DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE:

Behavioral Health Information Notice No: 23-XXX
Supersedes Behavioral Health Information Notice No: 22-019

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Updates to Documentation Requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Programs

PURPOSE: To update and clarify documentation requirements for all Specialty Mental Health (SMH), DMC, and DMC-ODS services.

REFERENCE: Welfare & Institutions Code (W&I), § 14184.402, subd. (h)(3)

BACKGROUND:
As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to update Medi-Cal behavioral health documentation requirements to improve the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate, and effective beneficiary care; address equity and disparities; and ensure quality and program integrity.

To achieve this, DHCS is streamlining and standardizing clinical documentation requirements for SMHS, DMC, and DMC-ODS delivery systems (referred to as “Medi-Cal behavioral health delivery systems” in this document). These updated documentation requirements better align with the Centers for Medicare and Medicaid

Services' (CMS) national coding standards and physical health care documentation practices. These guidelines do not apply to behavioral health services in Fee-for-Service and Medi-Cal managed care delivery systems.

Assembly Bill (AB) 133 (Committee on Budget, Chapter 143, Statutes of 2021) implemented various components of the CalAIM initiative, including those components in W&I sections 14184.100, et seq. and authorized DHCS to develop and implement documentation standards through this Behavioral Health Information Notice (BHIN) until DHCS promulgates or amends regulations. (W&I, § 14184.402, subds. (h)(3) and (i)(1)).

This BHIN updates beneficiary chart documentation requirements for most SMH, DMC, and DMC-ODS services (exceptions are noted below). These updated standards are effective January 1, 2024. This documentation policy was initially developed and published in 2022 and subsequently updated based on feedback from stakeholders, including county behavioral health directors, consumer advocates, labor organizations representing county behavioral health workers, and behavioral health treatment providers.

To the extent that there is conflict between the Mental Health Plan (MHP) contract, DMC contract, or the DMC-ODS Intergovernmental Agreement terms and this BHIN, the policy contained within this BHIN supersedes the contract terms.

POLICY:
Applicability
The documentation standards identified in this policy apply to SMHS, DMC, and DMC-ODS services, including, but not limited to, adult residential, crisis residential, and SUD (SUD) residential services. They do not apply to:

- Narcotic Treatment Programs,
- Psychiatric inpatient services provided in hospitals, Psychiatric Health Facilities, or Psychiatric Residential Treatment Facilities, and
- DMC-ODS inpatient services provided in Chemical Dependency Recovery Hospitals and acute psychiatric hospitals.

For concurrent review and documentation standards for psychiatric inpatient services, see BHIN 22-017.

Overarching Policy
If there is a conflict between Enclosure 1a requirements and the documentation requirements within this BHIN, then the Enclosure 1a requirements supersede the requirements within this BHIN. When no conflict exists, documentation must comply

with both Enclosure 1a requirements and the documentation requirements within this BHIN.

(a) ***Standardized Assessment Requirements***

(1) Timely assessments: SMHS, DMC, and DMC-ODS

(i) To ensure that beneficiaries receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible and in accordance with generally accepted standards of practice. As described in (2)(i) below, specific timeframes are required for completion of ASAM Level of Care (LOC) assessments for DMC-ODS Residential Treatment and Withdrawal Management Services.

(ii) As part of a Medi-Cal behavioral health delivery system's Quality Assessment and Performance Improvement Program (SMHS and DMC-ODS), or programmatic and utilization review of providers (DMC), Medi-Cal behavioral health delivery systems shall monitor timely completion of assessments to ensure appropriate access and utilization of services. Medi-Cal behavioral health delivery systems shall not enforce timely assessment standards in a manner that fails to permit adequate time to complete assessments when such time is necessary due to a beneficiary's individual clinical presentation.

(iii) Assessments shall be updated as clinically appropriate, such as when the beneficiary's condition changes.

(iv) Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, during the assessment, or prior to determination of whether SMHS, DMC, or DMC-ODS access criteria are met, even if the assessment ultimately indicates the beneficiary does not meet the access criteria for the delivery system in which they initially sought care.[1]

(2) DMC and DMC-ODS

(i) DMC and DMC-ODS providers of Residential Treatment Services and Withdrawal Management Services shall ensure each beneficiary receives a multidimensional ASAM LOC assessment within 72 hours of admission.[2]

[1] For more detailed information on this policy and how it relates to SMHS and co-occurring substance use disorder refer to the No Wrong Door policy in BHIN 22-011. For information on diagnostic coding during the assessment refer to BHIN 22-013.

[2] See BHIN 21-001 Exhibit A.

(ii) Medi-Cal behavioral health delivery systems shall require providers to use an American Society of Addiction Medicine (ASAM) Criteria assessment for DMC and DMC-ODS beneficiaries.[3]

(iii) Medi-Cal behavioral health delivery systems shall accept an ASAM assessment completed by a qualified provider using either the ASAM Criteria® Assessment Interview Guide, which was developed by the University of California – Los Angeles and offered free to all clinicians, or ASAM CONTINUUM software.

(iv) Medi-Cal behavioral health delivery systems may require providers to use one of the above ASAM assessment tools only if the Medi-Cal behavioral health delivery system provides for licensing and distribution, as applicable. Effective January 1, 2025, DMC and DMC-ODS providers shall use one of the two ASAM assessment tools described in (iii) above.

(v) The assessment shall include a typed or legibly printed name, signature of the service provider, provider title (or credentials), and date of signature.

(vi) The assessment shall include the licensed provider's recommendation for medically necessary services and additional provider referrals, as clinically appropriate. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

(vii) If the assessment of the beneficiary is completed by a registered or certified counselor, then a Licensed Practitioner of the Healing Arts (LPHA) shall review 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.

(3) SMHS

(i) MHPs shall require providers to use uniform assessment domains as identified in section (b) below.

(ii) The assessment shall include a typed or legibly printed name, signature of the service provider, provider title (or credentials), and date of signature.

(iii) The assessment shall include the licensed provider's recommendation for medically necessary services and additional provider referrals, as clinically appropriate. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

[3] W&I § 14184.402(a), (e), and (i).

(iv) The diagnosis, current mental status, medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating within their scope of practice under California state law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan. (California State Plan, Sec. 3, Att. 3.1-A).

(v) The MHP may allow clinical or non-clinical staff, including those not qualified to diagnose a mental health condition or SUD, to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan Section 3, Att.3.1-B, Supp. 2).

(vi) For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool continues to be required and may be utilized to inform the assessment domain requirements. An initial CANS shall be completed or an existing CANS shall be updated by a CANS certified provider. For additional guidance on CANS requirements, please refer to MHSUDS IN 17-052 and MHSUDS IN 18-007.

(b) ***SMHS Assessment Domain Requirements***

(1) For the purposes of this BHIN, a domain is a reference to categories of information that should be captured within the SMHS assessment. To the extent the information is available, all components listed within each of the seven domains shall be included as part of a comprehensive assessment.

Domain 1:
Presenting Problem(s)
Current Mental Status
History of Presenting Problem(s)
Beneficiary-Identified Impairment(s)

Domain 2:
Trauma

Domain 3:
Behavioral Health History
Co-occurring Substance Use

Domain 4:

Medical History
Current Medications
Co-occurring Conditions (other than substance use)

Domain 5:
Social and Life Circumstances
Culture/Religion/Spirituality

Domain 6:
Strengths, Risk Behaviors, and Protective Factors

Domain 7:
Clinical Summary and Recommendations
Diagnostic Impression
Medical Necessity Determination/LOC/Access Criteria

(2) Crisis assessments completed during the provision of SMHS crisis intervention or crisis stabilization are not required to include all of the above domains and components. However, crisis assessments are not a replacement for a full SMHS domains assessment. When a beneficiary who has received crisis intervention or crisis stabilization subsequently receives other SMHS, an assessment shall be completed in accordance with the requirements above.
(3) For Medi-Cal Mobile Crisis Services assessment and documentation requirements, please refer to BHIN 23-025.

(c) ***SMHS, DMC, and DMC-ODS Problem List***

(1) The provider(s) responsible for the beneficiary's care shall create and maintain a problem list.
(2) The problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list shall include, but is not limited to, the following:
    (i) Diagnosis/es identified by a provider acting within their scope of practice, if any.
        (A) Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders shall be included with the diagnosis, when applicable.
    (ii) Current International Classification of Diseases (ICD) Clinical Modification (CM) codes.

(iii) Problems identified by a provider acting within their scope of practice, if any.
(iv) Problems identified by the beneficiary and/or significant support person, if any.
(v) The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.

(3) A problem identified during a service encounter (e.g., crisis intervention encounter) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.

(4) The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary. Providers, within their scope of practice, shall add to, amend, or resolve problems from the problem list when there is a relevant change to a beneficiary's condition.
(i) DHCS 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, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

(5) For beneficiaries that were receiving services prior to July 1, 2022 (the date that problem list requirements first took effect), a problem list is not required to be created retroactively. However, a problem list should be started when the beneficiary receives a subsequent SMH, DMC, or DMC-ODS service after July 1, 2022.

(d) ***SMHS, DMC, and DMC-ODS Progress Notes***

(1) Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.[4]

(2) Progress notes shall include:
(i) The type of service rendered.

[4] For valid Medi-Cal claims, appropriate ICD-CM diagnostic codes, as well as HCPCS/CPT codes, must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note. However, current ICD-CM codes and HCPCS/CPT codes are not required to be included in the progress note narrative. For further guidance on use of ICD-10 codes during the assessment process, refer to the Code Selection Prior to Diagnosis BHIN 22-013.

(ii) A narrative describing the service, including how the service addressed the beneficiary'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 direct patient care for the service.[5]
(v) Location/place of service.
(vi) A typed or legibly printed name, signature of the service provider, and date of signature.
(vii) Next steps. Next steps may include, but are not limited to, planned action steps by the provider or by the beneficiary; collaboration with the beneficiary; collaboration with other provider(s); goals and actions to address health, social, educational, and other services needed by the beneficiary; progress on goals or treatment outcomes; referrals; discharge planning; continuing care planning; and any update to the problem list as appropriate.
(viii) If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note.
(ix) Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0).

(3) Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (e.g., bundled services), such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation). If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.
(4) With regards to group services:
(i) When a group service is rendered, a list of participants is required to be documented and maintained by the provider.
(ii) Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group.
(iii) Should more than one provider render a group service, one progress note shall be completed for each beneficiary that participates in a group session and the note shall be signed by at least one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall

[5] Direct patient care time is defined in the SMHS and DMC/DMC-ODS billings manuals; see https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx.

clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity. All other progress note requirements listed above shall also be met.

(e) *Care Planning Requirements*

DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal SMHS, or prospectively completed, standalone treatment plans for DMC and DMC-ODS services. The intent of this change is to affirm that care planning[6] is an ongoing, interactive component of service delivery rather than a one-time event. Where possible, DHCS has modified state-level requirements for care, client, service, and treatment plans (hereafter referred to as "care plans") to eliminate additional care planning specifications and align with the Medi-Cal requirements described in this BHIN.

There are some programs and services for which federal or state law continues to require the use of care plans and/or specific care planning activities (see Enclosure 1a). For Medi-Cal behavioral health delivery system services for which care plan requirements remain in effect:

(1) Providers must adhere to all relevant care planning requirements in state or federal law.
(2) The provider shall document the required elements of the care plan within the beneficiary record. For example, care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within an Electronic Health Record.
(3) To support delivery of coordinated care, the provider shall be able to produce and communicate the content of the care plan to other providers, the beneficiary, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws.
(4) Medi-Cal behavioral health delivery systems shall not enforce requirements for the location, format, or other specifications for documentation of the care plan that differ from those described within this BHIN.

DOCUMENTATION OF TELEHEALTH SERVICES:

Please refer to BHIN 23-018 (or subsequent telehealth policy guidance) for complete information on telehealth services, including documentation of beneficiary consent for telehealth services.

[6] For purposes of this BHIN, the terms "care planning" and "care plans" are used as general terms to describe the activities and requirements listed in Enclosure 1a, inclusive of references to "client plans," "treatment plans," or "service plans," that appear in other state or federal authorities.

IMPLEMENTATION:
Unless otherwise specified, Medi-Cal behavioral health delivery systems shall implement the updated documentation requirements established in this BHIN by January 1, 2024. Implementation shall include updating policies and procedures, as well as supporting materials for DHCS compliance reviews of Medi-Cal behavioral health delivery systems. Medi-Cal behavioral health delivery systems shall ensure their staff, including subcontracted staff providing or administering the behavioral health services are trained on the compliance requirements of applicable statues, regulations, and BHINs.

COMPLIANCE MONITORING:
DHCS will continue to carry out its responsibility to monitor and oversee Medi-Cal behavioral health delivery systems and their operations as required by state and federal law. This oversight will include verifying that clinical documentation complies with the requirements in this BHIN, that services provided to Medi-Cal beneficiaries are medically necessary, and that documentation complies with the applicable state and federal laws, regulations, the MHP contract, DMC State Plan Contract, and the DMC-ODS Interagency Agreement/Contract.

Questions regarding this BHIN may be directed to BHCalAIM@dhcs.ca.gov.

Sincerely,

Original signed by

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Enclosure 1a: Care Planning Requirements that Remain in Effect

Requirement	Authority/ Background	Description
Community Treatment Facilities	9 CCR § 1927, subds. (a)(6), (e)	A Needs and Services Plan (NSP) is required for services provided to children in Community Treatment Facilities. The NSP must be completed within fifteen (15) calendar days of admission.
DMC Continuing Services	22 CCR § 51341.1 (h)(5)(A)(i-iii)	Documentation of physician review of medical necessity for DMC continuing services (outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services) must adhere to state requirements.
DMC-ODS Residential Treatment Services and Withdrawal Management Services provided in DHCS LOC certified AOD Treatment Facilities	BHIN 21-001 and attachments	Development of treatment or recovery plan for DMC-ODS Residential Treatment and Withdrawal Management Services shall be documented by a facility staff member within 72 hours of the provision of the service.
Enhanced Care Management (ECM)	ECM Policy Manual	Managed Care Plans and ECM providers must follow assessment and care planning requirements when delivering ECM.
Mental Health Rehabilitation Centers (MHRC)	9 CCR § 786.11, subd. (b); 9 CCR § 786.15, subds. (a), (g)	An individual service plan is required for services provided in MHRCs.

Mental Health Services Act Full-Service Partnership (FSP) Individual Services and Supports Plan (ISSP)	9 CCR § 3620	An ISSP is required for FSP clients.
Peer Support Services	SPA 21-0051; SPA 21-0058; SPA 20-0006-A; CMS Directors' Letter 07-011	Peer support services will be based on an approved plan of care that includes specific, individualized goals.
Short-Term Residential Therapeutic Programs (STRTPs)	Interim STRTP Regulations Version II, Section 10	A care plan is required for services provided in STRTPs.
Social Rehabilitation Programs	9 CCR § 532.2, subd. (c)	A treatment/rehabilitation plan is required for services provided in Social Rehabilitation Programs, including STRTP, Transitional Residential Treatment, and Long-Term Residential Treatment.
Substance Abuse Block Grant (SABG)	45 CFR § 96.136(d)(3)	SABG performance contracts require SABG-funded programs to observe federal regulations in 45 CFR 96.136, which refer to the process of treatment planning. The regulations do not require treatment planning to be documented in a specified format.
Targeted Case Management; Intensive Care Coordination (ICC)	22 CCR § 51351 42 CFR § 440.169(d)(2)	Providers must adhere to state and federal regulations listed in 22 CCR § 51351 and 42 CFR § 440.169(d)(2) but are not required to document treatment planning activities in a specific format.
Therapeutic Behavioral Services (TBS)	DMH IN 08-38	TBS requires a client plan.
Perinatal Practice Guidelines (PPG)	Perinatal Practice Guidelines	California PPG outlines required treatment planning activities for pregnant and parenting women receiving SABG funded services.

Enclosure 1b: Other Data and Documentation Requirements that Remain in Effect

Requirement	Authority/ Background	Description
American Society of Addiction Medicine (ASAM)	MHSUDS IN 18-046; BHIN 21-071; BHIN 23-001	ASAM Criteria is a multidimensional assessment used to determine the appropriate level of care across a continuum.
CalOMS Treatment (CalOMS)	Data Collection Guide; Data Compliance Standards; Data Dictionary	CalOMS is a data collection and reporting system for SUD treatment services.
Child and Adolescent Needs and Strengths (CANS)	MHSUDS IN 17-052; MHSUDS IN 18-007	CANS is a structured assessment for identifying youth and family actionable needs and useful strengths.
Client and Service Information (CSI)	MHSUDS IN 19-020	CSI system is a system used to collect encounter data for Medi-Cal and non-Medi-Cal clients for services provided in County or City Mental Health Plan programs.
Drug and Alcohol Treatment Access Report (DATAR)	45 CFR § 96.126 DATAR Web User Manual	DATAR is a DHCS system used to collect data on SUD treatment capacity and waiting lists.
LOC Designations for AOD Treatment Facilities (applies to DMC/DMC-ODS Providers of Residential Treatment Services and	BHIN 21-001 and attachments HSC § 11832	DMC and DMC-ODS providers of Residential Treatment Services and Withdrawal Management Services shall meet all required Level of Care components, including those for assessments, and treatment and recovery services documentation.

Withdrawal Management Services)		
Enhanced Care Management (ECM)	ECM Policy Guide	Managed Care Plans must follow assessment requirements outlined in the ECM Policy Guide when delivering ECM.
ICC, Intensive Home-Based Services (IHBS)/Therapeutic Foster Care (TFC)	Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries	The Medi-Cal Manual for ICC, IHBS, and TFC for Medi-Cal Beneficiaries includes additional service delivery and operational guidance for these services. Services may be documented in accordance with this BHIN.
Physical Exam Requirements (DMC & DMC-ODS)	22 CCR § 51341.1, subd. (h)(1)(A)(iv)(a-c)	Documentation requirements are retained.
Primary Prevention SUD Data Service (PPSDS)	Primary Prevention SUD Data Service; Data Quality Standards	The PPSDS system is a system used by counties to collect and report their primary prevention SUD program and activity data.
Pediatric Symptom Checklist (PSC)	MHSUDS IN 17-052	The PSC is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.
Social Rehabilitation Programs	9 CCR § 532.2, subds. (b), (g)	Treatment/Rehabilitation plan, documentation and assessment, requirements listed in 9 CCR § 532.2, subds. (b), (g) remain in effect.

Enclosure 2: Superseded Regulations

Regulation Title and Section Number	Superseded Part of Regulation
Title 9 Section 1810.205.2 Client Plan.	Superseded entirely.
Title 9 Section 1810.206 Collateral.	Requirement that the needs of the beneficiary are understood “in terms of achieving the goals of the beneficiary's client plan” is superseded.
Title 9 Section 1810.232 Plan Development.	Superseded entirely.
Title 9 Section 1810.440 MHP Quality management Programs.	Subdivisions (c)(1)(A)-(C) and (c)(2)(A)-(B) are superseded.
Title 9 Section 1840.112 MHP Claims Certification and Program Integrity.	Subdivision (b)(5) is superseded.
Title 9 Section 1840.314 Claiming for Service Functions-General.	Subdivision (e)(2)’s requirements related to approval of client plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(2)’s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(3)’s requirements related to treatment planning are superseded.

Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(4)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(5)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (g)(1)(B)(ii) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (g)(2)(E) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(1)(A)(iv)(c)'s requirements related to updated treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(1)(A)(v)(b)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(i) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(ii)(a-c) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(iii)(a-c) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(A-B) is superseded.

Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(A)(ii)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(B)(i)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(4)(A)(ii) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(5)(A)(ii)(c)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (k)(3)'s requirements related to treatment plans are superseded.