EL DORADO COUNTY SUBSTANCE USE DISORDER SERVICES

El Dorado County Substance Use Disorder Services

DMC-ODS Quality Assurance Training Series

February 12, 2021

Documentation Standards

If you have questions…

- If you have a microphone, please use the Raise Hand button on your Participants tab and I will try to get to them as we go.

- If you do not have a microphone use the Chat tab to ask your question and I will get to them as we go.

You will be able to…

- **Understand key documentation sections**
- **Understand elements of individual ODS modalities**
- **Know mandatory documentation timelines**
- **Know your role and responsibilities, esp. to consult with the LPHA**
- **Improve the quality of care to our beneficiaries**

Reasons for Disallowances

- Assessment tool missing required elements
- ASAM not supporting level of care
- Chart did not have appropriate LPHA diagnosis
- Medical necessity not established in required time frame
- Treatment plans not completed in time frame
- Client's attendance in sessions not documented properly
- Services at Residential programs not documented properly
- Residential notes do not document 20 hours minimum of services
- Session note not completed in required time frame
- Client activities conducted in non-confidential settings
- Discharge policy did not meet required elements

Reasons for Disallowances

- Services provided by a Physician, Clinician, Counselor or Registrant whose Licensure, Certification or Registration has expired may cause a disallowance

- Treatment, Case Management or Recovery Services provided by a Clinician, Counselor or Registrant who has not completed ASAM Modules I & II may cause a disallowance

Provider Responsibilities

- Know and follow ALL applicable regulations and statutes
- Work within your scope of practice
- Provide quality individualized care in a comprehensive chart record
- Ensure beneficiary's challenges identified during assessment are addressed in the treatment plan and progress notes
- Ensure medical necessity is documented
- Treatment is provided under the direction of a Licensed LPHA

Roles

- Within DMC-ODS, roles are defined for:
- Medical Director
- Licensed Practitioner of the Healing Arts
- Counselors/Registrants

Medical Director

- Develop & Implement Medical Policies & Standards
- Physicians do not delegate their duties to non-physician personnel
- Ensure Physicians trained to perform diagnosis & determine medical necessity, within scope
- Receive five hours of continuing education related to addiction medicine annually

Licensed Practitioner of the Healing Arts

- **LPHAs include:**
  - Physician
  - Nurse Practitioners
  - Physician Assistants
  - Registered Nurses
  - Registered Pharmacists
  - Licensed Clinical Psychologists
  - Licensed Clinical Social Worker
  - Licensed Professional Clinical Counselor
  - Licensed Marriage and Family Therapists
  - License Eligible Practitioners working under the supervision of licensed clinicians

Counselor/Registrant

- Certified or registered with one of the following:
- California Association for Alcohol and Drug Educators (CAADE)
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- California Association of DUI Treatment Programs (CADTP)
- California Consortium of Addiction Programs and Professionals (CCAPP)

Admission Screening

- **Who can document?**
  - **LPHA**
  - **Counselor/registrant**

- **Timeframe**
  - As needed

- **What Must be Documented?**
- All referrals made by the provider staff shall be documented in the beneficiary record.
- If deemed medically appropriate, document urinalysis results in the beneficiary's file.

Intake

- **Who can Document?**
  - LPHA
  - Counselor/Registrant
- **Timeframe**
  - Due within thirty (30) calendar days from the beneficiary's admission to treatment.
- **What Must be Documented?**
  - Drug/Alcohol History
  - Medical History
  - Family History
  - Psychiatric/Psychological History
  - Social/recreational History
  - Financial Status/History
  - Educational History
  - Employment History
  - Criminal History, Legal Status
  - Previous SUD Treatment History
  - American Society of Addiction Medicine (ASAM) Criteria

Intake

Intake Assessment and ASAM Level of Care Determination Procedure

- The provider (either in-county or contacted SUD Network Provider) will meet with the beneficiary and complete the full assessment to provide additional information for determining the diagnosis, medical necessity, and appropriate ASAM level of care.

- In instances when the beneficiary requests services from the treatment SUD Network Provider without a scheduled appointment, a qualified staff will conduct the initial assessment, if available.

Intake

- **The assessment, diagnosis, and medical necessity will be clearly documented in the beneficiary's electronic health record (EHR) and/or medical record.**

- For beneficiaries under the age of 21, the diagnosis may also include an assessed risk for developing a SUD. Assessments will be conducted by a Licensed Practitioner of the Healing Arts (LPHA) or a certified /registered Drug and Alcohol Counselor.

Intake

- When beneficiaries access DMC-ODS services they must be provided:
  - Member Handbook (offered).
  - Rights and Problem Resolution Process.
  - What are grievances and appeals forms.
  - Disclosure of Privacy Practices including CFR 42 Part 2.
  - Interpreter information.
  - Signed acknowledgment receipt.

- Every chart must have signed acknowledgment receipt.

Physical Examinations

- **Who can document?**
- Physician
- Registered nurse practitioner
- Physician's assistant (physician extenders)
- Physician Registered nurse practitioner
-
- **Timeframe**
- Within thirty (30) calendar days of the beneficiary's admission to treatment date
-
- **What Must be Documented?**
- Copy of physical examination completed within prior 12 months in beneficiary record,
- OR
- The beneficiary's initial and updated treatment plans include a goal to obtain a physical examination, until this goal has been met.

Diagnosis

- **Who can document?**
- Medical director
- LPHA
-
- **Timeframe**
- Within 30 calendar days from admission to treatment
-
- **What must be documented?**
- Basis of diagnosis must be based on DSM 5 criteria
- Documented separately from the treatment plan

Medical Necessity

- **Who Can Document?**
- Medical Director
- LPHA
-
- **Timeframe**
- Within 30 days from admission to treatment

- **What Must be Documented?**
- The medical director or LPHA evaluated the beneficiary's assessment and intake information.
- If the beneficiary's assessment and intake information is completed by a counselor/registrant, the medical director or LPHA shall also document they met with the counselor/registrant through a face-to-face or telehealth review to establish a beneficiary meets medical necessity criteria.
- Substance Use Disorder Diagnosis based on the DSM
- Identification of level of care based on ASAM

Treatment Planning

- **Who can document?**
  - LPHA
  - Counselor/Registrant

- **Timeframe**
  - Within 30 days from admission to treatment for Outpatient Services
  - With 10 days for Residential Services

- **What must be documented?**
- Statement of problems
- Goals
  - Physical exam, if needed
  - Goal of obtaining treatment for an identified significant medical illness
- Action steps
- Intervention Action steps
- Target dates for Goals, Action and Intervention Action Steps
- Type & frequency of counseling/services
- Diagnosis
- Assignment of primary therapist or counselor

Progress Notes

For all Treatment Notes

Individual-Group-Case Management

The Counselor/Registrant or LPHA who facilitated the session shall also write the note that documents the session.

Progress Notes are not to be passed off to a Counselor/Registrant or LPHA who did not facilitated the session.

Progress Notes

Specific to outpatient services

- **Who can document?**
- LPHA
- Counselor

- **Timeframe**
- Within seven calendar days of the counseling session

- **What must be documented?**
- The topic of the session
- A description of the beneficiary's progress towards treatment plan goals
- Date of each treatment service
- Start and end time of each treatment service
- Typed or legibly printed name of LPHA or counselor, signature and date progress noted was documented
  - Adjacent to each other
- **Must identify if service was in-person, by telephone, or telehealth**
- **Must document location of service and how confidentiality was ensured if in community**

Progress Notes

Specific to outpatient services

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- **Must document location of service and how confidentiality was ensured if in community**

Progress Notes

Specific to case management services

- **Who can document?**
- LPHA
- Counselor/Registrant

- **Timeframe**
- Within seven calendar days of the service

- **What must be documented?**
- Beneficiary's name
- Purpose of the service
- A description of how the service relates to the beneficiary's treatment plan
- Date
- Start and end time of each service
- Printed or typed & signed name of LPHA or counselor
  - Adjacent to each other
- **Must identify if service was in-person, by telephone, or telehealth**
- **Must document location of service and how confidentiality was ensured if in community**

Continuing Services Justification

- **Who can document?**
- Medical Director
- LPHA

- **Timeframe**
- No sooner than 5 months and no later than 6 months
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- **What should be documented?**
- Review of the following:
  - Beneficiary's personal, medical, substance use history
  - Most recent physical exam
  - Progress notes & treatment plan goals
  - LPHA's/counselor's recommendation
  - Beneficiary's prognosis

Discharge Planning

- **Who can document?**
- LPHA
- Counselor

- **Timeframe**
- Within 30 days of last face-to-face service
- During last face-to-face, LPHA/counselor and beneficiary sign and date plan

- **What must be documented?**
- List of relapse triggers
- Plan for avoiding relapse when faced with triggers
- Support plan
  - People
  - Organizations
- A copy must be provided to beneficiary
  - Must be documented

Discharge Summary

- **Who can document?**
- LPHA
- Counselor /Registrant

- **Timeframe**
- Within 30 days of last face-to-face

- **What must be documented?**
- Unexpected lapse in treatment services for 30+ days
  - Duration of the treatment episode
  - Reason for discharge
  - Narrative summary of the treatment episode
  - Prognosis

Documentation Timelines Based on ASAM LOC

Outpatient (OS) & Intensive Outpatient services (IOS) (ASAM Levels 1, 2.1)

Encounter Type	Timelines	Process
Intake	First face-to-face contact must be within 10 days of receipt of referral	• Review all acknowledgments, advisements and consents. • HSQ must be reviewed with beneficiary and obtain beneficiary signature • Complete a LOC to determine/confirm LOC • Document Intake summary with description of symptomology, nature of impairment or distress and specific criteria indication LOC. • Document Intake Summary.
Admission	Due within first 30 days	• HSQ must be reviewed & signed by MD within 30 days and prior to completion of Tx plan. • Proof of physical examination within past 12 months obtained or referral to PCP made and documented. • Determination of medical necessity must be made by MD or LPHA within 30 days of admit. • DSM 5 Diagnoses made and documented by LPHA or MD. • Complete full biopsychosocial assessment. • CalOMS admission form completed by 3rd session.
Treatment Engagement	4 clinical contacts within 30 days of admit.	• All outpatient beneficiaries should receive a minimum of 4 counseling sessions within first 30 days and as determined by individual need.

Documentation Timelines Based on ASAM LOC

Encounter Type	Timelines	Process
ASAM Review	Admission, Discharge, Transfers, Authorizations	• The ASAM must be completed at Admit and at Discharge, for transfers and for residential authorization. • The ASAM 6 Dimensions should be regularly reviewed with the beneficiary, documented within progress notes and be reflected in the TX Plan.
Initial Treatment Plan	Within 30 days of admission	• Must be completed, signed and dated by primary counselor and beneficiary • Must be reviewed by LPHA, if primary counselor is not a LPHA, and signed and dated within 15 days of the initial signature of the counselor. • If clinician is unable to obtain beneficiary's signature within 30 days then this must be documented within the progress notes including reason for not obtaining the signature and the plan to obtain it. • Frequency, duration, and type of treatment (i.e. Individual, Group, and Targeted Case Management) must be documented on the TX Plan.
Updated Treatment Plans	90 days after last Treatment Plan	• Subsequent Treatment Plans are completed no later than 90 days calendar days after last Treatment Plan or when a change in problem or focus of treatment. • Must be reviewed, approved, signed, and dated by the counselor and beneficiary no later than 90 calendar days after signing the initial Treatment Plan. • Must be reviewed by LPHA if the primary counselor is not a LPHA, and signed and dated within 15 days of the initial signature of the counselor.

Documentation Timelines Based on ASAM LOC

Encounter Type	Timelines	Process
Clinical Justification for Services 6 month	Between 5th and 6th month of Treatment	• This must be reviewed by the LPHA and signed by date CJS is due if the primary counselor is credentialed or certified.
Clinical Justification for Services Annual	Between 11th and 12th month of Treatment	• This must be reviewed by the LPHA and signed by date CJS is due if the primary counselor is credentialed or certified.

Documentation Timelines Based on ASAM LOC

Encounter Type	Timelines	Process
Discharge Plan	Developed during treatment & completed by discharge date	• The Discharge Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources. • Must be signed and dated by the counselor and the beneficiary with a copy offered to the beneficiary and placed in the beneficiary record.
Discharge Summary	Within 30 days of last face-to-face or clinical telephone contact with beneficiary. *See Note	• Written summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary and discharge prognosis. • Complete CalOMS Discharge Questionnaire. • Use the CalOMS Administrative Discharge if beneficiary has left treatment and cannot be interviewed. • A LOC should be completed at Discharge ***Note: All documentation is required within 48 hours of date of service, thus when a beneficiary successfully completes treatment, the completion of DC should also be done at that time. The 30-day timeline is appropriately used for beneficiaries who stop attending treatment and it is unclear whether they are returning. DHCS allows for 30 days.**

Residential Specific Requirements (ASAM Levels 3.1)

Encounter Type	Timelines	Process
Intake First Face to Face contact with the beneficiary & starts clock for all Timelines requirements	First face to face contact by clinician within 24 hours of admission	• Review all acknowledgements, advisements and consents. • HSQ must be reviewed with beneficiary and obtain beneficiary signature at admission. • Complete ASAM to determine/confirm LOC • Document Intake summary with description of symptomology, nature of impairment or distress and specific criteria indicating LOC. • Document Intake summary.
Other Admission Procedures	Due within 10 calendar days	• HSQ must be reviewed prior to completion of TX plan and signed by the MD within 30 days of admission to Tx. • Determination of medical eligibility by the M.D. must be signed and completed within 30 days of admit • Determine whether beneficiary had physical examination within last 12 months and obtain documentation of exam or document no exam and referral made. • Complete full Biopsychosocial Assessment. • Diagnoses based on medical necessity criteria from DSM 5 and ASAM must be confirmed within 10 days by LPHA with written documentation of face to face w non LPHA counselor. • Complete CalOMS admission form by 10th day.

Residential Specific Requirements (ASAM Levels 3.1)

ASAM Review	Admission, Discharge, Transfers, Authorizations	• The ASAM should be completed at Admission and Discharge for Transfers and Authorizations. • The ASAM 6 Dimensions should be regularly reviewed with the beneficiary, are documented within progress notes, and be reflected in the Treatment Plan.
Initial Treatment Plan	Due within 10 calendar days	• Must be completed, signed, and dated within 10 days of beneficiary's admission to treatment. • Must be reviewed and signed by LPHA within 15 days of completion with client.
Updated Treatment Plans	As needed	• Subsequent Treatment Plans are completed when a change in problem identification or focus of treatment occurs. • Must be reviewed and signed by LPHA by due date of updated TX plan if primary counselor is not a LPHA.

Residential Specific Requirements (ASAM Levels 3.1)

Discharge Plan	Completed by discharge date with beneficiary	• The Plan addresses triggers for relapse and how to avoid them, along with a support plan that includes referrals for ongoing care and resources. • Must be signed and dated by the counselor and the beneficiary with a copy offered to the beneficiary & placed in the beneficiary record.
Discharge Summary	Completed within 48 hours of last face to face or last clinical telephone contact with beneficiary.	• Written summary of the treatment episode including duration of treatment, reason for discharge and discharge prognosis. • Complete CalOMS Discharge Questionnaire • Use the CalOMS Administrative Discharge if beneficiary has left treatment and cannot be interviewed • Updated ASAM

Individual Counseling Notes

- Individual counseling sessions between a LPHA or Registered/Certified Counselor and a beneficiary are to be conducted in a confidential setting where individuals not participating in the counseling session cannot see or hear the comments of the beneficiaries, LPHA, or counselor. Individual counseling sessions can be provided in person in an office, home, or community setting or via telephone or telehealth as long as confidentiality and informed consent requirements are met.

Individual Counseling Notes

- Individual counseling sessions are available at all levels of care.
- Individual counseling sessions are designed to support direct communication and dialogue between the staff and beneficiary. Sessions will focus on psychosocial issues related to substance use and goals outlined in the individualized treatment plan.
- A progress note must be written for each session and documented in the beneficiary's chart.
- The frequency of individual counseling sessions, in combination with other treatment services shall be based on medical necessity and individualized needs rather than a prescribed program required for all beneficiaries.

Group Counseling Notes

- Group counseling sessions are available at all levels of care.
- A separate Progress Note must be written for each beneficiary and documented in the beneficiary's chart.
- Group sign-in sheets must include signatures and printed names of beneficiaries and group facilitators, date, start/end times, location, and group topic. The frequency of group counseling sessions in combination with other treatment services shall be based on medical necessity and individualized beneficiary needs rather than a prescribed program required for all beneficiaries.

Group Counseling Notes

- Group counseling sessions are face-to-face treatment services offered between an LPHA or Registered/Certified counselor and between 2-12 other Beneficiaries simultaneously. Group counseling occurs in a confidential setting where individuals not participating in the counseling session cannot see participants or hear the comments of the beneficiary or LPHA/Counselor.

Crisis Intervention Counseling Note

- Crisis intervention counseling must be provided face-to-face between an LPHA or a Registered/Certified Counselor and a beneficiary in a crisis. A crisis must be an actual relapse or an unforeseen event or circumstance causing imminent threat of relapse. Crisis intervention services mush include a focus on alleviating crisis challenges and must be limited to stabilization of the beneficiary's emergency situation.

Crisis Intervention Counseling Note

- These sessions are immediate and short-term encounters that focus on (1) stabilization and immediate management of the crisis, often by strengthening coping mechanisms and (2) alleviating a beneficiary's biopsychosocial functioning and well-being after a crisis.
- Crisis interventions are provided when there is a relapse or an unforeseen event or circumstance causing imminent threat of relapse.
- A component of this service includes linkages to ensure ongoing care following the alleviation of the crisis. Crisis Intervention sessions are available at all levels of care
- A progress note must be written for each session and documented in the beneficiary chart.
- Crisis intervention sessions are not scheduled events, but need to be available to beneficiaries as needed during the agency's normal operating hours or in alignment with afterhours crisis procedures.

Case Management

- Case management services are defined as a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services

- The focus of case management services includes: coordination of SUD care, integration around primary and mental health care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.

Case Management

- Case management is available at all levels of care.
- Meant to enhance the capacity of each beneficiary to achieve long-term recovery.
- Case management will be utilized as a method to provide thorough discharge planning, access to ongoing recovery support services, vocational rehabilitation, sober living housing, and access to childcare and parenting services.
- **A progress note must be written for each case management interaction and documented in the beneficiary's chart.**

Case Management-Important Note

- A progress note must be written for each case management interaction and documented in the beneficiary's chart.
- Case management services must reflect treatment plan or case management plan goals/action steps etc.
- **Case management notes must reflect the time spent.**
- **EDC DMC-ODS will review case management notes for accuracy during annual site monitoring reviews.**

What Must Be In a Case Management Note

- For each beneficiary provided a case management service, the services shall be recorded in a progress note and the notes shall include
  - Beneficiary's name.
  - The purpose of the service.
  - A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
  - Date, start and end times of each service.
  - Identify if services were provided in-person, by telephone, or by telehealth.
  - If services were provided in the community, identify the location and how the provider ensured confidentiality.

A word about Intakes

- All El Dorado County Enrollment notifications must be sent to

- ODSAccess@edcgov.us

- **Do not send them to any other email address. Failure to do so may lead to a delay of funding authorization for the beneficiary's episode.**

A word about Agency Reports

- Agency Level of Care Reports, Yearly Attestations, Timeliness Reports, NOABDS, Complain Logs, Grievances, Appeals, Verification of Exclusion Checks, New Hire Documentation and Updates of Physician/Clinician/Counselor/Registrant Licensure and/or Certification must be sent to

- sudsqualityassurance@edcgov.us

A final word about other Documentation

- All Extension Requests, Treatment Plans, Progress Reports and any other paperwork connected to the beneficiary's episode should be sent directly to the EDC SUDS Case Manager's email address

QUESTIONS?

El Dorado County
Substance Use Disorder Services

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