - Fails to return to the program
    - Transfers to another program
    - Meets program discharge criteria

2. ACCESS TO SUBSTANCE USE DISORDER SERVICES
    A. In collaboration with the County, Contractor will work to ensure that individuals to whom the Contractor provides SUD services meet access criteria and medical necessity requirements, as per DHCS guidance specified in BHIN 23-001. Specifically, the Contractor will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time of service provision as specified below in sections G and H.
    B. Contractor shall have written admission criteria for determining the client's eligibility and suitability for treatment and services. All clients admitted shall meet the admission criteria and this shall be documented in the client's record.
    C. Programs shall ensure that their policies, procedures, practices, and rules and regulations do not discriminate against the above special populations. Whenever the needs of the client cannot be reasonably accommodated, efforts shall be made to make referral(s) to appropriate programs.
    D. Contractor should recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to SUD services.
    E. Contractor will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time-of-service provision as outlined in this Agreement.
    F. The initial assessment shall be performed face-to-face, by telehealth or by telephone by a Licensed Practitioner of the Healing Arts (LPHA) or registered or certified counselor and may be done in the community or the home, except for residential treatment services and narcotic treatment programs (NTPs). If the assessment of the client is completed by a registered or certified counselor, then an LPHA shall evaluate that assessment with the counselor and the LPHA shall make the final diagnosis. The consultation between the LPHA

and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

G. Contractor shall comply with beneficiaries' access criteria and services provided during the initial assessment process requirements:

I. For beneficiaries 21 years of age and older, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered or certified counselor, or Peer Support Specialist (except for residential treatment services)

II. For beneficiaries under the age of 21, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered or certified counselor (except for residential treatment services).

III. For beneficiaries experiencing homelessness and where the provider documents that due to homelessness additional time is required to complete the assessment, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered or certified counselor (except for residential treatment services).

IV. If a client withdraws from treatment prior to completion of the assessment or prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorder, and later returns, the 30-day or 60-day time period starts over.

H. Contractor shall comply with beneficiaries' access criteria after initial assessment requirements:

I. Beneficiaries 21 years of age and older, to qualify for DMC-ODS services after the initial assessment, must meet one of the following criteria:

a. Have at least one diagnosis from the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, OR

b. Have had at least one diagnosis from the most current edition of the DSM for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

II. Beneficiaries under the age of 21, qualify for DMC-ODS medically necessary services after the initial assessment, in the following circumstances:

a. All services that are Medi-Cal-coverable, appropriate, and medically necessary, needed to correct and ameliorate health conditions shall be provided, as per federal Early & Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations.

b. Services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs, consistent with federal guidance.

c. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

3. ASAM LEVEL OF CARE DETERMINATION

A. Contractor shall use the ASAM Criteria to determine placement into the appropriate level of care (LOC) for all beneficiaries, which is separate and distinct from determining medical necessity. LOC determinations shall ensure that beneficiaries are able to receive care in the least restrictive LOC that is clinically appropriate to treat their condition.

B. A full ASAM Criteria assessment and an SUD diagnosis is not required to deliver prevention and early intervention services for beneficiaries under the age of 21; a brief screening ASAM Criteria tool is sufficient for these services.
C. For clients who withdraw from treatment prior to completing the ASAM Criteria assessment or prior to establishing a diagnosis from the DSM for Substance-Related and Addictive Disorders, and later return, the time period for initial assessment starts over.
D. A full ASAM Criteria assessment, or brief screening ASAM Criteria tool for preliminary LOC recommendations, shall not be required to begin receiving DMC-ODS services.
E. A full ASAM Criteria assessment does not need to be repeated unless the client's condition changes.
F. Requirements for ASAM LOC assessments apply to NTP clients and settings.

4. TRANSITION BETWEEN LEVELS OF CARE

Appropriate care coordinators/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, and documenting all information in the client's medical record.

Performance Standard:

a. Transitions between levels of care shall occur within five (5) and no later than ten (10) business days from the time of re-assessment indicating the need for a different level of care.

5. MEDICAL NECESSITY
   A. Pursuant to BHIN 23-001 and consistent with Welfare & Institutions Code § 14059.5, DMC-ODS services must be medically necessary.
   B. For beneficiaries 21 years of age and older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
   C. For beneficiaries under the age of 21, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

6. ADDITIONAL COVERAGE REQUIREMENTS AND CLARIFICATIONS
   A. The target population for DMC-ODS SUD services includes clients who are enrolled in Medi-Cal, reside in the County, and meet the criteria for DMC-ODS services as per established requirements above.
   B. Consistent with Welfare & Institutions Code § 14184.402(f), covered SUD prevention, screening, assessment, treatment, and recovery services are reimbursable Medi-Cal services when:
      I. Services are provided prior to the completion of an assessment or prior to the determination of whether DMC-ODS access criteria are met, or prior to the determination of a diagnosis.

a. Clinically appropriate and covered DMC-ODS services provided to clients over the age of 21 are reimbursable during the assessment process. Similarly, if the assessment determines that the client does not meet the DMC-ODS access criteria after initial assessment, those clinically appropriate and covered DMC-ODS services provided are reimbursable.
b. All Medi-Cal claims shall include a current CMS approved International Classification of Diseases (ICD) diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10 code list, for example, codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services".

II. Prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan, or if the client signature was absent from the treatment plan.
a. While most DMC-ODS providers are expected to adopt problem lists as specified in BHIN 22-019, treatment plans continue to be required for some services in accordance with federal law.
b. Treatment plans are required by federal law for:
i. Narcotic Treatment Programs (NTPs)
ii. Peer Support Services

III. The beneficiary has a co-occurring mental health condition.
a. Medically necessary covered DMC-ODS services delivered by Contractor shall be covered and reimbursable Medi-Cal services whether or not the client has a co-occurring mental health condition.

7. DIAGNOSIS DURING INITIAL ASSESSMENT

A. Contractor may use the following options during the assessment phase of client's treatment when a diagnosis has yet to be established as specified in BHIN 22-013:

I. ICD-10 codes Z55-Z65 Potential health hazards related to socioeconomic and psychological circumstances: may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision, of, an LPHA.

II. ICD-10 code Z03.89 Encounter for observation for other suspected diseases and conditions ruled out: may be used by an LPHA during the assessment phase of a client's treatment when a diagnosis has yet to be established.

III. CMS approved diagnosis code on the ICD 10 tabular, available in the CMS 2022 ICD-10-CM page at: https://www.cms.gov/medicare/icd-10/2022-icd-10-cm, which may include Z codes. LPHAs may use any clinically appropriate ICD-10 code, for example, codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services".

IV. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. *Please note that no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria© assessment.*

8. COVERED SERVICES

Covered services are based on recommendations by an LPHA, within their scope of practice. Services shall be provided by DMC-certified practitioners. Services shall be "medically necessary".

9. COORDINATION AND CONTINUITY OF CARE
   A. Contractor shall comply with the care and coordination requirements established by the County and per 42 C.F.R. § 438.208.
   B. Contractor shall ensure the following related to tuberculosis (TB)
      - Routinely make available TB services to each individual receiving treatment for alcohol and other drug use and/or abuse;
      - Reduce barriers to patients accepting TB treatment and,
      - Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance. (Per State Substance Use Disorder Contract)
   C. Contractor shall ensure that all care, treatment, and services provided pursuant to this Agreement are coordinated among all providers who are serving the client. Coordination and continuity of care procedures shall meet the following requirements:
      I. Ensure that each client has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity.
      II. All services provided to clients shall be coordinated:
         a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
         b. With the services the client receives from any other managed care organization.
         c. With the services the client receives in FFS Medi-Cal.
         d. With the services the client receives from community and social support providers.
      III. Share with other providers serving the client, as allowed by regulations, the results of any identification and assessment of that client's needs to prevent duplication of those activities.
      IV. Ensure that each provider furnishing services to clients maintains and shares, as appropriate, a client health record in accordance with professional standards.
      V. Ensure that in the process of coordinating care, each client's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 subparts A and E and 42 C.F.R. Part 2, to the extent that they are applicable.
   D. Contractor shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.
   E. To facilitate care coordination, Contractor will request a 42 C. F. R. Part 2, HIPAA and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state, and federal privacy laws and regulations.

10. SITE LICENSES, CERTIFICATIONS, PERMITS REQUIREMENTS

A. As specified in BHIN 21-001 and in accordance with Health and Safety Code § 11834.015, DHCS adopted the ASAM treatment criteria as the minimum standard of care for licensed AOD facilities. All licensed AOD facilities shall obtain at least one DHCS LOC Designation and/or at least one residential ASAM LOC Certification consistent with all of its program services. If an AOD facility opts to obtain an ASAM LOC Certification, then that facility will not be required to obtain a DHCS LOC Designation. However, nothing precludes a facility from obtaining both a DHCS LOC Designation and ASAM LOC Certification.
B. Contractor shall obtain and comply with DMC site certification and ASAM designation or DHCS Level of Care Designation for each type of contracted service being delivered, as well as any additional licensure, registration or accreditation required by regulations for the contracted service being delivered.
C. Contractor shall obtain and maintain all appropriate licenses, permits, and certificates required by all applicable federal, state, and county and/or municipal laws, regulations, guidelines, and/or directives.
D. Contractor shall have and maintain a valid fire clearance at the specified service delivery sites where direct services are provided to clients.

11. MEDICATIONS
    A. If Contractor provides or stores medications, the Contractor shall store and monitor medications in compliance with all pertinent statutes and federal standards.
    B. Contractor shall have written policies and procedures regarding the use of prescribed medications by clients, and for monitoring and storing of medications.
    C. Prescription and over the counter medications which expire and other bio-hazardous pharmaceuticals including used syringes or medications which are not removed by the client upon termination of services shall be disposed of by the program director or a designated substitute, and one other adult who is not a client. Both shall sign a record, to be retained for at least one year.
    D. Contractor shall have at least one program staff on duty at all times trained to adequately monitor clients for signs and symptoms of their possible misuse of prescribed medications, adverse medication reactions and related medical complications.

12. ALCOHOL AND/OR DRUG-FREE ENVIRONMENT
    A. Contractor shall provide an alcohol and/or drug-free environment for clients. The use of medications for the treatment of SUD, mental illness, or physical conditions, shall be allowed and controlled as per Contractor's written policies and procedures.
    B. Contractor shall have written policies regarding service delivery for when clients experience relapse episodes. These policies shall be supportive of and consistent with the alcohol and/or drug-free environment of the program.

13. ASSESSMENT OF TOBACCO USE DISORDER
    A. As required by Assembly Bill (AB) 541 and BHIN 22-024, all licensed and/or certified SUD recovery or treatment facilities shall conduct an assessment of tobacco use at the time of the client's initial intake. The assessment shall include questions recommended in the most recent version of Diagnostic and Statistical Manual of Mental Disorders (DSM) under Tobacco Use Disorder, or County's evidence-based guidance, for determining whether a client has a tobacco use disorder.
    B. The licensed and/or certified SUD recovery or treatment facility shall do the following:

I. Provide information to the client on how continued use of tobacco products could affect their long-term success in recovery from SUD.
II. Recommend treatment for tobacco use disorder in the treatment plan.
III. Offer either treatment, subject to the limitation of the license or certification issued by DHCS, or a referral for treatment for tobacco use disorder.

C. Licensed and/or certified SUD recovery or treatment facilities can also adopt tobacco free campus policies, to change the social norm of tobacco use, promote wellness, and reduce exposure to secondhand smoke.

14. NALOXONE REQUIREMENTS

A. As required by AB 381, Health and Safety Code, § 11834.26, and BHIN 22-025, all licensed and/or certified SUD recovery or treatment facilities shall comply with the following requirements:
I. Maintain, at all times, at least 2 unexpired doses of naloxone, or any other opioid antagonist medication that is approved by the FDA for the treatment of an opioid overdose, on the premises of the licensed SUD recovery or treatment facility.
II. Have at least one staff member, at all times when clients are present, on the premises who knows the specific location of the naloxone, or other FDA-approved opioid antagonist medication, and who has been trained in its administration. Training shall include review of online resources and the National Harm Reduction Coalition's Opioid Overdose Basics website to respond effectively to an opioid-associated overdose emergency. Staff shall certify that they have reviewed and undergone training in opioid overdose prevention and treatment.
III. The proof of completion of such training shall be documented in the staff member's individual personnel file, in accordance with California Code of Regulations (CCR), Title 9, § 10564(k).

Article 3. AUTHORIZATION AND DOCUMENTATION PROVISIONS

1. SERVICE AUTHORIZATION

A. Contractor will collaborate with County to complete authorization requests in line with County and DHCS policy.
B. Contractor shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.
C. County shall provide Contractor with written notice of authorization determinations within the timeframes set forth in BHIN 23-001, or any subsequent DHCS notices.
D. For SUD Non-Residential and Non-Inpatient Levels of Care service authorization:
I. Contractor shall follow County's policies and procedures around non-residential/non-inpatient levels of care according to BHIN 23-001.
II. Contractor is not required to obtain service authorization for non-residential/non-inpatient levels of care. Prior authorization is prohibited for non-residential DMC-ODS services.
E. For SUD Residential and Inpatient Levels of Care service authorization:
I. Contractor shall have in place, and follow, County written authorization policies and procedures for processing requests for initial and continuing authorization, or prior authorization, for residential treatment services, including inpatient services, but excluding withdrawal management services.

II. County will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.

III. Prior authorization for residential and inpatient services (excluding withdrawal management services) shall be made within 24 hours of the prior authorization request being submitted by the provider.

a. County will ensure that prior authorization processes are completed in a manner that assures the provision of a covered SUD service to a client in a timely manner appropriate for the client's condition.

IV. Contractor shall alert County when an expediated service authorization decision is necessary due to a client's specific needs and circumstances that could seriously jeopardize the client's life or health, or ability to attain, maintain, or regain maximum function. Expediated service authorizations shall not exceed 72 hours after receipt of the request for service, with a possible extension of up to 14 calendar days if the client or provider requests an extension.

V. Contractor shall alert County when a standard authorization decision is necessary. Standard service authorizations shall not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the client or provider requests an extension.

F. Contractor, if applicable, shall ensure that length of stay (LOS) in residential program complies with the following:

I. LOS shall be determined by individualized clinical need (statewide LOS goal is 30 days). LOS for clients shall be determined by an LPHA and authorized by the County as medically necessary.

II. Clients receiving residential treatment must be transitioned to another LOC when clinically appropriate based on treatment progress.

III. Perinatal clients may receive a longer LOS than those described above, if determined to be medically necessary.

IV. Nothing in this section overrides any EPSDT requirements. EPSDT clients may receive a longer length of stay based on medical necessity.

2. DOCUMENTATION REQUIREMENTS

G. Contractor agrees to comply with documentation requirements for non-hospital services as specified in Article 4.2-4.9 inclusive in compliance with federal, state and County requirements.

H. All Contractor documentation shall be accurate, complete, legible, and shall list each date of service. Contractor shall document the face-to-face duration of the service, including travel and documentation time for each service. Services must be identified as provided in-person, by telephone, or by telehealth.

I. All services shall be documented utilizing County-approved templates and contain all required elements. Contractor agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between County and DHCS. Failure to comply with documentation standards specified in this Article require corrective action plans.

3. ASSESSMENT

J. Contractor shall use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC-ODS clients to determine the appropriate level of SUD care.

K. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature. Assessment shall include the provider's LOC determination and recommendation for services. If the assessment of the client is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.
L. The problem list and progress note requirements shall support the medically necessary services or medical necessity of each service provided.
M. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes. Additional information on assessment requirements can be found in Article 3 Section 2 Access to Substance Use Disorder Services or BHIN 23-001.

4. ICD-10

N. Contractor shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.
O. Once a DSM diagnosis is determined, the Contractor shall determine the corresponding diagnosis in the current edition of ICD. Contractor shall use the ICD diagnosis code(s) to submit a claim for SUD services to receive reimbursement from County.
P. Under the EPSDT mandate, for youth under the age of 21, a diagnosis from the ICD-10 for Substance-Related and Addictive Disorders is not required for early intervention services.
Q. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by DHCS.

5. PROBLEM LIST

R. Contractor will create and maintain a Problem List for each client served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
S. Contractor must document a problem list that adheres to industry standards utilizing at minimum SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, March 2021 Release, and ICD-10-CM 2023.
T. A problem identified during a service encounter may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.
U. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client.
V. The problem list shall include, but is not limited to the following:
   I. Diagnoses identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
   II. Problems identified by a provider acting within their scope of practice, if any.
   III. Problems or illnesses identified by the client and/or significant support person, if any.

IV. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

W. Contractor shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.

X. County does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, Contractor shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the client, in accordance with generally accepted standards of practice and in specific circumstances specified in BHIN 22-019.

2. PROGRESS NOTES

A. Contractor shall create progress notes for the provision of all DMC-ODS services provided under this Agreement.

B. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

C. Progress notes shall include all elements specified in BHIN 22-019, whether the note be for an individual or group service, and shall include:

I. The type of service rendered

II. A narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)

III. The date that the service was provided to the beneficiary

IV. Duration of the service

V. Location of the client at the time of receiving the service

VI. A typed or legibly printed name, signature of the service provider and date of signature

VII. ICD-10 code

VIII. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code

IX. Next steps, including, but not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with other provider(s) and any update to the problem list as appropriate.

D. Contractor shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

E. Contractor shall complete a daily progress note for services that are billed on a daily basis, such as residential and inpatient services, if applicable.

F. When a group service is rendered by the Contractor, the following conditions shall be met:

I. A list of participants is required to be documented and maintained by the Contractor.

II. If more than one provider renders a group service, one progress note may be completed for a group session and signed by one provider. Contractor shall ensure that in this case, the progress note clearly documents the specific involvement and the specific amount of time of involvement of each provider during the group activity, including documentation time.

6. PLAN OF CARE

A. As specified in BHIN 22-019, when a plan of care is required, Contractor shall follow the DHCS requirements outlined in the Alcohol and/or Other Drug Program Certification Standards document, available in the DHCS Facility Certification page at: https://www.dhcs.ca.gov/provgovpart/Pages/Licensing-and-Certification-Facility-Certification.aspx

B. Contractor shall develop plans of care for all clients, when required, and these plans of care shall include the following:
   I. Statement of problems experienced by the client to be addressed.
   II. Statement of objectives to be reached that address each problem.
   III. Statement of actions that will be taken by the program and/or client to accomplish the identified objectives.
   IV. Target date(s) for accomplishment of actions and objectives.

C. Contractor shall develop the plan of care with participation from the client in accordance with the timeframes specified below:
   I. For outpatient programs, the plan of care shall be developed within 30 calendar days from the date of the client's admission. The client's progress shall be reviewed and documented within 30 calendar days after signing the plan of care and not later than every 30 calendar days thereafter.
   II. For residential programs, the plan of care shall be developed within 10 calendar days from the date of the client's admission.
   III. An LPHA, registered or certified counselor shall ensure and document, that together with the client, the plan of care is reviewed and updated, as necessary, when a change in problem identification or focus of treatment occurs, or no later than 90 calendar days after signing the plan of care and no later than every 90 calendar days thereafter, whichever comes first.

D. Contractor is not required to complete a plan of care for clients under this Agreement, except in the below circumstances:
   I. Peer Support Services require a specific care plan based on an approved Plan of Care. The plan of care shall be documented within the progress notes in the client's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.
   II. Narcotic Treatment Programs (NTP) are required to create a plan of care for clients as per federal law. This requirement is not impacted by the documentation requirements in BHIN 22-019. NTPs shall continue to comply with federal and state regulations regarding plans of care and documentation requirements.

3. TELEHEALTH

A. Contractor may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.

B. All telehealth equipment and service locations must ensure that client confidentiality is maintained.

C. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.

D. Medical records for clients served by Contractor under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Contractor. Such consent must be obtained at least once prior to initiating applicable health care services and consent must include all elements as specified in BHIN 22-019.
E. County may at any time audit Contractor's telehealth practices, and Contractor must allow access to all materials needed to adequately monitor Contractor's adherence to telehealth standards and requirements.

4. DISCHARGE PLANNING
    A. Contractor shall have written policies and procedures or shall adopt the County's policies and procedures regarding discharge. These procedures shall contain the following:
        I. Written criteria for discharge defining:
            a. Successful completion of program;
            b. Administrative discharge;
            c. Involuntary discharge;
            d. Transfers and referrals.
        II. A discharge summary that includes:
            a. The duration of the beneficiary's treatment as determined by the dates of admission to the discharge from treatment.
            b. Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;
            c. Description of treatment episodes;
            d. Description of recovery services completed;
            e. Current alcohol and/or other drug usage;
            f. Vocational and educational achievements;
            g. Client's continuing recovery or discharge plan signed by an LPHA, or registered or certified counselor and client;
            h. Beneficiary's prognosis
            i. Transfers and referrals; and
            j. Client's comments.

Article 4. CHART AUDITING AND REASONS FOR RECOUPMENT

MAINTENANCE OF RECORDS

A. Contractor shall maintain proper clinical and fiscal records relating to clients served under the terms of this Agreement, as required by the Director, DHCS, and all applicable state and federal statutes and regulations. Client records shall include but not be limited to admission records, diagnostic studies and evaluations, client interviews and progress notes, and records of services provided. All such records shall be maintained in sufficient detail to permit evaluation of the services provided and to meet claiming requirements.
B. RETENTION OF RECORDS: Except as provided below, Contractor shall maintain and preserve all clinical records related to this Contract for seven (7) years from the date of discharge for adult clients, and records of clients under the age of eighteen (18) at the time of treatment must be retained until either one (1) year beyond the clients eighteenth (18th) birthday or for a period of seven (7) years from the date of discharge, whichever is later. Psychologists' records involving

minors must be kept until the minor's 25th birthday. Contractor shall also contractually require the maintenance of such records in the possession of any third party performing work related to this Contract for the same period of time. Such records shall be retained beyond the seven year period, if any audit involving such records is then pending, until the audit findings are resolved. The obligation to ensure the maintenance of the records beyond the initial seven year period shall arise only if County notifies Contractor of the commencement of an audit prior to the expiration of the seven year period.

C. To the extent Contractor is a Managed Care Organization ("MCO"), a Prepaid Inpatient Health Plan, a Prepaid Ambulatory Health Plan ("PAHP"), or a Medi-Cal services provider, Contractor shall maintain and preserve all records related to this contract for ten (10) years from the start date of this Contract, pursuant to CFR 42 438.3(u). If the client or patient is a minor, the client's or patient's health service records shall be retained for a minimum of ten (10) years from the close of the State fiscal year in which the Contract was in effect, or the date the client or patient reaches 18 years of age, whichever is longer, regardless of when services were terminated with the client. Health service records may be retained in either a written or an electronic format. Contractor shall also contractually require the maintenance of such records in the possession of any third party performing work related to this contract for the same period of time. Such records shall be retained beyond the ten (10) year period if any audit involving such records is then pending, and until the audit findings are resolved. The obligation to ensure the maintenance of the records beyond the initial ten (10) year period shall arise only if County notifies Contractor of the commencement of an audit prior to the expiration of the ten (10) year period.

D. CalMHSA Streamline SmartCare Electronic Health Record: As the department is implementing and will go live with the CalMHSA Streamline SmartCare products for an Electronic Health Records System, the Contractor shall be required to use the Streamline SmartCare product functionality that is relevant to the scope of work of this contract, as requested by the County. This may include the following Streamline SmartCare functionality: use of the Billing System, client chart, physician or nursing specific home pages, E-Prescribing, other clinical documentation, and any other Electronic Health Record data collection necessary for the County to meet billing and quality assurance goals. The Contractor shall receive training as needed to be able to comply with this requirement and will be required to complete CalMHSA Learning Management System Modules specific to the Streamline SmartCare product prior to being able to enter into the system.

1. ACCESS TO RECORDS

A. LOCATION / OWNERSHIP OF RECORDS: If Contractor works primarily in a County facility, records shall be kept in County's facility and owned by County. If Contractor works in another facility or a school setting, the records shall be owned and kept by Contractor and upon demand by County, a copy of all original records shall be delivered to County within a reasonable time from the conclusion of this Contract.

B. Contractor shall provide County with access to all documentation of services provided under this Agreement for County's use in administering this Agreement. Contractor shall allow County, CMS, the Office of the Inspector General, the Controller General of the United States, and any other authorized federal and state agencies to evaluate performance under this Agreement, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the

Contractor pertaining to such services at any time and as otherwise required under this Agreement.

C. COPIES OF RECORDS: Upon termination of this Contract, Contractor agrees to cooperate with client/patients, County and subsequent providers with respect to the orderly and prompt transfer of client or patient records. This Contract does not preclude Contractor from assessing reasonable charges for the expense of transferring such records if appropriate. Said charges shall be twenty-five Cents ($0.25) per page, plus the cost of labor, not to exceed Sixteen Dollars ($16.00) per hour or pro rata fraction thereof, for actual time required to photocopy said records.

FEDERAL, STATE AND COUNTY AUDITS

In accordance with 42 C.F.R. § 438.66 and as applicable with 42 C.F.R. §§ 438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq., County will conduct monitoring and oversight activities to review the Contractor's SUD programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, who meet medical necessity and criteria for access to DMC-ODS as established in BHIN 23-001, in compliance with the applicable state and federal laws and regulations, and/or the terms of the Agreement between Contractor and County, and future BHINs which may spell out other specific requirements.

INTERNAL AUDITING

A. Contractors of sufficient size as determined by County shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a minimum a system for verifying that all services provided and claimed for reimbursement shall meet DMC-ODS definitions and be documented accurately.
B. Contractor shall have a method to verify whether services billed to Medi-Cal were actually furnished to Medi-Cal beneficiaries. Contractor's verification method shall be based on random samples and will specify the percentage of total services provided that shall be verified. Contractor's verification process shall be submitted to and approved by the NCBH Quality Assurance Manager**.** Contractor will report the outcome of service verification activities to the NCBH Quality Assurance Manager quarterly. Contractor shall provide County with notification and a summary of any internal audit exceptions and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Contractor's internal audit process. Contractor shall provide this notification and summary to County in a timely manner.

CONFIDENTIALITY IN AUDIT PROCESS

A. Contractor and County mutually agree to maintain the confidentiality of Contractor's client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA, 42 CFR Part 2, and California Welfare and Institutions Code, § 5328, to the extent that these requirements are applicable. Contractor shall inform all of its officers, employees and agents of the confidentiality provisions of all applicable statutes.
B. Contractor's fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with standard procedures and accounting principles.

C. Contractor's records shall be maintained as required by the Director and DHCS on forms furnished by DHCS or the County, or as approved by the County. All statistical data or information requested by the Director shall be provided by the Contractor in a complete and timely manner.

1. REASONS FOR RECOUPMENT
   A. County will conduct periodic audits of Contractor files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and county regulations.
   B. Such audits may result in requirements for Contractor to reimburse County for services previously paid in the following circumstances:
      I. Identification of Fraud, Waste or Abuse as defined in federal regulation.
         a. Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and Welfare & Institutions Code, § 14107.11, subdivision (d).
         b. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.
      II. Overpayment of Contractor by County due to errors in claiming or documentation.
   C. Contractor shall reimburse County for all overpayments identified by Contractor, County and/or state or federal oversight agencies as an audit exception within the timeframes required by law or Country or state or federal agency.

2. COOPERATION WITH AUDITS
   A. Contractor shall cooperate with County in any review and/or audit initiated by County, DHCS, or any other applicable regulatory body. This cooperation may include such activities as onsite program, fiscal, or chart reviews and/or audits.
   B. In addition, Contractor shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.
   C. Contractor shall notify the County of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. County shall reserve the right to attend any or all parts of external review processes.
   D. Contractor shall allow inspection, evaluation and audit of its records, documents and facilities for 10 years from the term end date of this Agreement or in the event Contractor has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii).
   E. Contractor shall comply with findings and recommendations of any audits; certification process and / or state reviews.

Article 5. CLIENT PROTECTIONS

1. GRIEVANCES, APPEALS AND NOTICES OF ADVERSE BENEFIT DETERMINATION
   A. Contractor shall inform Medi-Cal Beneficiaries of their rights regarding appeals and grievances. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).
   B. All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by Contractor must be immediately forwarded to the County's Quality Management Department or other

designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.

C. Contractor shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
D. Aligned with MHSUDS 18-010E and 42 C.F.R. § 438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by Contractors within the specified timeframes using the template provided by the County.
E. Contractor shall immediately notify the County in writing of any actions that may require a NOABD be issued, including, but not limited to:
    - not meeting timely access standards
    - not meeting medical necessity for any substance use disorder treatment services
    - Terminating or reducing authorized covered services.
F. NOABDs must be issued to clients anytime the Contractor has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice must have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. The Contractor must inform the County immediately after issuing a NOABD. The Contractor must use the County approved NOABD forms.
A. Contractor must provide clients with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.
B. Contractor must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

2. ADVANCED DIRECTIVES

Contractor must comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 422.128 and 438.6(i) (l), (3) and (4).

3. TRANSITION OF CARE

A. Contractor shall follow County's transition of care policy in accordance with applicable state and federal regulations, MHSUDS IN 18-051: DMC-ODS Transition of Care Policy, and any BHINs issued by DHCS for parity in SUD and mental health benefits subsequent to the effective date of this Agreement (42 C.F.R. § 438.62(b)(1)-(2).)
B. Clients shall be allowed to continue receiving covered DMC-ODS services with an out-of-network provider when their assessment determines that, in the absence of continued services, the client would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. DMC-ODS treatment services with the existing provider (out-of-network) provider shall continue for a period of no more than 90 days unless medical necessity requires the services to continue for a longer period of time, not exceeding 12 months. Specific criteria must be met (please see transition of care request criteria 1-6 on page 2 of MHSUDS Information Notice 18-051 available on DHCS Forms and Pubs Website)
C. Denial of Service, Involuntary Discharge from Service, or Reduction of Service

a. Contractor shall inform all beneficiaries of their right to a Fair Hearing related to denial, involuntary discharge, or reduction in Drug Medi-Cal substance abuse services as it relates to their eligibility or benefits.
    i. Contractor shall advise beneficiaries in writing at least 10 days prior to the effective date of the intended action to deny, reduce or terminate services. The written notice shall include:
        1. Statement of Action the Contractor intends to take.
        2. Reason for intended action.
        3. A citation of the specific regulation(s) supporting intended action.
        4. Explanation of beneficiary's right to a Fair Hearing for the purpose of appealing intended action.
        5. An explanation that the beneficiary may request a Fair Hearing by submitting a written request to:

            California Department of Social Service State Hearings Division
            P.O. Box 944243, MS 9-17-37
            Sacramento, CA 94244-2430
            Telephone: 1-800-952-525 T.D.: 1-800-952-8349

        6. An explanation that the Contractor shall continue treatment services pending a Fair Hearing decision only if the beneficiary appeals in writing to the Department of Social Services for a hearing within 10 calendar days of the mailing or personal delivery of the notice of intended action.

4. ADVERTISING REQUIREMENTS
    A. Contractor, to protect the health, safety, and welfare of clients with a SUD, shall not use false or misleading advertisement for their medical treatment or medical services as per SB 434 Health and Safety Code § 11831.9 and BHIN 22-022.
    B. Licensed SUD recovery or treatment facilities and certified alcohol or other drug programs shall not do any of the following:
        I. Make a false or misleading statement or provide false or misleading information about the entity's products, goods, services, or geographical locations in its marketing, advertising materials, or media, or on its internet website or on a third-party internet website.
        II. Include on its internet website a picture, description, staff information, or the location of an entity, along with false contact information that surreptitiously directs the reader to a business that does not have a contract with the entity.
        III. Include on its internet website false information or an electronic link that provides false information or surreptitiously directs the reader to another internet website.
    C. Contractor shall comply with these requirements and any subsequent regulations around advertising requirements for SUD recovery or treatment facilities issued by DHCS.

ORIENTATION, TRAINING AND TECHNICAL ASSISTANCE

A. County will endeavor to provide Contractor with training and support in the skills and competencies to (a) conduct, participate in, and sustain the performance levels called for in the Agreement and (b) conduct the quality management activities called for by the Agreement.

B. County will provide the Contractor with all applicable standards for the delivery and accurate documentation of services.
C. County will make ongoing technical assistance available in the form of direct consultation to Contractor upon Contractor's request to the extent that County has capacity and capability to provide this assistance. In doing so, the County is not relieving Contractor of its duty to provide training and supervision to its staff or to ensure that its activities comply with applicable regulations and other requirements included in the terms and conditions of this Agreement.
D. Any requests for technical assistance by Contractor regarding any part of this Agreement shall be directed to the County's designated contract monitor.
E. Contractor shall require all new employees in positions designated as "covered individuals" to complete compliance training within the first 30 days of their first day of work. Contractor shall require all covered individuals to attend, at minimum, one compliance training annually.
    I. These trainings shall be conducted by County or, at County's discretion, by Contractor staff, or both, and may address any standards contained in this Agreement.
    II. Covered individuals who are subject to this training are any Contractor staff who have or will have responsibility for, or who supervises any staff who have responsibility for, ordering, prescribing, providing, or documenting client care or medical items or services.
F. Contractor shall require that physicians receive a minimum of five hours of continuing medical education related to addiction medicine each year.
G. Contractor shall require that professional staff (LPHAs) receive a minimum of five hours of continuing education related to addiction medicine each year.
H. Additional Requirements
    A. Applicable staff are required to participate in the following training:
        i. DMC ODS overview and documentation training (annually)
        ii. Information Privacy and Security (At least annually)
        iii. ASAM E-modules 1 and 2
    B. All direct treatment staff will complete the ASAM E-modules 1 and 2 upon hire and prior to delivering services. All service providers using the ASAM criteria to determine Level of Care will complete an annual refresher.
    C. Cultural Competency (At least annually)
    D. All LPHA staff is required to complete a minimum of five (5) hours of continuing education related to addiction medicine each year.
    E. All direct treatment staff will attend at least two of the following Evidence-Based Practices (EBPs) each year:
        - Motivational Interviewing
        - Relapse Prevention
        - Trauma Focused Care
        - Seeking Safety
        - Cognitive Behavioral Therapy
        - Matrix Model

Article 6. PROGRAM INTEGRITY

1. GENERAL

As a condition of receiving payment under a Medi-Cal managed care program, the Contractor shall comply with the provisions of 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610. (42 C.F.R. § 438.600 (b)).

2. ASAM STANDARDS OF CARE
   A. In accordance with Health and Safety Code section 111834.015, DHCS has adopted the ASAM treatment criteria, or other equivalent evidenced based criteria as the minimum standard of care for AOD facilities.
   B. For this Agreement and subsequential services, Contractor shall adopt ASAM as the evidenced based practice standard for LOC.
   C. Contractor shall ensure treatment staff of all SUD treatment programs receive adequate training in ASAM criteria prior to providing services that includes but is not limited to in person or e-training modules:
      I. ASAM Module I- Multidimensional Assessment
      II. ASAM Module II- From Assessment to Service Planning and Level of Care
      III. ASAM Module III-Introduction to the ASAM Criteria

3. CREDENTIALING AND RE-CREDENTIALING OF PROVIDERS
   A. Contractors must follow the uniform process for credentialing and recredentialing of network providers established by County, including disciplinary actions such reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.
   B. Upon request, the Contractor must demonstrate to the County that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waivered, and/or certified.
   C. Contractor must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. See relevant section below regarding specific requirements for exclusion monitoring.
   D. Contractors shall ensure that all of their network providers, delivering covered services, sign and date an attestation statement on a form provided by County, in which each provider attests to the following:
      I. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
      II. A history of loss of license or felony convictions;
      III. A history of loss or limitation of privileges or disciplinary activity;
      IV. A lack of present illegal drug use; and
      V. The application's accuracy and completeness
   E. Contractor must file and keep track of attestation statements for all of their providers and must make those available to the County upon request at any time.
   F. Contractor is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow County's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.
   G. Contractor is required to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements as per the County's uniform process for credentialing and recredentialing. If any of the requirements are not up-to-date, updated information should be obtained from network providers to complete the re-credentialing process.

4. SCREENING AND ENROLLMENT REQUIREMENTS
   A. County shall ensure that all Contractor providers are enrolled with the state as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455, subparts B and E. (42 C.F.R. § 438.608(b)).
   B. County may execute this Agreement, pending the outcome of screening, enrollment, and revalidation of Contractor, of up to 120 days but must terminate this Agreement immediately upon determination that Contractor cannot be enrolled, or the expiration of one 120-day period without enrollment of the Contractor, and notify affected clients (42 C.F.R. § 438.602(b)(2)).
   C. Contractor shall ensure that all Providers and/or subcontracted Providers consent to a criminal background check, including fingerprinting to the extent required under state law and 42 C.F.R. § 455.434(a). Contractor shall provide evidence of completed consents when requested by the County, DHCS or the US Department of Health & Human Services (US DHHS).

5. PROVIDER APPLICATION AND VALIDATION FOR ENROLLMENT (PAVE)

Contractor shall ensure that all of its required clinical staff, who are rendering SUD services to Medi-Cal clients on behalf of Contractor, are registered through DHCS' Provider Application and Validation for Enrollment (PAVE) portal, pursuant to DHCS requirements, the 21st Century Cures Act, and the CMS Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule.

6. COMPLIANCE PROGRAM, INCLUDING FRAUD PREVENTION AND OVERPAYMENTS
   A. Contractor shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. § 438.608 (a)(1), that must include:
      I. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable federal and state requirements.
      II. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the CEO and the Board of Directors.
      III. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.
      IV. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.
      V. Effective lines of communication between the Compliance Officer and the organization's employees.
      VI. Enforcement of standards through well-publicized disciplinary guidelines.
      VII. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.

VIII. The requirement for prompt reporting and repayment of any overpayments identified.

B. Contractor must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Contractor must report fraud and abuse information to the County including but not limited to:
   I. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7),
   II. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42C.F.R. § 438.608(a), (a)(2).
   III. Information about change in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. § 438.608(a)(3).
   IV. Information about a change in the Contractor's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the Contractor as per 42 C.F.R. § 438.608 (a)(6).
C. Contractor shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
D. Contractor shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.
E. County may suspend payments to Contractor if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. (42 C.F.R. § 438.608 (a)(8)).
F. Contractor shall report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Contractor shall return any overpayments to the County within 30 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)). County shall maintain the right to suspend payments to Contractor when County determines there is a credible allegation of fraud. Contractor shall comply with County's retention policies for the treatment of recoveries of all overpayments from Contractor, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

7. INTEGRITY DISCLOSURES
   A. Contractor shall provide information on ownership and controlling interests, disclosures related to business transactions, and disclosures related to persons convicted of crimes in the form and manner requested by the County, by the Effective Date, each time the Agreement is renewed and within 35 days of any change in ownership or controlling interest of Contractor. (42 C.F.R. §§ 455.104, 455.105, and 455.106)
   B. Upon the execution of this Agreement, Contractor shall furnish County a Provider Disclosure Statement, which, upon receipt by County, shall be kept on file with County and may be disclosed to DHCS. If there are any changes to the information disclosed in the Provider Disclosure Statement, an updated statement should be completed and submitted to the County within 35 days of the change. (42 C.F.R. § 455.104).
   C. Contractor must disclose the following information as requested in the Provider Disclosure Statement:
      I. Disclosure of 5% or More Ownership Interest:

a. In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security Number must be disclosed.
b. In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.
c. For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.
d. For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Agreement. (42 C.F.R. § 455.434)

II. Disclosures Related to Business Transactions:
a. The ownership of any subcontractor with whom Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.
b. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)

III. Disclosures Related to Persons Convicted of Crimes:
a. The identity of any person who has an ownership or control interest in the Contractor or is an agent or managing employee of the Contractor who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)
b. County shall terminate the enrollment of Contractor if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.

D. Contractor must provide disclosure upon execution of Contract, extension for renewal, and within 35 days after any change in Contractor ownership or upon request of County. County may refuse to enter into an Agreement or terminate an existing Agreement with a Contractor if the Contractor fails to disclose ownership and control interest information, information related to business transactions and information on persons convicted of crimes, or if the Contractor did not fully and accurately make the disclosure as required.
E. Contractor must provide the County with written disclosure of any prohibited affiliations under 42 C.F.R. § 438.610. Contractor must not employ or subcontract with providers or have other relationships with providers Excluded from participating in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610.

8. CERTIFICATION OF NON-EXCLUSION OR SUSPENSION FROM PARTICIPATION IN A FEDERAL HEALTH CARE PROGRAM

A. Prior to the effective date of this Agreement, the Contractor must certify that it is not excluded from participation in Federal Health Care Programs under either section 1128 or 1128A of the Social Security Act. Failure to certify will render all provisions of this Agreement null and void and may result in the immediate termination of the Agreement.
B. Contractor shall certify, prior to the execution of the Contract, that the Contractor does not employ or subcontract with providers or have other relationships with providers Excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. Contractor shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:
    I. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
    II. www.sam.gov/portal/SAM - GSA Exclusions Extract
    III. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
    IV. https://nppes.cms.hhs.gov/#/ - National Plan and Provider Enumeration System (NPPES)
    V. any other database required by DHCS or DHHS.
C. Contractor shall certify, prior to the execution of the Agreement, that Contractor does not employ staff or individual contractors/vendors that are on the Social Security Administration's Death Master File. Contractor shall check the following database prior to employing staff or individual contractors/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS.
    I. https://www.ssdmf.com/ - Social Security Death Master File
D. Contractor is required to notify County immediately if Contractor becomes aware of any information that may indicate their (including employees/staff and individual contractors/vendors) potential placement on an exclusions list.
E. Contractor shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
F. Contractor must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.
G. If a Contractor finds a provider that is Excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). Contractor shall not certify or pay any Excluded provider with Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.

Article 7. QUALITY IMPROVEMENT PROGRAM

1. QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION
    A. Contractor shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.
    B. Contractor shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in relation to state and federal requirements and responsibilities, to improve health outcomes and clients'

satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. Contractor shall measure, monitor, and annually report to the County its performance.

C. Contractor shall implement mechanisms to assess client/family satisfaction based on County's guidance. The Contractor shall assess client/family satisfaction by:
    I. Surveying client/family satisfaction with the Contractor's services at least annually.
    II. Evaluating client grievances, appeals and State Hearings at least annually.
    III. Evaluating requests to change persons providing services at least annually.
    IV. Informing the County and clients of the results of client/family satisfaction activities.
D. Contractor, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.
E. Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually and shared with the County.
F. Contractor shall collaborate with County to create a QI Work Plan with documented annual evaluations and documented revisions as needed. The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.
G. Contractor shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. Contractor shall ensure that there is active participation by the Contractor's practitioners and providers in the QIC.
H. Contractor shall assist County, as needed, with the development and implementation of Corrective Action Plans.
I. Contractor shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

2. NETWORK ADEQUACY
    A. Contractor shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. § 438.206 (a),(c)).
    B. Contractor shall submit, when requested by County and in a manner and format determined by the County, network adequacy certification information to County, utilizing a provided template or other designated format.

C. Contractor shall submit updated network adequacy information to the County any time there has been a significant change that would affect the adequacy and capacity of services. Significant changes include, but are not limited to, changes in services or providers available to clients, and changes in geographic service area.

3. TIMELY ACCESS
   A. Contractor shall comply with the requirements set forth in CCR, Title 9, § 1810.405, including meeting County and State Contract standards for timely access to care and services, taking into account the urgency of the need for services. County shall monitor Contractor to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.
   B. Timely access standards include:
      I. Contractors must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the Contractor offers services to non-Medi-Cal clients. If the Contractor's provider only serves Medi-Cal clients, the provider must provide hours of operation comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the Agreement or another County.
      II. Appointments data, including wait times for requested services, must be recorded and tracked by Contractor, and submitted to the County on a monthly basis in a format specified by the County. Appointments' data should be submitted to the County's Quality Management department or other designated persons.
      III. Contractor shall ensure that all clients seeking NTP services are provided with an appointment within three (3) business days of a service request.
      IV. Contractor shall ensure that all clients seeking outpatient and intensive outpatient (non-NTP) services are provided with an appointment within ten (10) business days of a non-NTP service request.
      V. Contractor shall ensure that all clients seeking non-urgent appointments with a non-physician SUD provider are provided within ten (10) business days of the request for the appointment. Similarly, Contractor shall ensure that all clients seeking non-urgent follow-up appointments with a non-physician SUD provider are provided within ten (10) business days of the prior appointment for those undergoing a course of treatment for an ongoing SUD condition. These timely standards must be followed, except in the following circumstances:
         a. The referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined and noted that in the relevant record that a longer waiting time will not have a detrimental impact on the client's health.
         b. Preventive care services and periodic follow-up care, including office visits for SUD conditions, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.
      VI. Contractor shall ensure that, if necessary for a client or a provider to reschedule an appointment, the appointment is promptly rescheduled in a manner that is appropriate for the client's health care needs and ensures continuity of care consistent with good professional practice.

VII. Contractor shall ensure that during normal business hours, the waiting time for a client to speak by telephone with staff knowledgeable and competent regarding the client's questions and concerns does not exceed ten (10) minutes.

4. DATA REPORTING REQUIREMENTS
   A. Contractor shall comply with data reporting compliance standards as established by DHCS and/or SAMHSA depending on the specific source of funding.
   B. Contractor shall ensure that all data stored or submitted to the County, DHCS or other data collection sites is accurate and complete.
      I. California Outcomes Measurement System Treatment (CalOMS Tx)
         a. Contractor agrees to cooperate with the County for the collection of data for the California Outcomes Measurement System (CalOMS), a statewide client-based data compilation and outcomes measurement system, as related to services rendered under this Agreement or as may be needed for completion of state report(s). Contractor shall collect and report data for the California Outcomes Measurement System (CalOMS), pursuant to state regulations and county protocols.
         b. CalOMS forms must be submitted within two (2) weeks of admitting the client to the facility. When a client has completed treatment with the Contractor, CalOMS closing will be completed and sent to Behavioral Health within two weeks.
         c. All new Contractor staff involved in completing and/or submitting CalOMS forms to County will complete a six (6) hour web based training and present a Certificate of Completion to County AOD Program Manager or Designee for the CalOMS web-based training prior to completing and/or submitting CalOMS forms to County.
      II. Drug and Alcohol Treatment Access Report (DATAR)
         a. DATAR data shall be submitted by Contractor as specified by County, either directly to DHCS or by other means established by County, by the 10th of the month following the report activity month.
      III. Substance Abuse and Prevention Treatment Block Grant (SABG) Funding reporting
         a. Contractors providing services to beneficiaries in counties using SABG funds will collect and report performance data to County monthly.
      IV. Contractor shall also cooperate with County Behavioral Health Department and County Probation Department for collection of any other data of informational reports as may be needed pertaining to services rendered under this Agreement.

5. TREATMENT PERCEPTION SURVEY (TPS)

Contractor shall conduct the annual Treatment Perception Survey (TPS) consistent with DMC-ODS requirements and under the direction of County.

6. PRACTICE GUIDELINES
   A. Contractor shall adopt practice guidelines (or adopt County's practice guidelines) that meet the following requirements as per 42 C.F.R. § 438.236:
      I. Are based on valid and reliable clinical evidence or a consensus of providers in the field.
      II. Consider the needs of the Contractor's clients

III. Are adopted in consultation with network providers
IV. Are reviewed and updated periodically as appropriate

B. Contractor shall disseminate the guidelines to all affected providers and, upon request, to clients and potential clients.

7. EVIDENCE-BASED PRACTICES (EBPs)
   A. Contractors will comply with County and DHCS standards related to Evidenced Based Practices (EBPs).
   B. Contractor will implement at least two of the following EBP to fidelity per provider, per service modality:
      I. Motivational Interviewing
      II. Cognitive-Behavioral Services
      III. Relapse Prevention
      IV. Trauma-Informed Treatment
      V. Psychoeducation

8. PHYSICIAN INCENTIVE PLAN

If Contractor wants to institute a Physician Incentive Plan, Contractor shall submit the proposed plan to the County which will in turn submit the Plan to the State for approval, in accordance with the provisions of 42 C.F.R. § 438.6(c).

9. REPORTING UNUSUAL OCCURRENCES
   A. Contractor shall report unusual occurrences to the Director. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including, but not limited to, physical injury and death.
   B. Unusual occurrences are to be reported to the County within timelines specified in County policy after becoming aware of the unusual event. Reports are to include the following elements:
      I. Complete written description of event including outcome;
      II. Written report of Contractor's investigation and conclusions;
      III. List of persons directly involved and/or with direct knowledge of the event.
   C. County and DHCS retain the right to independently investigate unusual occurrences and the Contractor will cooperate in the conduct of such independent investigations.

Article 19. ADDITIONAL FINAL RULE PROVISIONS

1. NON-DISCRIMINATION
   A. Contractor shall not discriminate against Medi-Cal eligible individuals in its County who require an assessment or meet medical necessity criteria for DMC-ODS in the provision of SUD services because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), BHIN 22-060 Enclosure 4 and state law.
   B. Contractor shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.

2. PHYSICAL ACCESSIBILITY

In accordance with the accessibility requirements of section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973, Contractor must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal clients with physical or mental disabilities.

3. APPLICABLE FEES
   A. Contractor shall not charge any clients or third-party payers any fee for service unless directed to do so by the Director at the time the client is referred for services. When directed to charge for services, Contractor shall use the uniform billing and collection guidelines prescribed by DHCS.
   B. Contractor will perform eligibility and financial determinations for each beneficiary prior to rendering services in accordance with the Drug Medi-Cal Billing Manual, unless directed otherwise by the Director.
   C. Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the client or persons acting on behalf of the client for any SUD or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (California Code of Regulations, tit. 9, § 1810.365(c)).
   D. The Contractor must not bill clients, for covered services, any amount greater than would be owed if the County provided the services directly as per and otherwise not bill client as set forth in 42 C.F.R. § 438.106.

4. CULTURAL COMPETENCE

All services, policies and procedures must be culturally and linguistically appropriate. Contractor must participate in the implementation of the most recent Cultural Competency Plan for the County and shall adhere to all cultural competency standards and requirements. Contractor shall participate in the County's efforts to promote the delivery of services in a culturally competent and equitable manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

Performance Standard

- 100% of beneficiaries that speak a threshold language are provided services in their preferred language.
- At least 80% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5+ out of 5.0) with cultural sensitivity of services

Despite progress in addressing explicit discrimination, racial inequities continue to be deep, pervasive, and persistent across the country. Though we have made many strides toward racial equity, policies, practices, and implicit bias have created and still create disparate results. Through partnerships with the community, Nevada County Behavioral Health strives to address these inequities and continue progress in moving forward.

Contractor is encouraged to have a diverse and inclusive workforce that includes representation from the disparate communities served by our county. Contractor will be expected to think holistically about creating services, program sites and an employee culture that is welcoming and inclusive. Contractor

should track metrics on Diversity, Equity, and Inclusion outcomes within their service delivery. Additional efforts should be made to identify and highlight growth opportunities for equitable outcomes, access to services, and other opportunities. Contractor shall contact County contract manager about proposed metrics to track.

Services should be designed to meet clients' diverse needs. Contractor will be expected to participate in the NCBH Cultural Competency program, participate in trainings and tailor outreach efforts and marketing materials to engage a diverse population of community members. Given that Spanish is a threshold language in Nevada County, a special emphasis should be placed on engaging Latinx communities and providing services in Spanish.

5. CLIENT INFORMING MATERIALS
   A. Basic Information Requirements
      I. Contractor shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. § 438.10(c)(1)). Contractor shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. § 438.10(d)(6). Contractor shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.
      II. Contractor shall provide the required information in this section to each client receiving SUD services under this Agreement and upon request.
      III. Contractor shall utilize the County's website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all the requirements regarding the same set forth in 42 C.F.R. § 438.10.
      IV. Contractor shall use DHCS/County developed model beneficiary handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).
      V. Client information required in this section may only be provided electronically by the Contractor if <u>all</u> of the following conditions are met:
         a. The format is readily accessible;
         b. The information is placed in a location on the Contractor's website that is prominent and readily accessible;
         c. The information is provided in an electronic form which can be electronically retained and printed;
         d. The information is consistent with the content and language requirements of this Agreement;
         e. The client is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within five business days. (42 C.F.R. § 438.10(c)(6)).
   B. Language and Format
      I. Contractor shall provide all written materials for potential clients and clients in a font size no smaller than 12 point. (42 C.F.R. § 438.10(d)(6)(ii).)
      II. Contractor shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.

III. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Contractor's SUD health education materials, available in the prevalent non-English languages in the County. (42 C.F.R. § 438.10(d)(3).)Contractor shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Institutions Code § 14727(a)(1); California Code of Regulations. tit. 9 § 1810.410, subd. (e), para. (4))

IV. Contractor shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)- (4).)

V. Contractor shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).

VI. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

C. Beneficiary Informing Materials

I. Each client must receive and have access to the beneficiary informing materials upon request by the client and when first receiving SUD services. Beneficiary informing materials include but are not limited to:

a. County DMC-ODS Beneficiary Handbook (BHIN 22-060)
b. Provider Directory
c. DMC-ODS Formulary
d. Advance Health Care Directive Form (required for adult clients only)
e. Notice of Language Assistance Services available upon request at no cost to the client
f. Language Taglines
g. Grievance/Appeal Process and Form
h. Notice of Privacy Practices
i. EPSDT poster (if serving clients under the age of 21)

II. Contractor shall provide each client with a beneficiary handbook at the time the client first accesses services. The beneficiary handbook shall be provided to beneficiaries within 14 business days after receiving notice of enrollment.

III. Contractor shall give each client notice of any significant change to the information contained in the beneficiary handbook at least 30 days before the intended effective date of change as per BHIN 22-060.

IV. Required informing materials must be electronically available on the Contractor's website and must be physically available at the Contractor agency facility lobby for clients' access.

V. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.

VI. Informing materials will be considered provided to the client if Contractor does one or more of the following:

a. Mails a printed copy of the information to the client's mailing address before the client first receives a SUD service;
b. Mails a printed copy of the information upon the client's request to the client's mailing address;
c. Provides the information by email after obtaining the client's agreement to receive the information by email;
d. Posts the information on the Contractor's website and advises the client in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,
e. Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If the Contractor provides informing materials in person, when the client first receives SUD services, the date and method of delivery shall be documented in the client's file.

D. Provider Directory
   I. Contractor must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.
   II. Contractor must make available to clients, in paper form upon request and electronic form, specified information about its provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).
   III. Any changes to information published in the provider directory must be reported to the County within two weeks of the change.
   IV. Contractor will only need to report changes/updates to the provider directory for each licensed SUD service provider.

E. Medication Formulary
   I. Contractor shall make available in electronic or paper form, the following information about the County's formulary as outlined in 42 C.F.R. § 438.10(i):
      a. Which medications are covered (for both generic and name brand).
      b. What tier each medication resides on.
   II. Contractor shall inform clients about County's formulary drug lists availability in a machine-readable file and format on the County's website.

Article 10. CLIENT RIGHTS

Contractor shall take all appropriate steps to fully protect clients' rights, as specified in Welfare and Institutions Code § 5325 et seq; Title 9 California Code of Regulations (CCR), §§ 862, 883, 884; Title 22 CCR, § 72453 and § 72527; and 42 C.F.R. § 438.100.

Article 11. RIGHT TO MONITOR

1. County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, client records, other pertinent items as requested, and shall have absolute right to monitor the

performance of Contractor in the delivery of services provided under this Agreement, in full compliance of patient confidentiality. Full cooperation shall be given by the Contractor in any auditing or monitoring conducted, according to this Agreement.

2. Contractor shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least ten (10) years from the final date of the Agreement period or in the event the Contractor has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR § 438.230(c)(3)(I)-(ii)).
3. The County, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Contractor at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the Contractor's place of business, premises or physical facilities (42 CFR § 438.230(c)(3)(iv)).
4. Contractor shall cooperate with the County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the County. Should the County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, the County may audit, monitor, and/or request information from the Contractor to ensure compliance with laws, regulations, and requirements, as applicable.
5. County reserves the right to place Contractor on probationary status, as referenced in the Probationary Status Article, should Contractor fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Contractor may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.
6. Contractor shall retain all records and documents originated or prepared pursuant to Contractor's performance under this Agreement, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.
7. Contractor shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must

account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter 11, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

8. All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.
9. Contractor shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by County staff.
10. Contractor shall comply with Medical Records/Protected Health Information Article regarding relinquishing or maintaining medical records.
11. Contractor shall agree to maintain and retain all appropriate service and financial records for a period of at least ten (10) years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.
12. Contractor shall submit audited financial reports on an annual basis to the County. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
13. In the event the Agreement is terminated, ends its designated term or Contractor ceases operation of its business, Contractor shall deliver or make available to County all financial records that may have been accumulated by Contractor or subcontractor under this Agreement, whether completed, partially completed or in progress within seven (7) calendar days of said termination/end date.
14. Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of Contractor.
15. County has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the County or DHCS determines Contractor has not performed satisfactorily.
16. It is not the intent of the County to direct or control the hiring of Contractor's employees; however, the parties acknowledge that in the event a Contractor's employee fails to provide the required services set forth herein in a satisfactory manner, County reserves the right to demand Contractor take appropriate action, up to and including termination of the employee.
17. Contractor shall, at all times, maintain communication and coordination with the Director of the Department of Behavioral Health (hereinafter referred to as "Director") and/or his/her designee, the Director of the Social Services Department and/or his/her designee, the Chief Probation Officer and/or his/her designee, and meet with the Director and/or his designee as needed regarding alcohol/drug treatment services or for any problem/resolution solving related to this Agreement.

Article 12. SITE INSPECTION

A. Without limiting any other provision related to inspections or audits otherwise set forth in this Agreement, Contractor shall permit authorized County, state, and/or federal agency(ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. Contractor shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work and in accordance with all patient confidentiality rules, regulations, and laws.

EXHIBIT "E"
SCHEDULE OF HIPAA PROVISIONS
FOR COVERED ENTITY CONTRACTORS

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):
HEALTH CARE PROVIDER AGREEMENT

Contractor acknowledges that it is a "health care provider" and therefore is a Covered Entity, for purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") and therefore is directly subject to the privacy, security and breach notification requirements therein and the civil and criminal penalties and shall implement its standards.

Contractor agrees to:

1. Contractor shall comply with all applicable federal and state laws and regulations pertaining to the confidentiality of individually identifiable protected health information (PHI) or personally identifiable information (PII) including, but not limited to, requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, the California Welfare and Institutions Code regarding confidentiality of client information and records and all relevant County policies and procedures.

2. Contractor shall not use or disclose PHI or PII other than as permitted or required by law.

3. Develop and maintain a written information privacy and security program that includes the designation of Privacy and Security Officer and establishes and maintains appropriate safeguards to prevent any use or disclosure of PHI other than as provided for by this Contract and applicable law. Safeguards shall include administrative, physical, and technical safeguards appropriate to the size and complexity of Contractor's operations and the nature and scope of its activities. Contractor will provide County with information concerning such safeguards as County may reasonably request from time to time.

4. Track disclosures and make available the information required to provide an accounting of disclosures if requested by the individual or County in accordance with 45 CFR §164.528.

5. Ensure sufficient training and utilize reasonable measures to ensure compliance with requirements of this Contract by Contractor's workforce members who use or disclose PHI (in any form) to assist in the performance of functions or activities under this contract; and discipline such employees who intentionally violate any provisions of this Contract, including termination of employment. Workforce member training shall be documented and such documents retained for the period of this Contract and made available to County for inspection if requested.

6. Take prompt corrective action in the event of any security incident or any unauthorized use or disclosure of PHI to cure any such deficiencies and to take any action required by applicable federal and state laws and regulations.

7. Report to County any security incident or any unauthorized use or disclosure of PHI (in any form. Security incidents include attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an

information system. Contractor shall make this report by the next business day following discovery of the use, disclosure, or security incident. Any unauthorized use or disclosure or security incident shall be treated as discovered by Contractor on the first day on which such use or disclosure or security incident is known to Contractor, including any person, other than the individual committing the unauthorized use or disclosure or security incident, that is an employee, officer or other agent of Contractor, or who should reasonably have known such unauthorized activities occurred. Reports should be made by email to privacy.officer@nevadacountyca.gov or by calling (530) 265-1740

8. Make Contractor's internal practices, books, and records relating to the use and disclosure of Protected Health Information received from or created or received by Contractor on behalf of County available to County upon request. In addition, Contractor will make these items available to the Secretary of the United States Health and Human Services for purposes of determining County's or Contractor's compliance with HIPAA and its implementing regulations (in all events Contractor shall immediately notify County of any such request, and shall provide County with copies of any such materials).

9. Contractor agrees that this Contract may be amended from time to time by County if and to the extent required by the provision of 42 U.S.C. § 1171, et seq., enacted by HIPAA and regulations promulgated thereunder, in order to assure that this Contract is consistent therewith; and authorize termination of the Contract by County if County determines that Contractor has violated a material term of this Contract.

10. Ensure that Contractor will enter into "Business Associate Agreements" as required by HIPAA including provisions that the Business Associate agrees to comply with the same restrictions, conditions and terms that apply to Contractor with respect to this Contract and with applicable requirements of HIPAA and HITECH. The Business Associate Agreement must be a written contract including permissible uses and disclosures and provisions where the Business Associate agrees to implement reasonable and appropriate security measures to protect the information (PHI or ePHI) it creates, receives, maintains or transmits on behalf of Contractor or County with respect to this Contract.

SUMMARY PAGE

AEGIS TREATMENT CENTERS, LLC.

Description of Services: Provision of Drug Medi-Cal (DMC) outpatient Narcotic Treatment Program (NTP) for referred clients of the Nevada County Behavioral Health Department.

SUMMARY OF MATERIAL TERMS

Max Annual Price:	$806,000		
Contract Start Date:	7/1/2023	**Contract End Date:**	6/30/2024
Liquidated Damages:	N/A		

INSURANCE POLICIES

Commercial General Liability	($2,000,000)	Worker's Compensation	(Statutory Limits)
		Professional Errors and Omissions	($1,000,000)
Automobile Liability	($1,000,000)		

FUNDING

1589-40105-493-7831 / 521520	

LICENSES AND PREVAILING WAGES

Designate all required licenses: All licenses as required to perform professional services as contemplated under this contract.

NOTICE & IDENTIFICATION

COUNTY OF NEVADA:		**CONTRACTOR:**	
Nevada County Behavioral Health Department, Health and Human Services Agency		Aegis Treatment Centers, LLC.	
Address:	950 Maidu Ave	Address	1317 Route 73 North, Suite 200
City, St, Zip	Nevada City, CA 95959	City, St, Zip	Mount Laurel, NJ 08054-2202
Attn:	Kelly Miner-Gann	Attn:	Contracting
Email:	kelly.miner-gann@nevadacountyca.gov	Email:	contracting@pinnacletreatment.com
Phone:	(530) 470-2522	Phone:	(484) 888-8867

Contractor is a: (check all that apply)						**EDD Worksheet Required** Yes ☐ No☒
Corporation:	☒	Calif. ☐	Other ☐	LLC ☒		**Additional Terms & Conditions Included**
Non- Profit:	☐	Corp. ☐				**(Grant Specific)** Yes ☒ No☐
Partnership:	☐	Calif. ☐	Other ☐	LLP ☐	Limited☐	**Subrecipient** Yes ☐ No☒
Person:	☐	Indiv. ☐	DBA ☐	Ass'n ☐	Other☐	

ATTACHMENTS

Exhibit A: Schedule of Services	**Exhibit D:** Behavioral Health Provisions
Exhibit B: Schedule of Charges and Payments	**Exhibit E:** Schedule of HIPAA Provisions
Exhibit C: Insurance Requirements	

NEVADA COUNTY BEHAVIORAL HEALTH DEPARTMENT

DECLARATION OF ELIGIBILITY FOR PROSPECTIVE EMPLOYEES/CONTRACTORS

POLICY:
The Nevada County Behavioral Health Department ("BHD") will not employ or engage as contractors any Ineligible Person for any department or program receiving federal funds.
An "Ineligible Person" is any individual or entity who: (a) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs or in Federal procurement or non-procurement programs; or, (b) has been convicted of a criminal offence related to the provision of health care items or services, but has not yet been debarred, or otherwise declared ineligible.

INSTRUCTIONS:
As a prospective employee or contractor with the BHD, please complete the declaration under penalty of perjury below. If you are or the entity you represent is an Ineligible Person as defined above, please immediately notify the BHD Director.

DECLARATION

I, _____ (name) on behalf of

____ myself, or
____ _____

declare under penalty of perjury under the laws of the State of California that:

____ I am not, or
____ the entity I represent is not

an Ineligible Person as defined in the Policy recited above. If, while employed or engaged as a contractor by BHD, I (or the entity I represent) become an Ineligible Person, I will notify the BHD Director immediately.

_____ _____
(Signature) (Date)