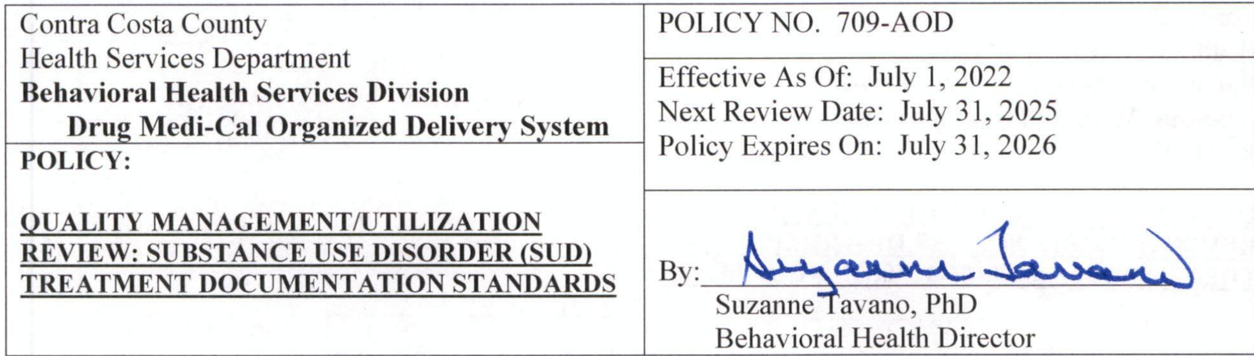

Contra Costa County Health Services Department **Behavioral Health Services Division** **Drug Medi-Cal Organized Delivery System**	POLICY NO. 709-AOD
POLICY: **QUALITY MANAGEMENT/UTILIZATION REVIEW: SUBSTANCE USE DISORDER (SUD) TREATMENT DOCUMENTATION STANDARDS**	Effective As Of: July 1, 2022 Next Review Date: July 31, 2025 Policy Expires On: July 31, 2026
	By: Suzanne Tavano Suzanne Tavano, PhD Behavioral Health Director

POLICY: QUALITY MANAGEMENT/UTILIZATION REVIEW: SUBSTANCE USE DISORDER TREATMENT DOCUMENTATION STANDARDS

I. PURPOSE:

The purpose of this policy is to establish documentation standards for substance use disorder (SUD) treatment providers for Contra Costa Behavioral Health Services Division Alcohol and Other Drugs Services (AODS), including providers for the Drug Medi-Cal Organized Delivery System Plan (DMC-ODS). This policy applies to both County Owned and Operated Clinics and Community Based Organizations (CBOs) and is to ensure that AODS complies with current State and Federal regulations.

II. REFERENCES:

- CFR, Title 42, Section 438
- CFR, Title 42, Section 8.12
- CCR, Title 9, Chapters 5 and 11
- California State Department of Health Care Services (DHCS), Alcohol and/or Other Drug Program Certification Standards
- DHCS, DMC-ODS Intergovernmental Agreement for Substance Use Disorder Services (IA)
- DHCS, MHSUDS Information Notice No. 16-044
- DHCS, Behavioral Health Information Notice No. 21-075
- DHCS, Behavioral Health Information Notice No. 22-019

III. POLICY:

It is the policy of AODS that all services provided with the client be documented in client records. In addition, AODS shall ensure that all documentation is completed following established documentation standards and that such documentation is completed in a timely manner.

IV. AUTHORITY/RESPONSIBILITY:

Behavioral Health Director or Designee
Behavioral Health Medical Director or Designee
AODS Program Chief
AODS Program Managers/Supervisors
Utilization Review (UR) Staff
SUD Treatment Service Providers

V. PROCEDURE:

Service providers are required to produce timely, accurate and complete documentation of each client's history and current treatment. County Owned and Operated Clinics and CBOs shall use County-authorized forms and templates for documentation.

Treatment services shall be provided and documented in a culturally competent, age-appropriate manner and be in accordance with Federal, State and County regulations.

It is the service provider's responsibility to ensure that the client is currently enrolled in Medi-Cal and meets all medical necessity criteria, admission and service activity criteria, or payment may be withheld.

Documentation is required, as follows:

A. Assessment.

1. A client seeking SUD treatment services shall be assessed by either an LPHA working within their scope of practice or a certified/registered Substance Abuse Counselor to establish need for services and the appropriate LOC.

   a. Level of Care Placement Assessment (LOCPA).

      i) The LOCPA must be completed during the assessment period by all SUD treatment providers, with the exception of Narcotic Treatment Program providers.

      ii) The LOCPA must be completed as part of the intake/admission process and shall be completed by a LPHA or a certified/registered Substance Abuse Counselor according to the timelines referenced below.

      iii) The LOCPA shall be completed within the following time frames.

a) Residential treatment.

i. Within ten (10) calendar days of admission.

ii. Within five (5) business days prior to the end of an authorization period, if the client is remaining in treatment past the authorization period.

iii. Any time there is a change in the client's condition.

iv. To support a LOC change.

b) Outpatient Treatment.

i. Within thirty (30) calendar days of admission.

ii. Within sixty (60) calendar days of admission if the provider documents that the client is experiencing homelessness.

iii. Within sixty (60) days of admission if the client is under twenty-one (21) years of age. Any time there is a change in the client's condition, to help support a LOC change.

B. Intake/Admission Form.

1. Once the assessing clinician has determined that the client meets the admission criteria for that service provider and LOC, the service provider must begin the admission by completing Form AODC-005, Intake/Admission Form.

a. Form AODC-005 shall include complete client information in the following areas:

i) Demographics.

ii) Health insurance.

iii) Financial.

iv) Education and employment.

v) Childcare (for Perinatal Program participants only).

2. Form AODC-005 must be completed at admission into both outpatient and residential treatment, and no later than the following:
    a. For residential treatment, ten (10) calendar days from the initial meeting with the client.
    b. For outpatient and intensive outpatient, thirty (30) calendar days from the initial meeting with the client.
3. Once completed, Form AODC-005 must be filed in the client's chart.

C. Health Questionnaire.

1. All beneficiaries participating in SUD programs shall have a completed health questionnaire within the client chart. The health questionnaire is an assessment of their current health status and shall be completed and signed as part of the client's admission to the program.
2. Programs may use DHCS form 5103, Client Health Questionnaire and Initial Screening Questions, or they may use their own health questionnaire as long as it contains all required elements.
3. Program staff shall review and sign each completed health questionnaire. When appropriate, the client shall be referred to licensed medical professionals for physical, psychiatric and laboratory examinations. Medical issues that are identified in the health questionnaire should be included in the problem list and addressed accordingly in the client's treatment services.

D. Physical Examination.

1. All beneficiaries participating in outpatient or residential SUD programs must document whether they have had a physical examination within the twelve (12)-month period prior to the date of admission to treatment. The physical examination must be conducted by a qualified physician, nurse practitioner or physician assistant.
2. Within thirty (30) calendar days from the date of admission to treatment, a physician, nurse practitioner or physician assistant shall review each client's personal, medical, and substance use history and document as follows:
    a. If a physical examination has been conducted within the twelve (12)-month time frame:

i) Proof of examination must be obtained and included within the client's record.

ii) A physician, nurse practitioner or physician assistant employed by the program shall review documentation of the client's most recent physical examination within thirty (30) calendar days of client's admission.

iii) Documentation of the review must be included in the client chart by either:

a) A progress note, ***or***

b) By signing and dating the copy of the physical examination in the client chart and noting that client is physically capable of participating in treatment.

iv) If documentation of a client's physical examination that was performed during the prior twelve months indicates the client has a significant medical illness, it should be included in the problem list.

b. If the provider is unable to obtain documentation of the most recent physical examination:

i) The provider shall describe efforts made to obtain this documentation in the client's chart.

ii) A physician, registered nurse practitioner, or physician assistant must conduct an exam within thirty (30) calendar days of the client's admission to treatment date.

iii) The need to obtain a physical shall be documented on the Problem List.

E. Medical Necessity Determination Form.

1. Medical Necessity shall be documented through Form AODC-014. Substance Use Disorders Medical Necessity Determination.

2. The initial and updated AODC-014 forms must be completed by a LPHA.

3. For a client to receive ongoing DMC-ODS services, the LPHA shall complete Form AODC-014, at a minimum, each time:

a. A client has an admission into treatment services.

b. A request for continued services is submitted.

c. A copy of each Form AODC-014 shall be placed in the client chart.

F. Problem List.

1. A problem list shall be created and maintained for clients by the provider(s) responsible for the client care. The problem list is a listing of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

2. Each problem listed shall include the date of identification and the individual who identified the problem. Problems may be identified by providers within their respective scopes of practice and by the client and/or significant support person. A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.

3. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client. The problem list shall include, but is not limited to, the following:

   a. Diagnoses identified by an LPHA acting within their scope of practice, if any.

   b. Problems identified by other providers acting within their respective scopes of practice, if any.

   c. Problems identified by the client and/or significant support person, if any.

   d. The name and title of the provider that added or removed the problem and the date the problem was added or removed.

   e. Providers shall add to or remove problems from the problem list when there is a relevant change to a client's condition.

   f. Diagnosis-specific specifiers from the DSM-5 shall be included with the diagnosis, when applicable.

4. The problem list should be created within the following time frames:

   a. Ten (10) calendar days for adult residential treatment.

   b. Thirty (30) calendar days for adult outpatient treatment.

c. Sixty (60) calendar days for adult outpatient treatment when homelessness has been documented.

d. Sixty (60) calendar days for adolescent treatment.

G. Continued Service Justification.

1. In addition to requests for extensions, an LPHA or a certified/registered Substance Abuse Counselor must review each client's progress and eligibility to continue to receive SUD treatment services no sooner than five (5) months and no later than six (6) months after the client's admission to treatment date or the date of completion of the most recent justification for continuing services and shall recommend whether the client should or should not continue to receive treatment services.

2. The LPHA or medical director of the program shall determine whether continued services are medically necessary for each client no sooner than five (5) months and no later than six (6) months after the client's admission to treatment date or the date of completion of the most recent justification for continuing services.

3. The determination of medical necessity shall be documented by the LPHA or medical director in the client's individual patient record and shall include documentation that all of the following have been considered:

a. The client's personal, medical and substance use history.

b. The client's most recent physical examination.

c. The client's progress notes.

d. The client's prognosis.

4. If the LPHA or medical director determines that continuing treatment services for the client is medically necessary, Form AODC-007, Clinical Justification for Continuing SUD Treatment Services, must be completed and signed prior to any extension of services. Form AODC-007 must meet submission guidelines and timelines as follows:

a. Residential treatment services must submit Form AODC-007 to the UR Unit when there is a request for extended time in treatment. It should be submitted (five) 5 days prior to the start of a requested authorization.

b. Outpatient and intensive outpatient service providers must place a signed copy of Form AODC-007 in the client's chart when extending services longer than six (6) months and shall follow guidelines outlined in this section regarding continued service justification.

5. If the LPHA or medical director determines that continuing treatment services for the client is not medically necessary,

   a. The provider shall determine the appropriate LOC needed and begin the transfer process.

   b. The provider shall refer the client to appropriate services and then discharge the client from their current treatment.

H. Episode Opening/Episode Closing.

1. As part of the initial admission process, the service provider must complete Form AODC-003, Client Registration (AOD). This form is then entered into the billing system to initiate client tracking.

2. The service provider must complete Form AODC-002, CalOMS Information; Form AODC-004, Admission & Discharge; and Form AODC-005, Intake /Admission; as part of the admission process.

3. At discharge, the service provider that provided services to the client must complete Form AODC-004. The information is then entered into ShareCare.

4. The appropriate Notice of Adverse Benefit Determination (NOABD) form must be completed for any changes in authorization (e.g., denial or reduction in services). A copy of the NOABD must be placed in the client chart.

5. When a client's medical necessity indicates a change in LOC, the provider must close the current client chart and open a new chart. This requires all intake paperwork and assessments to be completed in the new chart and submitted as required.

6. All forms used in the episode opening and closing must be placed in the client chart.

I. Service Authorization.

1. Service authorization is required for residential treatment services. Authorizations are not necessary for outpatient, intensive outpatient, case management and recovery services.
2. Form AODC-008, Service Authorization Form (SUD), must be completed by the UR Unit for each client receiving SUD Residential treatment services.
3. A copy of Form AODC-008 must be placed in the client chart.
4. Form AODC-008 details the following:
   a. The UR Track.
   b. The length of service authorization indicated by the number of days/weeks/months approved.
   c. An extension request, using Form AODC-007, must be submitted for extensions past the initial authorization.
   d. Changes in authorization (e.g., denial or reduction in services) necessitate the completion of the appropriate NOABD. Indication of the NOABD is marked on the Form AODC-008, if applicable.
   e. Utilization Review Authorization Committee member initials and signature.
   f. Date authorization was granted.

J. Progress Note.

1. Providers shall create progress notes for the provision of all SUD treatment 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.
   a. The purpose of the SUD progress note is to provide written documentation of a service provided to a client.
   b. Programs may identify and use a specific format for progress notes (i.e.. DAP, SOAP, BIRP).
   c. All levels of care must use Form AODC-013, or an electronic equivalent approved by AODS, as a Progress Note template.
2. Progress notes are individual narrative summaries and shall include the following:

a. The type of service rendered.

b. 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).

c. The date that the service was provided to the client.

d. Duration of the service, including travel and documentation time.

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

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

g. An ICD-10 code must be attached to the episode.

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

i. 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.

3. 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 twenty-four (24) hours.

4. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive and day rehabilitation). Weekly summaries will no longer be acceptable.

5. When a group service is rendered, a list of participants is required to be documented and maintained by the provider. Should more than one (1) provider render a group service, one (1) progress note may be completed for a group session and signed by one (1) provider. While one (1) progress note with one (1) provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements listed above shall also be met.

K. Group Sign-In Sheets.

1. Providers shall establish and maintain a sign-in sheet for every group counseling session, which shall include the following:
   a. The typed or legibly printed name and signature of the LPHA or certified/registered Substance Abuse Counselor conducting the counseling session. By signing the sign-in sheet, the certified/registered Substance Abuse Counselor or LPHA verifies that the sign-in sheet is accurate and complete.
   b. The date of the counseling session.
   c. The topic of the counseling session.
   d. The start and end time of the counseling session.
   e. A typed or legibly printed list of the client names.
2. All group sign-in sheets must be stored in a HIPAA-compliant manner.

L. Discharge Plan.

1. An LPHA or a certified/registered Substance Abuse Counselor shall complete Form AODC-009, Discharge Plan, for each client and place in the client's medical record, except for a client with whom the provider loses contact.
2. The discharge plan shall include, but not be limited to, the following:
   a. A description of each of the client's relapse triggers and a plan to assist the client to avoid relapse when confronted with each trigger.
   b. An individualized support plan.
   c. The discharge plan shall be prepared within thirty (30) calendar days prior to the date of the last face-to-face session with the client.
   d. During the certified/registered Substance Abuse Counselor or LPHA's last face-to-face session with the client, the LPHA or certified/registered Substance Abuse Counselor and the client shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be offered to the client.

M. Discharge Summary.

1. A discharge summary is only necessary when a client has lost contact with the provider and a discharge plan was not completed. The provider shall

complete Form AODC-006 for these clients in accordance with the following requirements:

a. For outpatient, intensive outpatient, and residential treatment services, the provider shall complete the discharge summary within thirty (30) calendar days of the date of the provider's last face-to-face treatment contact with the client.

b. The discharge summary shall include the following:

i) The duration of the client's treatment as determined by the dates of admission to and discharge from treatment.

ii) The reason for discharge.

iii) A narrative summary of the treatment episode.

iv) The client's prognosis.

N. AODS Documentation Standards.

1. All AODS service providers shall comply with AODS documentations standards as follows:

a. Documentation must be legible.

b. Signatures shall include at a minimum service provider's first initial, last name followed by license number or designation.

c. All forms shall be fully completed using black or blue indelible ink pens.

d. The following is not allowed:

i) Erasable ink pens.

ii) Pencils.

iii) Correction fluid (e.g., Liquid Paper) or tape.

iv) Ink pens in a color other than black or blue.

e. All forms must be fully completed.

f. The service provider shall fill in all lines and spaces on a form.

i) If the statement does not fit a certain situation or an answer cannot be obtained, the service provider shall indicate with N/A, a hyphen ("-") or "UTO" (unable to obtain) or another

similar phrase to indicate that the question was asked and not answered.

ii) Beneficiaries can only be asked to sign fully completed forms.

g. Use of abbreviations in clinical documentation should be avoided.

h. Once entered into the medical record, documentation becomes a legal document. Service providers, therefore, may not do the following once entered:

i) Obliterate material in the medical record.

ii) Erase documentation from progress notes.

iii) Remove pages from documentation.

iv) Use correction fluid or tape.

i. If an error is made on a hard-copy document, the error must be corrected in the following manner:

i) A single line is drawn through the error.

ii) The service provider shall write "error", initial, and date.

iii) EXAMPLE: ~~ERROR~~ error cb 5-10-17