Alameda County
BHCS – Substance Use Disorder (SUD)
Documentation Training

March 8, 2017

BHCS QA Contacts

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Today's Agenda

9:00-9:45a	Introductions
9:45-10:15a	SUD Regulations
10:15-11:15a	Intake &Admission
11:00-11:15a	Morning Break
11:15-12:00p	Assessment & Establishing Criteria For Medical Necessity
12:00p-12:30p	Lunch Break
12:30-1:45p	Treatment Plans
1:45p-2:00p	Afternoon Break
2:00p-3:00p	Progress Notes
3:00p-3:30p	Group Notes & Requirements
3:30p-4:00p	Discharge Plans & Summaries

Introduction & Auditing Plan-FY 16-17

- **Annual & Quarterly; ACBHCS SUD System Of Care Medical Records Review**
  - **Expected to begin 5/2017**
  - Minimum 2 charts from ALL SUD programs
  - Technical Assistance Feedback

- DHCS monitoring Unit is providing on-site technical assistance independent of BHCS
  - Please let Sharon know if DHCS contacts your agency to conduct a chart review
  - This will assist us in providing accurate technical assistance to all of our providers

DMC Provider Responsibilities

- It is you and your staffs' responsibility to know and follow ALL applicable regulations
  - Title 22 § CCR 51341.1 can be found here: https://govt.westlaw.com/
- Employ qualified staff and make sure staff stay within their scope of practice!
- Develop and document procedures for admission
- Establish an individual record for every DMC beneficiary. Maintain record for a minimum of 3 years (or as required by law)
- Ensure medical necessity is documented in beneficiary records
- Complete a personal, medical, and substance use history upon admission
- Ensure that client's challenges identified are addressed in treatment plan and progress notes.
- Complete discharge plan OR discharge summary upon discharge
- SUD Treatment MUST be provided under the direction of a licensed physician

Role of the SUD Medical Director

Each DMC provider must have a *Medical Director who* has medical responsibility for ALL CLIENTS and MUST be available on a regularly scheduled basis. Duties of a *Medical Director* may vary, but at a minimum, DMC certified treatment provider medical directors are responsible for:

- Establishing, reviewing, & maintaining medical policies and standards - source: 22 CCR §51341.1 (b)(28)(A)
- Ensuring the quality of medical services provided to all clients - source: 22 CCR §51341.1 (b)(28)(A)(i)(a)
- Ensuring that a physician has assumed medical responsibility for all clients treated by the provider – source: 9 CCR § 10110
- **SUD Medical Director must obtain 5 hrs. continuing education in Addiction Medicine Annually.** - source: 22 CCR §51341.1 (b)(28)(A)(iii)

Alameda County SUD Providers' Admission/Pre-Admission Process

COMING SOON!!

Call Screening Tool

--Form Highly Recommended—

Three (3) page form that will comply with upcoming pre-admission screening requirements.

This form is included with the handouts

Call Screening Tool
Substance Use Disorder Services

Date: ________ Time: __________ Screener: ____

Client Name: ____ Date of Birth: __________________

Age: _______ Ethnicity: ____________________ Gender Identity: Male / Female / Transgender / Other

Phone # 1: __________________________ Phone # 2: ___________________________

*** What is most important to you, that you want help with, or that made you decide to call today?** *(If caller is not seeking SUD Services provide appropriate referrals and end call & form ends here)* **Referral Made**: Yes / No

____

____

____

Drug of Choice	Route of Administration	Frequency last 30 days	Frequency last 12 months	Continuous use at age:

Do you have Current Medical Coverage: Y / N If Yes: Insurance Provider: _________________________

Primary Physician: ______________________________________

Current Medical Condition(s):____

Psychiatric Diagnosis/Condition(s):____________________

If yes, is the Mental Health Professional Involvement: past / present / both past & present?

If yes, Mental Health Professional Name; ___________________________ Location:____________________

Current Prescribed Medications: ____________________ ____ Pharmacy: ___________________________

Any current mental health symptoms you would like a referral for (i.e. depression or anxiety)? Yes / No

Living Situation: Married / Living with a Partner / Living with Family / Other / Single

Female Clients Only: Are you pregnant? Yes / No / Unknown

Do you have children? Yes / No / Unknown If yes, do you have custody? Yes / No / Unknown

Number of children: ______ Children(s) Ages: ___________________________

Are you Employed / Attending School / Unemployed / Disability / Other? ______________________________

If employed, do you work: Part Time / Full Time Do you work: Evenings / Days

Hours per Week: ______ Employer Location: ______________________________

Client Address/Place of Residence: ______________________City: __________________ Zip: __________

Social Security #: ______________________ Source of Income: ____________________________________

Health Screening / Questionnaire

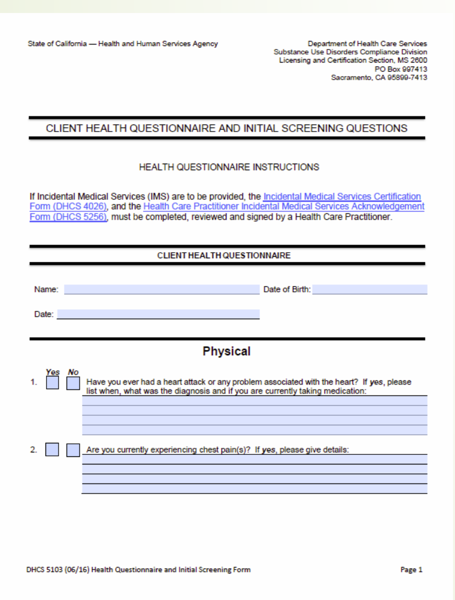
-DHCS Form 5103 highly recommended-

- REQUIRED be completed during admission process, **PRIOR TO INTAKE**
- AOD-Certified programs' Health Questionnaire MUST contain at minimum the information in the DHCS 5103
  - Client should complete on their own unless they require assistance
  - Must be reviewed and signed by staff
- Used to help determine if client has immediate medical needs that would impact their ability to safely participate in SUD Treatment
- Health Questionnaire requirement is NOT a substitute for medical history in screening/assessment

DHCS Form 5103: Health Screening Questionnaire

Meets requirements of Title 22 CCR §51341.1 (h)(1)(A)(ii)&(iii) and AOD Alcohol And Drug Certification Standards Section 12020

DHCS Form 5103, Version (06/16) this is a 10 page form:
http://www.dhcs.ca.gov/provgovpart/Documents/DHCS_5103.pdf



State of California — Health and Human Services Agency

Department of Health Care Services
Substance Use Disorders Compliance Division
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

CLIENT HEALTH QUESTIONNAIRE AND INITIAL SCREENING QUESTIONS

HEALTH QUESTIONNAIRE INSTRUCTIONS

If Incidental Medical Services (IMS) are to be provided, the Incidental Medical Services Certification Form (DHCS 4026), and the Health Care Practitioner Incidental Medical Services Acknowledgement Form (DHCS 5256), must be completed, reviewed and signed by a Health Care Practitioner.

CLIENT HEALTH QUESTIONNAIRE

Name: ______ Date of Birth: ______

Date: ______

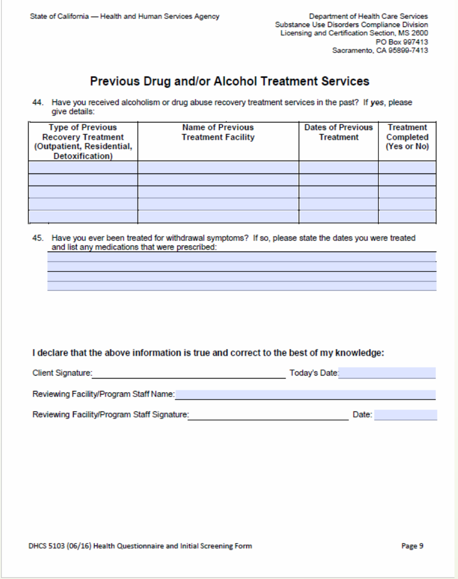
Physical

Yes No

1. ☐ ☐ Have you ever had a heart attack or any problem associated with the heart? If *yes*, please list when, what was the diagnosis and if you are currently taking medication:

2. ☐ ☐ Are you currently experiencing chest pain(s)? If *yes*, please give details:

DHCS 5103 (06/16) Health Questionnaire and Initial Screening Form — Page 1



State of California — Health and Human Services Agency

Department of Health Care Services
Substance Use Disorders Compliance Division
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Previous Drug and/or Alcohol Treatment Services

44. Have you received alcoholism or drug abuse recovery treatment services in the past? If **yes**, please give details:

Type of Previous Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Previous Treatment Facility	Dates of Previous Treatment	Treatment Completed (Yes or No)

45. Have you ever been treated for withdrawal symptoms? If so, please state the dates you were treated and list any medications that were prescribed:

I declare that the above information is true and correct to the best of my knowledge:

Client Signature: ______ Today's Date: ______

Reviewing Facility/Program Staff Name: ______

Reviewing Facility/Program Staff Signature: ______ Date: ______

DHCS 5103 (06/16) Health Questionnaire and Initial Screening Form — Page 9

Available in handout section!

Intake and Assessment of Substance Use Disorders under DMC

Intake Assessment

--AC BHCS Form Highly Recommended--

- Providers must complete a personal, medical, and substance use history for each beneficiary at admission
  - Physician must review within 30 days of episode opening date - source: 22 CCR §51341.1 (h)(1)(A)(iii)
- Required components of admission/intake - source: 22 CCR §51341.1 (b)(13)
  - Social, economic, family, education, employment, criminal, and medical history
  - Legal status and previous treatment history
  - Client substance use history
  - Evaluation or analysis of the cause or nature of mental , emotional, psychological, behavioral, and substance use disorder(s), the diagnosis of substance use disorders, and the assessment of treatment needs
  - Perinatal programs (DMC or non-DMC) have additional requirements (see Perinatal slide)
- ACBHCS has created a 12 page AOD/SUD Intake and Assessment Form that fulfills DMC requirements.
  - This form is available in the included documents—is highly recommended for compliance
  - and on the ACBHCS provider website (coming soon!)

AOD/SUD Intake Assessment

AOD/SUD INTAKE AND ASSESSMENT

INTAKE INSTRUCTIONS

Per Alcohol and/or other Drug Program Certification Standards (12020) Program staff shall review each completed health questionnaire that was completed by a participant. The health questionnaire can help identify a participant's treatment needs but it is the responsibility of staff to gather additional information on the following items: Social, economic and family history, education, employment history, criminal history, legal status, medical history, alcohol and/or other drug history, and previous treatment.

Per Title 22 CCR 51341.1 (b)(13): Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; the diagnosis of substance use disorders, and the assessment of treatment needs.

Gather the following information from Client.

Client Information

Client's First Name:__________ Client's Last Name:__________

Participant's Medi-Cal PSP#: __________ Client's Date of Birth:__________

Client's Preferred Name:__________ Admission Date:__________

Emergency Contact Information

Emergency Contact	Relationship	Contact Address (street, City, State, Zip)	Contact Phone Number

☐ Release for Emergency Contact obtained for this time period: __________

AOD/SUD Intake and Assessment Page 1 of 12

Instructions and regulations included in the form

Emergency contact information included in the form

12 page form available in handouts

AOD/SUD Intake Assessment

Form includes space for reported/ proposed/ historical DSM-5 diagnosis and code

To complete basis for diagnosis, simply check the appropriate check boxes and corresponding fields

Severity can be determined by following the instructions in this section

Space to write the clinical formulation for diagnosis

Information for MD or LPHA to Make Diagnosis:

DSM-5 Diagnosis may only be made by a LPHA or MD

SUD Counselors or Unlicensed LPHAs may only gather information below regarding signs and symptoms and may only list historically reported, client reported, or proposed DSM-5 SUD Diagnosis:

Diagnosis: ____

(Full diagnosis must be written out from DSM-5. ICD 10 codes are insufficient)

BASIS FOR DIAGNOSIS

A pattern of substance use leading to clinically significant impairment or distress as manifested by at least 2 of the following, occurring within a 12-month period. A diagnosis may be supported with a specifier if the beneficiary is on agonist therapy (maintenance) or was/is in a controlled environment.

Met	Symptom	Substance(s)	When Symptom Was Experienced
☐	1) The substance is often taken in larger amounts or over a longer period than was intended.		
☐	2) There is a persistent desire or unsuccessful efforts to cut down or control the use of the substance.		
☐	3) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.		
☐	4) Craving, or a strong desire or urge to use the substance.		
☐	5) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.		
☐	6) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.		
☐	7) Important social, occupational, or recreational activities are given up or reduced because of the use of the substance.		
☐	8) Recurrent substance use in situations in which it is physically hazardous.		
☐	9) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the use of the substance.		
☐	10) Tolerance, as defined by either of the following: a) A need for markedly increased		

AOD/SUD Intake and Assessment Page 10 of 12

☐	11) Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for the substance; and/or b) The substance is taken to relieve or avoid withdrawal symptoms.		
☐	Mild Substance Use Disorder (2-3 Symptoms):		
☐	Moderate Substance Use Disorder (4-5 Symptoms):		
☐	Severe Substance Use Disorder (6 or More Symptoms):		
☐	In Early Remission (no symptoms, except for craving, for 3 to under 12 months)		
☐	In Sustained Remission (no symptoms, except for craving, for more than 12 months)		
☐	On Maintenance Therapy (if taking a prescribed agonist medication and none of the criteria have been met for the agonist medication except symptoms 10 and 11)		

*Symptoms 10 and 11 are not applicable if the client is using sedative/hypnotic/anxiolytic, opioid, or stimulant medication as prescribed consistent with physician's orders (e.g. not combining with synergistic substances, not taking more frequently or in greater quantity than prescribed, not operating machinery, etc.)

AOD/SUD Intake and Assessment Page 11 of 12

Clinical Formulation

Instructions: Consider all information gathered in the intake for the Clinical Formulation. The formulation should identify each problem that is contributing to client's substance use disorder. All issues identified during the intake and assessment process must be listed as a problem statement on the treatment plan. However some problem statements can de deferred as determined appropriate by the treatment staff.

http://www.dhcs.ca.gov/services/adp/pages/dmc_FAQs.aspx

22 CCR 5134.1.(h)(2)(A)(i)(a)

AOD/SUD Intake and Assessment Page 12 of 12

Consent to Treat

- Written consent for treatment IS a requirement of ACBHCS
- If missing/not completed at the time of admission will result in a fully non-compliant chart.
- Consent to treat MUST be signed by the client, demonstrating informed consent has been reviewed

Perinatal Residential Assessment

Additional specific DMC requirements for Perinatal Residential treatment plans apply to both Drug Medi-Cal and Non-Drug Medi-Cal Perinatal programs.

- Was a need for mother/child habilitative services assessed in the Intake?
- Does the mother need assistance in accessing ancillary services (dental, social, community, educational/vocational, and other services that are medically necessary to prevent risk to the fetus)?
- Prenatal exposure to substances harms developing fetuses. Was this assessed in the Intake?
- Were sexual or physical abuse issues assessed in the Intake?
- Were service access needs (i.e. transportation, financial, other barriers) assessed in the Intake?

Source: 22 CCR § 51341.1 (c)(4)

Establishing Medical Necessity for SUD under DMC

Relevance of Medical Necessity for Documentation – GOLDEN THREAD

Initial assessment documentation identifies problems to be addressed in SUD treatment. The Physician establishes Medical Necessity by reviewing all information and making the diagnosis, complete with a written basis for the diagnosis (see exceptions for completing written basis).

↓

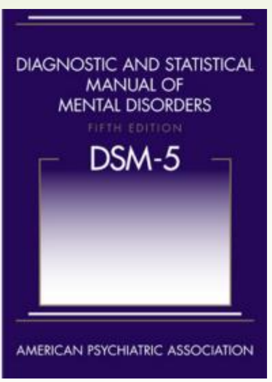
Initial client plans are based on the Initial Assessment and must indicate all identified problems that were identified unless counter indicated. These may be prioritized for work during the Tx Plan period.

↓

Client/Treatment plan updates document the ongoing Medical Necessity and progress towards completion of the program.

↓

Progress Notes must contain evidence that the services claimed for reimbursement are helping client achieve their treatment plan.

Switch to  &

- On or before, April 1, 2017 DHCS and ACBHCS are switching from DSM-IV to DSM-5/ICD-10 for diagnosis and coding
- DSM-5 codes are ICD-10 codes; however they are not always identical in their description (name)
- ACBHCS has developed tools to assist in this transition
- Any approved SUD diagnosis must be BOTH on the approved list AND in the DSM-5
- SUD DSM-5 DHCS included lists are available on BHCS provider website
  - http://www.acbhcs.org/providers/QA/memos.htm

approved ICD-10 codes*

2-22-17 ACBHCS SUD Medi-Cal Included Diagnoses alpha by DSM-5 description

ICD-10	DSM-5 Diagnosis Name	ICD-10 Diagnosis Name
F10.129	Alcohol intoxication, With mild use disorder	Alcohol abuse with intoxication, unspecified
F10.229	Alcohol intoxication, With moderate or severe use disorder	Alcohol dependence with intoxication, unspecified
F10.929	Alcohol intoxication, Without use disorder	Alcohol use, unspecified with intoxication, unspecified
F10.10	Alcohol use disorder, Mild	Alcohol abuse, uncomplicated
F10.20	Alcohol use disorder, Moderate	Alcohol dependence, uncomplicated
F10.20	Alcohol use disorder, Severe	Alcohol dependence, uncomplicated
F10.239	Alcohol withdrawal, Without perceptual disturbances	Alcohol dependence with withdrawal, unspecified
F15.229	Amphetamine or other stimulant intoxication, Without perceptual disturbances, With moderate or severe use disorder	Other stimulant dependence with intoxication, unspecified
F15.929	Amphetamine or other stimulant intoxication, Without perceptual disturbances, Without use disorder	Other stimulant use, unspecified with intoxication, unspecified
F15.23	Amphetamine or other stimulant withdrawal	Other stimulant dependence with withdrawal
F15.10	Amphetamine-type substance use disorder, Mild	Other stimulant abuse, uncomplicated
F15.20	Amphetamine-type substance use disorder, Moderate	Other stimulant dependence, uncomplicated
F15.20	Amphetamine-type substance use disorder, Severe	Other stimulant dependence, uncomplicated
F12.129	Cannabis intoxication, Without perceptual disturbances, With mild use disorder	Cannabis abuse with intoxication, unspecified
F12.229	Cannabis intoxication, Without perceptual disturbances, With moderate or severe use disorder	Cannabis dependence with intoxication, unspecified
F12.929	Cannabis intoxication, Without perceptual disturbances, Without use disorder	Cannabis use, unspecified with intoxication, unspecified
F12.10	Cannabis use disorder, Mild	Cannabis abuse, uncomplicated
F12.20	Cannabis use disorder, Moderate	Cannabis dependence, uncomplicated
F12.20	Cannabis use disorder, Severe	Cannabis dependence, uncomplicated

*ICD-10 diagnoses crossed out are not found in DSM-5 & can not be basis for SUD treatment.

approved ICD-10 codes*

2-22-17 ACBHCS SUD Medi-Cal Included Diagnoses List numeric by ICD-10 code

ICD-10	DSM-5 Diagnosis Name	ICD-10 Diagnosis Name
F10.10	Alcohol use disorder, Mild	Alcohol abuse, uncomplicated
F10.129	Alcohol intoxication, With mild use disorder	Alcohol abuse with intoxication, unspecified
F10.20	Alcohol use disorder, Moderate	Alcohol dependence, uncomplicated
F10.20	Alcohol use disorder, Severe	Alcohol dependence, uncomplicated
F10.229	Alcohol intoxication, With moderate or severe use disorder	Alcohol dependence with intoxication, unspecified
F10.239	Alcohol withdrawal, Without perceptual disturbances	Alcohol dependence with withdrawal, unspecified
F10.929	Alcohol intoxication, Without use disorder	Alcohol use, unspecified with intoxication, unspecified
F11.129	Opioid intoxication, Without perceptual disturbances, With mild use disorder	Opioid abuse with intoxication, unspecified
F11.20	Opioid use disorder, Moderate	Opioid dependence, uncomplicated
F11.20	Opioid use disorder, Severe	Opioid dependence, uncomplicated
F11.229	Opioid intoxication, Without perceptual disturbances, With moderate or severe use disorder	Opioid dependence with intoxication, unspecified
F11.23	Opioid withdrawal	Opioid dependence with withdrawal
F11.929	Opioid intoxication, Without perceptual disturbances, Without use disorder	Opioid use, unspecified with intoxication, unspecified
F12.10	Cannabis use disorder, Mild	Cannabis abuse, uncomplicated
F12.129	Cannabis intoxication, Without perceptual disturbances, With mild use disorder	Cannabis abuse with intoxication, unspecified
F12.20	Cannabis use disorder, Moderate	Cannabis dependence, uncomplicated
F12.20	Cannabis use disorder, Severe	Cannabis dependence, uncomplicated
F12.229	Cannabis intoxication, Without perceptual disturbances, With moderate or severe use disorder	Cannabis dependence with intoxication, unspecified
F12.929	Cannabis intoxication, Without perceptual disturbances, Without use disorder	Cannabis use, unspecified with intoxication, unspecified

*ICD-10 diagnoses crossed out are not found in DSM-5 & can not be basis for SUD treatment.

DMC Physical Examination Requirements

Physical Examinations are an integral part of DMC Treatment

Scenario A:

If the beneficiary has had a physical exam in the12 months prior to the date of admission, then the physician must review documentation of this exam. If the physician is unable to obtain documentation of this exam, then efforts to obtain should be documented.

Scenario B:

If beneficiary has not had a physical exam in the 12 months before admission, a physician, registered nurse practitioner, or physician's assistant may perform a physical examination within 30 days of admission. The physician MUST review documentation of this exam within 30 days of episode opening

Scenario C:

If a physical examination has not been completed within the last 12 months OR the physician does not review the exam record AND/OR new exam is not completed, then the initial treatment plan MUST have a goal of obtaining a physical exam.

It is not acceptable to roll this (or any other) goal over from one Plan to the next, without revisiting the current obstacles and what modified action steps will allow for the goal to be met in the new Plan time period. (Reason for chart non-compliance from that Plan date and onward.)

Source: 22 CCR § 51341.1 (h)(1)(A)(iv)

Physician Responsibilities

- “For a provider to receive reimbursement for Drug Medi-Cal substance use disorder services, those services shall be provided by or under the direction of a physician” - 22 CCR § 51341.1 (h)
- DMC physician MUST be licensed by the Medical Board Of California or the Osteopathic Medical Board of California - 22 CCR § 51341.1 (b)(21)
- That treatment provided is known to be effective in improving health outcomes and in accordance with generally accepted standards.
- Ensure physical exam requirements are met
  - Specific information on ‘DMC Physical Examination Requirements” slide
- Review, approve, and sign Treatment Plan and updates within accepted timelines
  - For specific information see Treatment Plan section
- For specific physician responsibilities for Naltrexone Treatment Services see Naltrexone Treatment Services Section

Physician Responsibilities & Medical Necessity

- The DMC physician MUST determine and document whether SUD services are medically necessary:
  - SUD Services are "…reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of the disease, illness or injury covered by the Medi-Cal program."
- Physician must indicate that they reviewed each client's personal, medical, and substance abuse history – Source: 22 CCR § 51341.1(h)(1)(A)(iii)
  - Document the basis for SUD diagnosis in the client's individual patient record—the MD must specify the DSM criteria that is met for the Dx (unless Licensed or Registered LPHA specifies and then MD co-signs); Chart out of compliance if incomplete - Source: 22 CCR § 51341.1 (h)(1)(A)(v)

Medical Necessity & Assessment Review Cont.

All are reasons for full chart non-compliance from the date of non-compliance until completed.

- What is the timeline for establishing medical necessity and on-going treatment for AOD Medi-Cal programs?
  - Within 30 days (NTP = 28 days, Residential = 14 days) of the Episode Opening Date (EOD);
  - 90 Days from therapist signing of the previous plan for Plan Update (Narcotic Treatment Programs at "least once every quarter --aka every three months)--from EOD"); and
  - Between 5 and 6 months (from the Initial Medical Necessity or Last Justification for Continuing Treatment) the Justification for Continuing Tx must be established by the Physician with determination of Medical Necessity and with a recommendation from the counselor or therapist to continue treatment (except NTP).

Non-Drug Medi-Cal Medical Necessity Requirements

- For AOD Residential with non Drug Medi-Cal (DMC) Claiming—Medical Necessity is not required to be signed by the MD.
- A "Therapist" (Licensed or Registered with Board of Psychology or California Board of Behavioral Sciences) may sign.
- If no such staff work for the agency indicate "Non DMC program" on signature line.

Initial Medical Necessity Form

INITIAL MEDICAL NECESSITY FORM IS REQUIRED BY BHCS

- Physician MUST indicate they have reviewed each client's personal, medical, and substance abuse history
- Document the basis for SUD diagnosis in the client's individual patient record—the MD must specify the DSM criteria that is met for the Dx (unless Licensed or Registered LPHA specifies and then MD co-signs); Chart out of compliance if incomplete
- Determine and document whether SUD services are medically necessary:
  - SUD Services are "…reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of the disease, illness or injury covered by the Medi-Cal program."
- MUST be completed within 30 days of the date of admission
- MUST be signed by physician

Source: 22 CCR § 51341.1 (h)(1)(A)(v)

Use the ACBHCS Medical Necessity Form(s) and always be in compliance!

DNF to complete this section too

Medical Necessity: Providing the Rationale for SUD Services

Check Box: ☐ Initial ☐ Justification for Continuing Services

Client Name:	Client ID#:	Client Admit Date:

Physician Evaluation:

The physician or Licensed Provider of the Healing Arts (LPHA - therapist, physician assistant, nurse practitioner) acting within their respective practice, shall evaluate each beneficiary, within thirty-(30) calendar days of the client's admission to treatment date, to diagnose whether the beneficiary has a substance use disorder. The diagnosis shall be based on the applicable diagnostic code from the DSM published by the American Psychiatric Association. The physician shall document approval of the diagnosis that is performed by signing and dating the beneficiary's treatment plan. Client Information that has been considered includes the Beneficiary's personal, medical and substance use history and, when available, the client's most recent physical exam.

Physician Determination of Medical Necessity:

Physician Must Initial Either 1 or 2:

1. ______After review of the above named information, I have determined that continued treatment is **not** medically necessary and the beneficiary should be discharged from treatment.
2. ______After review of the above information, I have determined there are not physical or mental disorders or conditions that would place the client at excess risk in the treatment program planned, and that the client is receiving appropriate and beneficial treatment that can reasonably be expected to improve the diagnosed condition.

Primary Diagnosis: Medi-Cal included	Secondary Diagnosis: (not required)

Physician Note: MUST State Specific Criteria for the DSM Medi-Cal Included Primary Diagnosis

Medical Necessity is determined by the following factors:

1. The client has a primary Medi-Cal Included SUD diagnosis from the Diagnostic and Statistical Manual (DSM) that is substantiated by chart documentation. ☐ Yes ☐ No
   - a) The basis for the diagnosis is documented in the client's individual client record. ☐ Yes ☐ No
   - b) DSM diagnostic criteria for each diagnosis that is a focus of treatment is identified above ☐ Yes ☐ No
2. The included diagnosis documents that the client meets at least one of the following criteria:

	Impairment Criteria must have one of the following:	AND	Intervention Criteria - proposed INTERVENTION will...
☐	A. Significant impairment in an important area of life function.	AND	A. Significantly diminish impairment.
☐	B. Probability of significant deterioration in an important area of functioning.	AND	B. Prevent significant deterioration in an important area of life functioning.
☐	C. None of the above.	AND	C. None of the above.

Impairments:

Behavioral-attendance, performance, arguing/fighting, DUI, risky situations, paranoid/secretive or suspicious, sleep or eating habit changes, attitude or personality change, mood swings, anxious or agitated, low motivation.

Physical- bloodshot eyes, dilated pupils, weight gain or loss, physical appearance deterioration, body smells-breath/clothing/personal hygiene, tremors, slurred speak impaired coordination.

Social-change in friends/ hangouts/interests, legal problems, money problems, relationship problems

Physician or Authorized LPHA Signature	Print Name and Title	Date
If LPHA Signed, M.D. Must Co-Sign	Print Name and Title	Date

AOD_SUD P&P Doc Standards Rev Med Nec 9-19-16

DMC requires 'basis for diagnosis' to be completed. This section can contain details that supports the SUD dx for the client—<u>if **NOT WRITTEN OUT** full chart non-compliance!</u>

Make sure ALL signatures are in compliance: legibly printed name, signature, and date MUST be included—<u>if all **three req's** not met; full chart non-compliance!</u>

Justification For Continuing Services Form

FORM REQUIRED BY BHCS

- JCS Form MUST be signed by a physician no sooner than 5 months and no later than 6 months from date of admission or previous medical necessity form
- Physician MUST indicate that they reviewed each client's personal, medical, and substance abuse history
- Document the basis for SUD diagnosis in the client's individual patient record—the MD must specify the DSM criteria that is met for the Dx; if not complete chart non-compliance. (Note, there is no exception to the written basis of the Dx by the MD if the Therapist does it as in the Initial Medical Necessity Form)
- Used to determine and document whether continuing SUD services are medically necessary:
  - SUD Services are "…reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of the disease, illness or injury covered by the Medi-Cal program."
- Signing of Treatment Plan Update by the physician DOES NOT meet requirement of Justification for Continuing Services
- Source: 22 CCR § 51341.1 (h)(5)(A)

Naltrexone Treatment Services (NTS)

--additional requirements of Medical Necessity Form--

- Provider shall document / confirm that the client has a documented history of opiate addition.
- Is at least 18 years of age
- Has been opiate free for a period of time to be determined by physician based on physician's clinical judgment
  - Provider shall administer a body specimen to confirm client is opiate free
- The physician shall certify the beneficiary's fitness for Naltrexone treatment based on medical history, physical examination, and laboratory results
- The physician shall advise the beneficiary of the overdose risk of using opiates while taking Naltrexone and ineffectiveness of opiate pain relievers
- Source: 22 CCR § 51341.1 (h)(1)(B)(i)

Perinatal / Pregnancy Residential

- Women in Perinatal Residential Treatment must be pregnant or less than 2 months postpartum—to claim AOD Medi-Cal.

- What COUNTS as proof of pregnancy or last date of pregnancy?
  - Hospital discharge paperwork
  - Forms signed by a medical professional

DMC regulations ONLY permit these as proofs of pregnancy.

- What does NOT count?
  - ~~Birth Certificates~~
  - ~~Home Pregnancy Tests~~

Both would result in full chart non-compliance.

Source: 22 CCR § 51341.1 (g)(1)(A)(iii)

Residential Treatment Programs Non-Perinatal, Non-DMC

- Similar charting requirements and documentation timelines as DMC perinatal residential
  - Justification For Continuing Services and Medical Necessity is required:
    - May be signed by LPHA or physician/MD
    - MD signature not required if no medications are being prescribed
  - BHCS is seeking clarification regarding treatment plan requirements for non-perinatal residential programs.

Medical Necessity & Assessment Review Questions

- What are the three (3) requirements for Medical Necessity?
  - A DHCS included SUD diagnosis which is the Primary Focus of Treatment
  - SUD Services are "…reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of the disease, illness or injury covered by the Medi-Cal program.?
  - Treatment provided is known to be effective in improving health outcomes and in accordance with generally accepted standards.
- Who is the ONLY final authorized signer for Initial Medical Necessity?
  - The Physician or Medical Director
  - For the Initial Medical Necessity documentation ONLY (not continuing justification) the Physician or Medical Director may co-sign the Therapist (Licensed or Registered: Psychologist, Clinical Social Worker, Professional Clinical Counselor or Married and Family Therapist), PA, or NP's Medical Necessity and Diagnosis (who must have described the basis for Dx).
- Who MAY NOT formulate a diagnosis?
  - Certified SUD Counselor and/or Registered SUD Counselor

Medical Record Requirements
version 3.7.2017
"Your Success is Our Success"

Charting Requirements Individual Client Record

- Each client must have an individual record that meets HIPAA compliance for confidentiality
- NO other identifying information is allowed in another client's record
  - In past audits, charts were fully disallowed because they contained multiple client information, often in the form of combined group notes
  - As a result, the patient record was not considered unique
  - References to other clients should happen only when absolutely necessary and done anonymously (e.g. "another client")
    - Never use other clients' initials, names, nicknames, etc.

Source: 22 CCR § 51341.1 (g)(1)(A)

HIPAA
Health Insurance Portability and Accountability Act

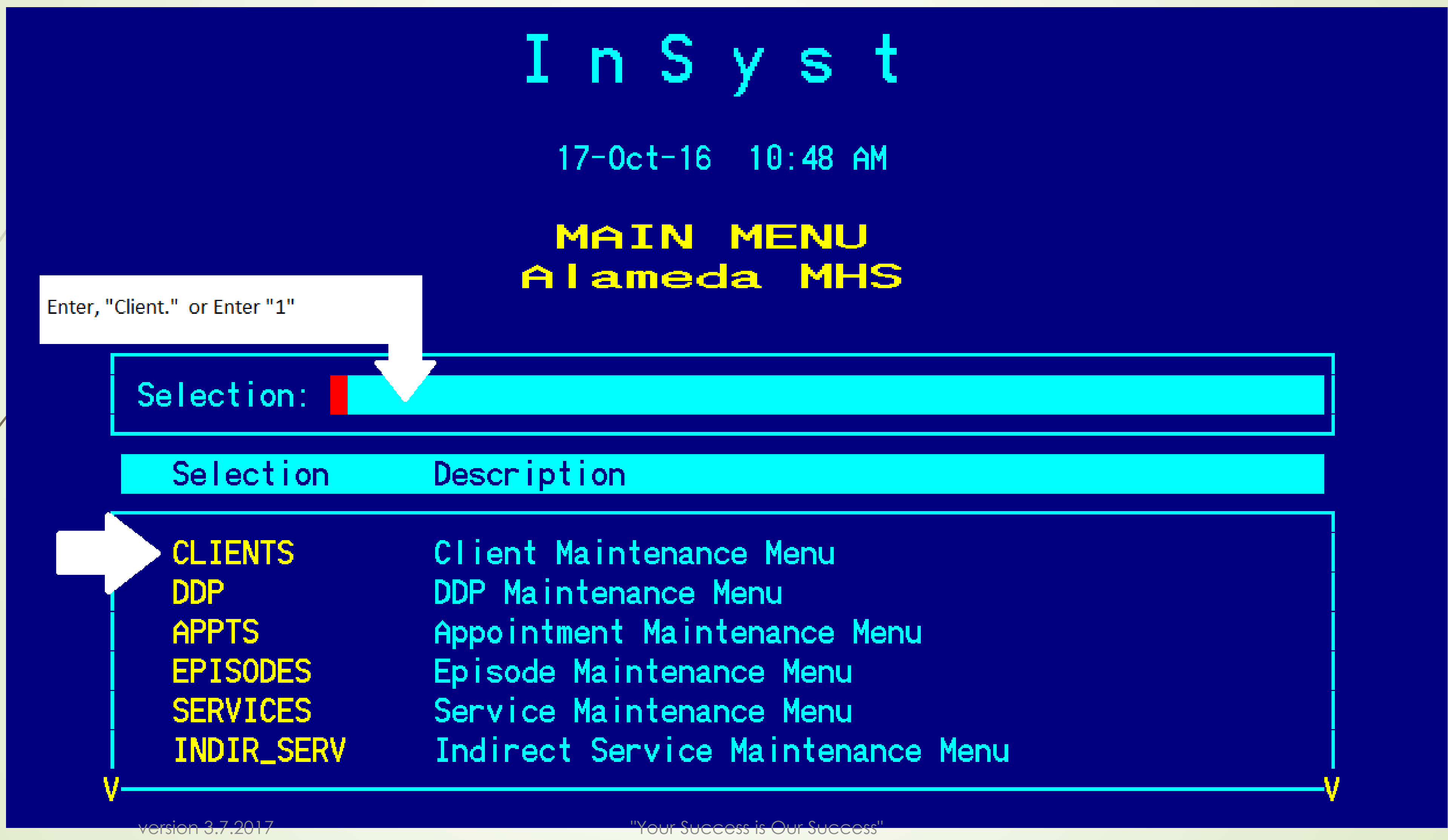
Individual Client Record

- Client record MUST include:
  - A unique identifier
  - Client's InSyst number
  - Client's DOB
  - Client's gender (aka sex), gender identity, sexual orientation and other cultural factors
  - Client's race or ethnicity
  - Client's address or indicate "homeless" for address
  - Client's telephone number or again indicate "homeless" for no telephone
  - Client's record and InSyst record must include emergency contact information with Release of Information (or reason why this was not provided)

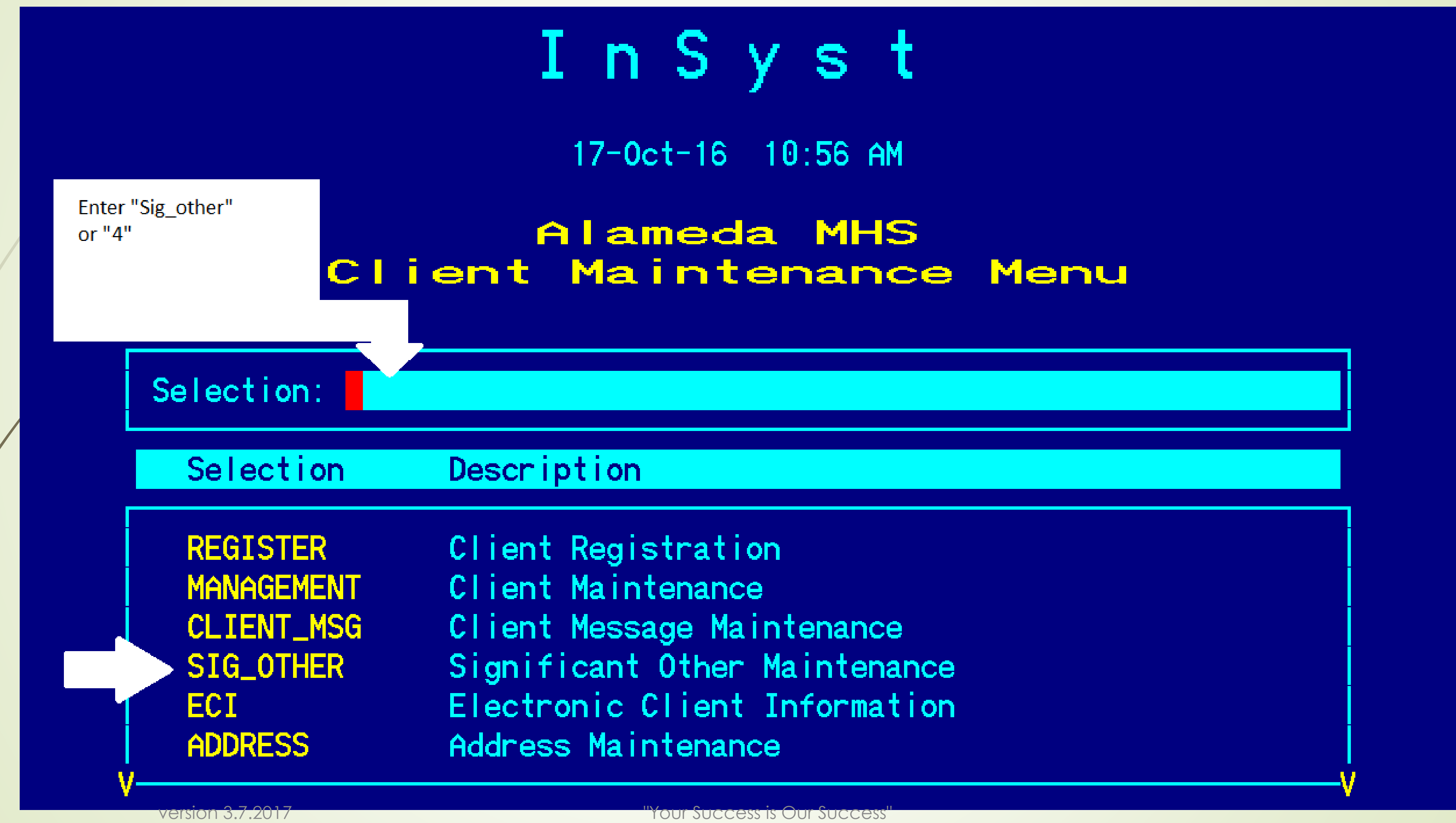
Without-will result in the entire chart being non-compliant

Source: 22 CCR § 51341.1 (g)(1)(A)

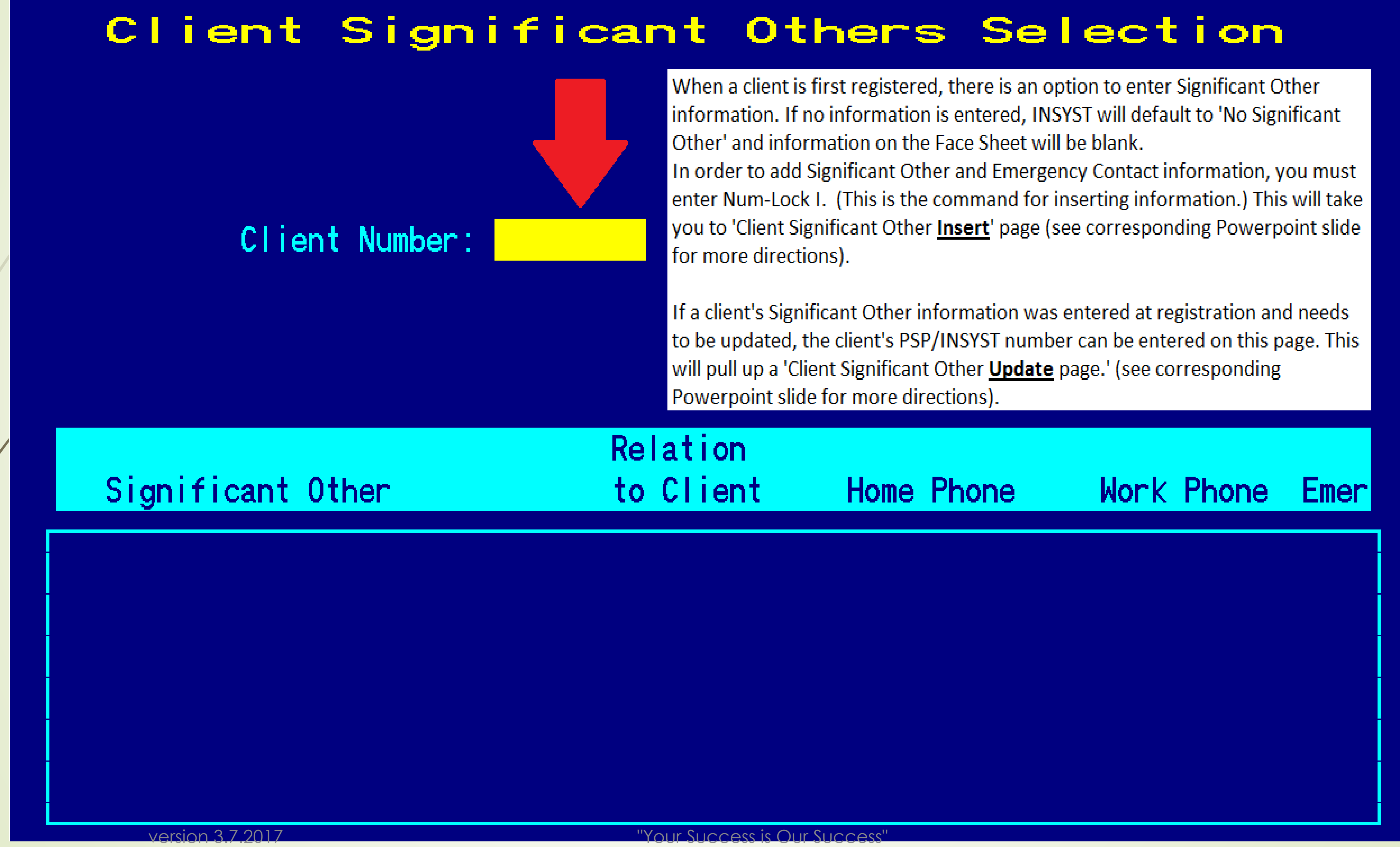
How to Update Emergency Contact Information



How to Update Emergency Contact Information



How to Update Emergency Contact Information



Inserting Significant Other Info if None was Entered at Episode Opening.

Client Significant Others Insert

Client Number: 75134621 BABY TEST

Name Last: SIMPSON First: MARGE Effective Date: 10/21/2016
Relationship to Client: MOTHER Expiration Date: / /

Street
Number: 742 City: SPRINGFIELD
Direction: State: CA Zip Code: 94619+ 555
Name: EVERYGREEN TERRACE Country: USA
Type:
Apartment: Home Phone: (510) 867-5309 Ext.: 0
Work Phone: ( ) - Ext.: 0

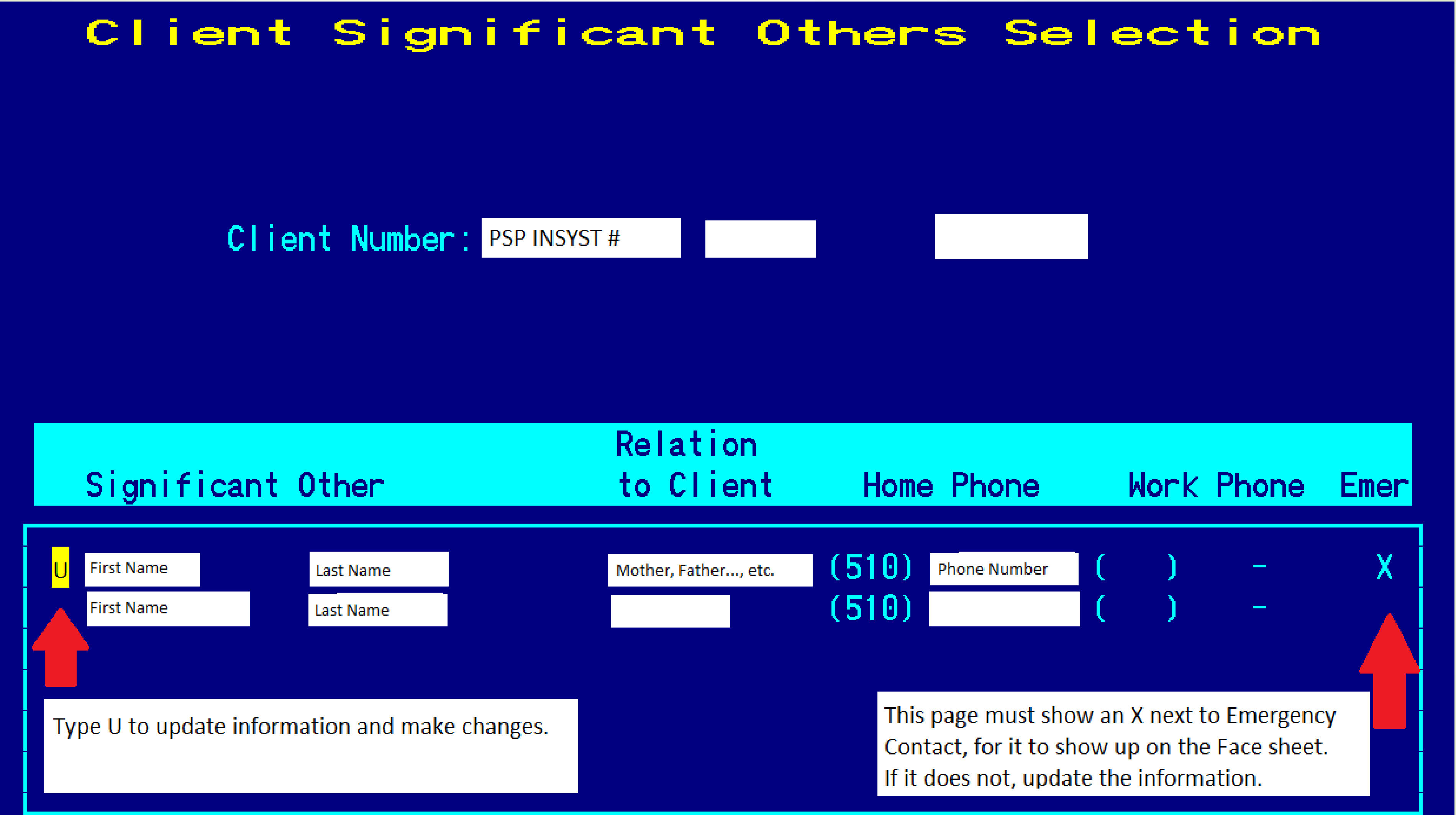
Comment:

Make sure to check 'Emergency Contact' and any other field that is appropriate.

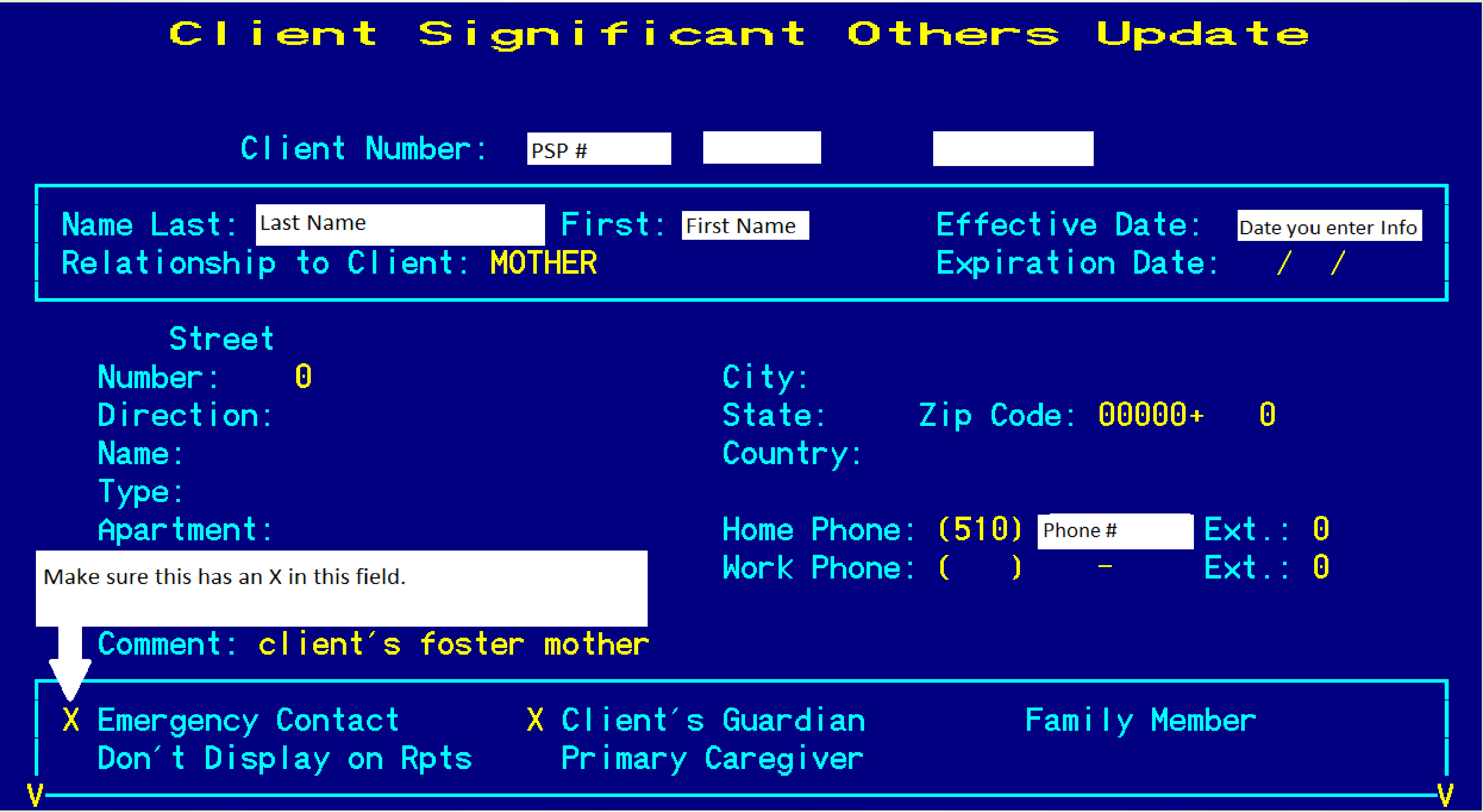
X Emergency Contact X Client's Guardian X Family Member
Don't Display on Rpts X Primary Caregiver

Continue: Y Confidential Information USER: SAMMISJ
Successful insert. Insert total = 1.

Updating Significant Other Information that has already been entered.



How to Update Emergency Contact Information



Face Sheet with Emergency Contact Info

Client Information Face Sheet

Report MHS 140
Run Date: 21-OCT-2016 Page: 1

C O N S U M E R   I N F O R M A T I O N

Name: BABY TEST | Number: 75134621 | Birthdate: 1-JAN-1950 | Age: 66
Address: | SSN: _____-____-_______ | Sex: F
, 00000 | Other ID #: 0 | Language: Thai
Phone: ( ) - | Marital: Nvr Marr | Education: None
Staff: | Disability: None | Ethnicity: O So Asian | Hispanic Origin:
Aliases: None
RP Owes: $0.00 | Medicaid: Not Eligible
Insurance: None

S I G N I F I C A N T   O T H E R S

Name	Relation	Home Phone	Work Phone	Address	Emergency
SIMPSON MARGE	MOTHER	(510) 867-5309	( ) -	742 EVERGREEN TERRACE, SPRINGFIELD, CA 94619-0555	X

C L I N I C A L   H I S T O R Y

RU	Opening	Closing	Primary Diag	Clinician	Physician	Total Units	Last Service	Legal Status	Legal Consent	Stability Rating & Date
-----CLOSED EPISODES-----										
WEST MHS	2-JUL-07	28-JUL-14	295.70	WHITE, R	Staff, G	0		W60000	NA	

Total Episode Count = 1

Treatment Plans & Documentation

"We are so *NSync"
Treatment Plans &
Documentation

DMC (And Non DMC Programs): Required Parts of a Treatment Plan

--BHCS Treatment Plan Form Highly Recommended--

- A statement of problems to be addressed
- Attainable goals of the client that focuses upon their personal vision of recovery, wellness, and the life they envision for themselves
  - Include strengths
- Challenges from reaching the goals which may include specific symptoms and impairments of the Approved Dx
- Indicate Area(s) of Difficulty: Alcohol and-or Drugs / Family & Social Skills / Legal / Employment & Support / Recovery Environment / Emotional, Behavioral and/or Cognitive Conditions & Complications
  - Indicate Level of Difficulty: Mild, Moderate, Severe

Source: 22 CCR § 51341.1 (h)(2)

DMC (And Non DMC Programs) Required Parts of a Treatment Plan Cont.

- Assignment of a primary therapist or counselor
- A description of services
  - Frequency-per week or per month
  - Type of Service-group, individual (intake, crisis and only scheduled-treatment planning), collateral
- If a beneficiary has not had a physical examination within the twelve month period prior to beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination—if goal is carried over to the following Tx Plan, the current Barriers and needed Action Steps must be indicated.
- DSM/ICD Dx

Source: 22 CCR § 51341.1 (h)(2)

DMC (And DMC Programs) Required Parts of a Treatment Plan Cont.

- Action Steps (by Client, family, significant other) with target dates for accomplishment (aka objectives)
  - Providers assist the client in developing the short-term action steps to his/her identified goal(s)
  - Includes Measurable Change in helping the client achieve his/her treatment goals;
    - Can address symptoms, behaviors and impairments (problems) identified in the assessment
    - Strength based SUD objectives replace problematic symptoms with positive coping skills/behaviors/ etc.
  - **SMART is ideal (but not required)**: **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**ime Bound

Source: 22 CCR § 51341.1 (h)(2)

DMC (And DMC Programs) Required Parts of a Treatment Plan Cont.

- Action Steps Continued—Provider's Action Steps (aka Interventions)
  - Provider Action Steps must focus upon and Problems identified in the Assessment and Intake process.
  - Interventions for Collateral (see prior slides) should include listing significant others by their names and roles (professional relationships do not qualify for Collateral services) for whom contact is planned and indicating "others as needed"
- Source: 22 CCR § 51341.1 (h)(2)

Initial Treatment Plan Signatures

Which providers can sign SUD Initial Treatment Plans?

- Non-MD (with MD co-signature, see upcoming slides with timelines--and exception for Plan Updates or Non-DMC programs).
  - Therapist
    - Psychologist licensed by CA Board of Psychology
    - LCSW or MFT licensed by CA BBS
    - Intern registered by the CA BBS or CA Board of Psychology
  - Counselor
    - Certified AOD Counselor or Registrant
- Or physician may be the sole Provider signer
- Non AOD Medi-Cal Programs require no Tx Plan signature by Physician or LPHA—SUD Counselor adequate.
- If the beneficiary is unable or unwilling to sign the plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment-if not full chart non-compliance.

Source: 22 CCR § 51341.1 (h)(2)(A)(i)(h)(ii)

All Treatment Plan Signatures

- Per Title 22 Reg. Treatment Plan signatures must include ALL of the following parts for each individual, including the beneficiary, signing the plan:
  - Typed or legibly written name
  - Signature
  - Date - Note that beneficiaries MUST write in the date themselves
  - Professional Credentials Recommended

  Source: 22 CCR § 51341.1 (h)(2)(A)(i)(h)(ii)(a),(b),&(c)

One of the most common causes of non-compliance is due to incomplete signatures that did not contain all three above requirements—if not on Plan, full chart non-compliance.

Initial Treatment Plans: Physician Responsibilities

- Physician MUST review the treatment plan and determine if treatment outline in the plan is medically necessary.
  - It is not required that the physician meet face to face with the client to develop the treatment plan.
- If the physician determines the services in the initial treatment plan are medically necessary, the physician shall type or legibly print their name and sign and date the treatment plan within 15 days of signature by the therapist or counselor (but no more than 30 days from EOD,)—if not full chart non-compliance.

Source: 22 CCR § 51341.1 (h)(2)(A)(i)(h)(ii)(c)

- Initial Narcotic Treatment Programs Treatment Plan is due within 28 calendar days and has an additional Plan Update due within 14 days of any confirmed pregnancy. MD has a full 14 days after the Counselor or Therapist's signature to sign the Plans.
- AOD Residential—non AOD M/C Claiming, Tx Plan is due within 14 days (of long-term programs 31 days or longer), and Updates no longer 90 days after prior Tx Plan. (No MD co-signatures required).

Treatment Plan Template

--Form Highly Recommended--

This treatment plan template is available as a handout in the binder and online at the BHCS Provider site—highly recommended to ensure compliance and avoid non-compliance. Address every field and instructions.

SUD Treatment Recovery Plan Page of

Client Name:	Clt ID#:	Assigned Primary Counselor-Name:	Intake Date:

Initial Plan ☐ Update ☐ Treatment Plan Update Due:	Primary Diagnosis Description & DSM Code:	Secondary Diagnosis Description & DSM Code:	Monthly Frequency of Tx Services: Individual: _____ Collateral: _____ # of Groups: _____

Date Identified	Index Number	Goals& Actions: (#A, # B)	Big Picture Goals (G) /Strengths (S) What personal strengths-mental, physical, resources & methods can I use to achieve this goal? G=Goals S=Strengths	Challenges (C)/Statement of Problem What keeps me from reaching my Goal? What changes in symptoms, behaviors, skills, and attitudes do I need to make? C=Challenges D=Deferred Challenge	My Plan of Change and Recovery/Action (A) Steps: What specific, observable & measurable changes will I make)? What are the small measurable steps towards my Goal? A=Action Indicate Action Steps By: a. client, b. counselor, c. family d. other support system R=Clinical reason for deferral	Target Date	Date Complete
					A.		
					A.		
					A.		

Client Signature:		Date:	**Physician Signature	Date:
Print Name:			**Print Name:	
Counselor Signature:		Date:	Index of Challenges / Barriers: 1) Substance Use Disorder 2) Mental Health 3) Physical Health 4) Employment/Education 5) Financial/Housing 6) Legal 7) Psycho-Social /Family 8) Spirituality 9) Deferred Challenges	
Print Name				

*Stage of Change: Pre-Contemplation - Contemplation - Preparation - Action - Maintenance – Relapse

BHCS TxPlan Form 3.1.17

Treatment Plan Example: Using BHCS Template

Primary dx must be on the plan

Primary counselor must be identified on the plan

Put challenge code in this column

Client goals for treatment AND strengths to facilitate goals.

Index of challenge codes

SUD Treatment Recovery Plan			Page of
Client Name:	Clt ID#:	Assigned Primary Counselor-Name:	Intake Date:
Initial Plan ☐ Update ☐ Treatment Plan Update Due:	Primary Diagnosis Description & DSM Code:	Secondary Diagnosis Description & DSM Code:	Monthly Frequency of Tx Services: Individual: _____ Collateral: _____ # of Groups: _____

Date Identified	Index Number	Goals & Actions: (#A, # B)	Big Picture Goals (G) /Strengths (S) What personal strengths-mental, physical, resources & methods can I use to achieve this goal? G=Goals S=Strengths	Challenges (C)/Statement of Problem What keeps me from reaching my Goal? What changes in symptoms, behaviors, skills, and attitudes do I need to make? C=Challenges D=Deferred Challenge	My Plan of Change and Recovery/Action (A) Steps: What specific, observable & measurable changes will I make)? What are the small measurable steps towards my Goal? A=Action Indicate Action Steps By: a. client, b. counselor, c. family d. other support system R=Clinical reason for deferral	Target Date	Date Complete
					A.		
					A.		
					A.		

Client Signature:		Date:	**Physician Signature	Date:
Print Name:			**Print Name:	
Counselor Signature:		Date:	Index of Challenges / Barriers: 1) Substance Use Disorder 2) Mental Health 3) Physical Health 4) Employment/Education 5) Financial/Housing 6) Legal 7) Psycho-Social /Family 8) Spirituality 9) Deferred Challenges	
Print Name				

*Stage of Change: Pre-Contemplation - Contemplation - Preparation - Action - Maintenance – Relapse

BHCS TxPlan Form 3.1.17

Treatment Plan Example: Using BHCS Template

Indicate initial or update. Must have plan fully completed and signed by due date.

Indicate initial or update. Must have plan fully completed and signed by due date.

What are the problems that require SUD treatment

Steps identified in order for client to accomplish plan goals

Plan must include frequency of services

Make sure modality is specified. Auditors can not assume if missing

SUD Treatment Recovery Plan			Page of
Client Name:	Clt ID#:	Assigned Primary Counselor-Name:	Intake Date:
Initial Plan ☐ Update ☐ Treatment Plan Update Due:	Primary Diagnosis Description & DSM Code:	Secondary Diagnosis Description & DSM Code:	Monthly Frequency of Tx Services: Individual: ______ Collateral: ______ # of Groups: ______

Date Identified	Index Number	Goals & Actions: (#A, # B)	Big Picture Goals (G) /Strengths (S) What personal strengths- mental, physical, resources & methods can I use to achieve this goal? G=Goals S=Strengths	Challenges (C)/Statement of Problem What keeps me from reaching my Goal? What changes in symptoms, behaviors, skills, and attitudes do I need to make? C=Challenges D=Deferred Challenge	My Plan of Change and Recovery/Action (A) Steps: What specific, observable & measurable changes will I make)? What are the small measurable steps towards my Goal? A=Action Indicate Action Steps By: a. client, b. counselor, c. family d. other support system R=Clinical reason for deferral	Target Date	Date Complete
					A.		
					A.		
					A.		

Client Signature:		Date:	**Physician Signature	Date:
Print Name:			**Print Name:	
Counselor Signature:		Date:	Index of Challenges / Barriers: 1) Substance Use Disorder 2) Mental Health 3) Physical Health 4) Employment/Education 5) Financial/Housing 6) Legal 7) Psycho-Social /Family 8) Spirituality 9) Deferred Challenges	
Print Name				

*Stage of Change: Pre-Contemplation - Contemplation - Preparation - Action - Maintenance – Relapse

BHCS TxPlan Form 3.1.17

Treatment Plan Example: Using BHCS Template

Primary dx must be on the plan

Primary counselor must be identified on the plan

Challenge code goes this column

Client goals for treatment AND strengths to facilitate goals.

Index of challenge codes

SUD Treatment Recovery Plan | Page of

Client Name:	Clt ID#:	Assigned Primary Counselor-Name:	Intake Date:

Initial Plan ☐ Update ☐ Treatment Plan Update Due:	Primary Diagnosis Description & DSM Code:	Secondary Diagnosis Description & DSM Code:	Monthly Frequency of Tx Services: Individual: ______ Collateral: ______ # of Groups: ______

Date identified	Index Number	Goals & Actions: (#A, # B)	Big Picture Goals (G) /Strengths (S) What personal strengths-mental, physical, resources & methods can I use to achieve this goal? G=Goals S=Strengths	Challenges (C)/Statement of Problem What keeps me from reaching my Goal? What changes in symptoms, behaviors, skills, and attitudes do I need to make? C=Challenges D=Deferred Challenge	My Plan of Change and Recovery/Action (A) Steps: What specific, observable & measurable changes will I make? What are the small measurable steps towards my Goal? A=Action Indicate Action Steps By: a. client, b. counselor, c. family d. other support system R=Clinical reason for deferral	Target Date	Date Complete
					A.		
					A.		
					A.		

Client Signature:		Date:	**Physician Signature	Date:
Print Name:			**Print Name:	
Counselor Signature:		Date:	**Index of Challenges / Barriers:** **1)** Substance Use Disorder **2)** Mental Health **3)** Physical Health **4)** Employment/Education **5)** Financial/Housing **6)** Legal **7)** Psycho-Social /Family **8)** Spirituality **9)** Deferred Challenges	
Print Name				

***Stage of Change:** Pre-Contemplation - Contemplation - Preparation - Action - Maintenance – Relapse

BHCS TxPlan Form 3.1.17

Treatment Plan Example: Deferring Challenges

Challenges identified in the assessment but not being addressed in the plan MUST be deferred. Include a clinical rationale what the challenge is and why it is being deferred.

SUD Treatment Recovery Plan — Page of

Client Name:	Clt ID#:	Assigned Primary Counselor-Name:	Intake Date:

Initial Plan ☐ Update ☐ Treatment Plan Update Due:	Primary Diagnosis Description & DSM Code:	Secondary Diagnosis Description & DSM Code:	Monthly Frequency of Tx Services: Individual: ______ Collateral: ______ # of Groups: ______

Date Identified	Index Number	Goals & Actions: (#A, # B)	Big Picture Goals (G) /Strengths (S) What personal strengths- mental, physical, resources & methods can I use to achieve this goal? G=Goals S=Strengths	Challenges (C)/Statement of Problem What keeps me from reaching my Goal? What changes in symptoms, behaviors, skills, and attitudes do I need to make? C=Challenges D=Deferred Challenge	My Plan of Change and Recovery/Action (A) Steps: What specific, observable & measurable changes will I make)? What are the small measurable steps towards my Goal? A=Action Indicate Action Steps By: a. client, b. counselor, c. family d. other support system R=Clinical reason for deferral	Target Date	Date Complete
					A.		
					A.		
					A.		

Client Signature:		Date:	**Physician Signature	Date:
Print Name:			**Print Name:	
Counselor Signature:		Date:	Index of Challenges / Barriers: 1) Substance Use Disorder 2) Mental Health 3) Physical Health 4) Employment/Education 5) Financial/Housing 6) Legal 7) Psycho-Social /Family 8) Spirituality 9) Deferred Challenges	
Print Name				

*Stage of Change: Pre-Contemplation - Contemplation - Preparation - Action - Maintenance – Relapse

BHCS TxPlan Form 3.1.17

Description of the identified challenge

Challenge code goes this column

Pro Tip: Include if any additional steps (referrals, plan for review at next plan update, etc.) will be taken.

Clinical rationale why challenge is being deferred

Deferred challenges index code

Treatment Plan Example: Using BHCS Template

Due date for next treatment plan update.

Plan updates are due 90 days from the date the counselor signed the previous plan

Must put deferred treatment plan goals in the treatment plan. Identify deferred goals with Item #9 and provide a description

SUD Treatment Recovery Plan — Page 1 of 1

Client Name: Mickey Mouse | **Clt ID#:** 123456 | **Assigned Primary Counselor-Name:** Daffy Duck, LAADC | **Intake Date:** 11/30/16

Initial Plan ☒ **Update** ☐

Treatment Plan Update Due: 3/13/17

Primary Diagnosis Description & DSM Code: F10.20, Alcohol Use Disorder, Severe

Secondary Diagnosis Description & DSM Code: F15.20 Amphetamine-Type Use Disorder, Moderate

Monthly Frequency of Tx Services:
Individual: 4
Collateral: 4
# of Groups: 12

Date Identified	Index Number	Goals & Actions: (#A, #B)	Big Picture Goals (G) /Strengths (S) What personal strengths- mental, physical, resources & methods can I use to achieve this goal? G=Goals S=Strengths	Challenges (C)/Statement of Problem What keeps me from reaching my Goal? What changes in symptoms, behaviors, skills, and attitudes do I need to make? C=Challenges D=Deferred Challenge	My Plan of Change and Recovery/Action (A) Steps: What specific, observable & measurable changes will I make)? What are the small measurable steps towards my Goal? A=Action Indicate Action Steps By: a. client, b. counselor, c. family d. other support system R=Clinical reason for deferral	Target Date	Date Complete
12/13/16	1	A	(G) I want to stop going in and out of jail and complete my DUI class. (S) Mickey is in a long term relationship and has the support of his wife, Minnie. (C) Mickey is employed but recently placed on probation due to increased absences. Mickey needs his license for work.		(A) Mickey will enroll in DUI class and with his counselor's input will coordinate his treatment schedule so he can complete the DUI class requirements and get his Driver's license back.	1/6/17	
12/13/16	7	A	(G) I want to gain self-respect and respect from my family and wife. (S) I take pride in my kids and want them to be proud of their father. (C) My drinking has caused a lot of shame and embarrassment, my wife is ready to leave me if I do not stop drinking.		(A) Mickey will attend the scheduled SUD group sessions and identify 5 triggers for drinking and/or using. (A) Mickey will attend 2 recovery support groups per week and provide his counselor with the times and locations of scheduled meetings. (A) Mickey will identity an outside support person, peer or sponsor and tell his counselor why he chose this person.	12/5/16 12/12/16 1/6/17	
12/13/16	7	A	(G) I want to improve communication and the relationship with my wife. (S) Mickey is optimistic about his marriage and also realizes there has been a lot of damage done due to his drinking. (C) The finances are a mess and his health has been negatively affected by his drinking.		(A) Mickey and Minnie will utilize collateral services to provide relationship support. Another counselor will be assigned for these services by the primary counselor.	2/6/17	
1/30/2016	9	D	(D) Client's physical examination indicates he has been diagnosed with arthritis.		(R) While client admits that he partially uses substances to self-medicate pain, Client declined to see a MD at this time and doesn't want to take any pain medications. Due to health implications, this will be reassessed at the next treatment plan update.	N/A	

Intake date field for reference

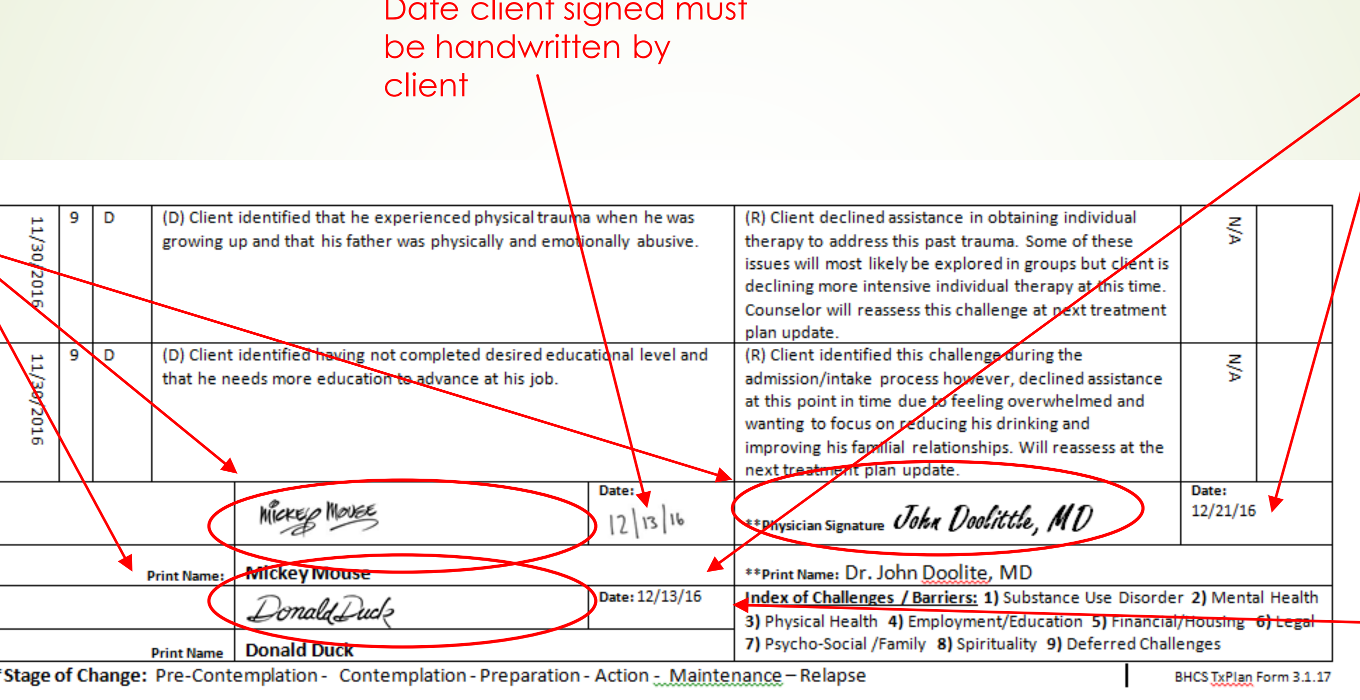
Put the clinical reason for not addressing an identified need here

Treatment Plan Example: Using BHCS Template

Complete, with legibly printed name, signature, and date.

Date client signed must be handwritten by client

Physician reviewed/signed within 15 days of counselor signature AND within 30 days Intake/EOD



11/30/2016	9	D	(D) Client identified that he experienced physical trauma when he was growing up and that his father was physically and emotionally abusive.	(R) Client declined assistance in obtaining individual therapy to address this past trauma. Some of these issues will most likely be explored in groups but client is declining more intensive individual therapy at this time. Counselor will reassess this challenge at next treatment plan update.	N/A
11/30/2016	9	D	(D) Client identified having not completed desired educational level and that he needs more education to advance at his job.	(R) Client identified this challenge during the admission/intake process however, declined assistance at this point in time due to feeling overwhelmed and wanting to focus on reducing his drinking and improving his familial relationships. Will reassess at the next treatment plan update.	N/A

Mickey Mouse	Date: 12/13/16	**Physician Signature John Doolittle, MD — Date: 12/21/16
Print Name: Mickey Mouse		**Print Name: Dr. John Doolite, MD
Donald Duck	Date: 12/13/16	Index of Challenges / Barriers: 1) Substance Use Disorder 2) Mental Health 3) Physical Health 4) Employment/Education 5) Financial/Housing 6) Legal 7) Psycho-Social /Family 8) Spirituality 9) Deferred Challenges
Print Name Donald Duck		

*Stage of Change: Pre-Contemplation - Contemplation - Preparation - Action - Maintenance – Relapse

BHCS TxPlan Form 3.1.17

Date of treatment plan = Date signed by counselor

Client MUST sign initial plan within 30 days of admission

And for plan update MUST sign within 30 days of counselor and no more than 90 days from previous plan counselor signature

Important Treatment Plan Update Timeline Requirements

All result in non-compliance if not met

- Treatment Plan Updates
  - Treatment Plans must be updated as client's functioning changes; at a minimum every 90 days (pregnant NTP clients have an additional Tx Plan due within 14 days of established pregnancy)
  - Therapist MUST complete the treatment plan update no later than 90 days after the signing of the previous treatment plan
  - The client must review and approve the update treatment plans within 30 days of the therapist or counselor signing the treatment plan AND within the required 90 day timeline
    - Remember per DMC All Signatures: must include not only a signature, but also: date signed, and legibly printed or typed name. Client must write-in the date of their signature themselves.

Source: 22 CCR § 51341.1 (h)(2)(A)(i)(h)(iii)

Important Treatment Plan Update Timeline Requirements Cont.

All result in non-compliance if not met

- The physician must review, sign, date, and legibly print their name within 15 days of the therapist or counselor's completed signature.
  - Non AOD M/C Programs do not require Physician signature—SUD Counselor is adequate.
- If the MD has not prescribed medications, a CA state board licensed psychologist may sign the treatment plan update - Source: 22 CCR § 51341.1 (h)(2)(A)(i)(h)(iii)(c)
  - MUST review, sign, date, and legibly print their name within 15 days of the therapist or counselor's completed signature

Narcotic Treatment Programs (NTP) - Treatment Plans

Two key differences

- Initial treatment plan must be completed within 28 days after initiation of maintenance treatment
- Pregnant NTP clients have an additional Tx Plan due within 14 days of established pregnancy
- Treatment plan updates are to be completed whenever necessary – due to changes in the client's functioning – or AT LEAST every 3 months
  - The effective date is based on the primary counselor's signature on the plan
  - NTP Treatment Plans are governed by Title 9, CCR §10305

Potential Treatment Plan non-compliance

- All services will be disallowed for the entire chart when:
  - Treatment Plan signatures (MUST INCLUDE date signed & printed/typed names) are missing or incomplete
  - The criteria for the diagnosis with physician's complete signature is not present (see limited exceptions on prior slides)
  - The additional Perinatal Assessment & Plan items were not assessed and addressed. (See Perinatal Slides)
- What are some common reasons for treatment plan non-compliance?
  - Primary counselor not identified in the treatment plan
  - Frequency, Duration and Type of Services (modalities) not specified
  - Goals, Objectives and Measurable Action Steps are missing or vague

Perinatal Residential Treatment Plans

Additional specific DMC requirements for Perinatal Residential treatment plans apply to <u>both Drug Medi-Cal and Drug Non-Medi-Cal Perinatal programs.</u>

- Was a need for mother/child habilitative services identified in the assessment?
  - If yes, the treatment plan must include a goal, action steps, and target date to accomplish this goal
- Does the mother need assistance in accessing ancillary services (dental, social, community, educational/vocational, and other services that are medically necessary to prevent risk to the fetus)?
  - If yes, the treatment plan must include a goal, action steps, and target date to accomplish this goal

Perinatal Residential Treatment Plans Cont.

- Prenatal exposure to substances harms developing fetuses. If this is identified as a need in the assessment there must be a goal to provide education to the mother, action steps, and target date must be included in the treatment plan to address this problem.

- Were sexual or physical abuse issues identified in the assessment?
  - If yes, the treatment plan must include a goal, action steps, and target date to accomplish this goal

- Are there service access needs (i.e. transportation, financial, other barriers) identified in the assessment?
  - If yes, the treatment plan must include a goal, action steps, and target date to accomplish this goal

Continuing SUD Services

Justification for Continuing SUD Treatment

— BHCS FORM REQUIRED --

- Must occur no sooner than five (5) months and no later than six (6) months from the date of admission / episode opening date—if not full chart non-compliance after six months of EOD.
  - Required for Narcotic Treatment Program Medical Director shall discontinue within 2 years of beginning of Tx unless completes the following: Evaluates progress of lack of progress of Tx Goals, and Determines in his/her clinical judgement that such treatment should be continued. Source: 9 CCR § Article 5, 10410
  - Therapist or counselor must review client's progress and eligibility to continue treatment and document recommendations - Source: 22 CCR § 51341.1 (h)(5)(A)(i)

Justification for Continuing SUD Treatment Cont.

- The physician must determine whether continued services are medically necessary (consistent with Title 22 CCR § 51303) and documented by the physician that the following has been considered:
  - Client's personal, medical, and substance use history
  - Documentation of the client's most recent physical exam
  - Client's progress notes and treatment plan goals
  - Therapist or counselor's recommendation
  - Client's progress

Source: 22 CCR § 51341.1 (h)(5)(A)(ii)

Justification for Continuing SUD Treatment Cont.

ACBHCS has created a form to assist with compliance for continued treatment. This form is available as a handout and on the BHCS provider website—required for compliance and to prevent non-compliance.

JUSTIFICATION FOR CONTINUING SUD TREATMENT SERVICES (JCSTS)

For each beneficiary, no sooner than 5 months and no later than 6 months after date of admission or date of last JCSTS shall be completed. DMC SUD Services 22 CCR § 51341.1 (i) (5)

Agency Name:		
Client Name:	Client ID:	Date:
Admission to Treatment Date:	Date of Most Recent JCSTS:	

Counselor Recommendation:
I recommend that the above named client continue to receive treatment services based on review of the beneficiary's progress in treatment and eligibility to continue to receive treatment services.

Counselor Additional Comment (not required):

Counselor Signature	Printed Name & Title	Date

Physician's Statement:
To ensure fulfillment of their role for establishing medical necessity, the physician shall sign a legible "individualized note using DSM Criteria" to document the basis for the DSM-SUD & Other diagnosis in the beneficiary's individual patient record.

PRIMARY DSM DIAGNOSIS:	**SECONDARY DSM DIAGNOSIS:**

Physician's Note:

Patient Information that has been considered includes the following:

- The beneficiary's personal, medical and substance use history;
- *Physical Exam (when available);
- The beneficiary's progress notes and treatment plan goals;
- The therapist or counselor's recommendation (initial or justification); and
- The beneficiary's prognosis.

***Physical Exam Requirements include vital signs; head, face, ear, throat, & nose; evaluation of organs for infectious disease; and neurological assessment conducted by a qualified physician. Check One of the Following:**

□ **A.** Within 30 calendar days of beneficiary's admission a physical exam was conducted by the provider's physician or another medical office of the beneficiary's choice.

□ **B.** Previous physical exam documentation no older than twelve (12) months from the date of beneficiary's admission to treatment.

□ **C.** The beneficiary has not completed either A. or B. above. The beneficiary and provider have documented this goal, to obtain and meet the physical exam requirements, in the client's treatment plan.

Initial One of the Following:

1. ______ After review of the above information, I have determined there are not physical or mental disorders or conditions that would place the patient at excess risk in the treatment program planned, and that the patient is receiving appropriate and beneficial treatment that can reasonable be expected to improve the diagnosed condition.
2. ______ After review of the above named information, I have determined that continued treatment is not medically necessary and the beneficiary should be discharged from treatment.

Physician's Signature	**Print Name & Title**	**Date Signed**

Just for Tx Form Title 22 51341.1 Endorsed & Approved 2015.07.14

Progress Notes

Progress Notes - ODF and Naltrexone Treatment Services(and Non-DMC non-residential programs)

All reasons for non-compliance.

- For each claimed service, there must be an individual progress note documenting that service
- Group counseling notes must be completed for each session and specific to the individual client
  - No other client information is allowed in another client's chart/record
- Notes must be completed and signed within seven (7) calendar days—and dated with date of signature (not just service date)— if not out of compliance
  - Alameda County BHCS documentation requirement

Progress Notes - ODF and Naltrexone Treatment Services(and Non-DMC non-residential programs) Cont.

All reasons for non-compliance.

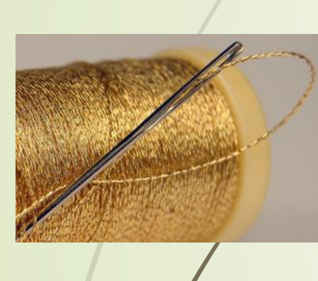
- Each note must contain:
  - The topic of the session (Relapse Prevention, Relationships, etc.)
  - A complete signature of the therapist or counselor
    - If multiple notes are combined on a single page, each note must have all of the required parts
  - The type of counseling format (i.e. individual, group, collateral, crisis)
  - A <u>description of the client's progress</u> towards treatment plan challenges, goals, action steps, objectives, and or referrals
  - Information about the client's attendance in the group and individual counseling sessions—including <u>Start and End Times (not just total minutes).</u>

Source: 22 CCR § 51341.1 (h)(3)(A)

Progress Notes – IOT & Perinatal Residential Programs (and-DMC Residential)

All reasons for non-compliance.

- Must have at least one (1) progress note per calendar week (recommend short note for each service to inform the weekly note), containing:
  - A description of the client's progress towards treatment plan challenges, goals, action steps, objectives, and or referrals
  - Information about client's attendance at each session, including the date, start and end time, and topic of the session
  - Each note must have the complete provider signature
  - Notes must be completed and signed within the following calendar week of the services



  - 22 CCR § 51341.1 (h)(3)(B)

Progress Notes – IOT Only

All reasons for non-compliance.

- The record must document a minimum of three (3) hours per day for three (3) days per week of individual or group sessions
  - Or structured therapeutic activities were offered & available (per schedule) AND one of the three

    1. Document the one-time occurrence as to why they didn't attend or attended less than 3 hours—specific to any given day or week--with proof such as scheduling slip for MD appt conflict, etc.

    2. If difficulty engaging, assess nature of difficulties and update Treatment Plan (within 1 – 2 weeks) with new action steps. If Plan is not updated by end of week 2—step down to ODF.

    3. If Plan is modified and client does not respond (by the end of 3rd week) then step down to ODF or consider other referrals such as co-occurring IOT.
  - If IOT no longer clinically indicated, step down to ODF
    - See attached SUD-IOT Services document

      and see 22 CCR § 51341.1 (h)(4)(A)(i),(ii)

Progress Notes

--Recommended form--

ACBHCS has developed a progress note form for providers that is available on the BHCS Provider website

CLIENT PROGRESS NOTES

Client Name: **ID#:**

Service Date	Type of Service	Start/ End Time	Tx Plan Index # (s)	**Behavior:** What are the Clt's observations, thoughts and comments? What are the Counselor's observations (affect, mood, appearance)?	**Intervention:** What Clt goals & objectives were discussed? Was homework reviewed or assigned?	**Response:** What was the Clt's response to the session and their progress in reaching treatment goals?	**Plan:** Does the tx plan need to be updated? What are the Counselor's next steps and when is the next session date?	Date Note Signed
		—						

Services Types: **Counselor or Therapist is required to legibly print their name, sign and date EACH note.**

Intake/Individual-I	Group=G	Crises=C	Collateral=CO	Case Mngt=CM	Tx Plan=TP	Transport=TR	Medication=M	Discharge Plan=DP	Other=O

Index #s: 1) Substance Use Disorder 2) Mental Health 3) Physical Health 4)Employment/Education 5) Financial/Housing 6) Legal 7) Psycho-Social /Family 8) Spirituality To Be Added=**TBA** Not Applicable=**N/A**

The date of the counseling session may be different than the date note is signed. Notes must be legibly printed, signed and dated by the counselor/therapist the day of service or no later than 7 calendar days from the date of the counseling session.

Sample Progress Notes

Available as a handout in the rear of your binder

CLIENT PROGRESS NOTES

Client Name: Mickey Mouse **ID#: 123456**

Service Date	Type of Service	Start/ End Time	Tx Plan Index # (s)	**Behavior:** What are the Clt's observations, thoughts and comments? What are the Counselor's observations (affect, mood, appearance)? **Intervention:** What Clt goals & objectives were discussed? Was homework reviewed or assigned? **Response:** What was the Clt's response to the session and their progress in reaching treatment goals? **Plan:** Does the tx plan need to be updated? What are the Counselor's next steps and when is the next session date?	Date Note Signed
1/16/17	Group	6p to 7:30p	1	B: Client shared that he continues to drink alcohol daily and discussed how he does not know how to stop. Mood and affect appeared angry, agitated, and with feelings of stress. I: Client participated in Anger Management / SUD Group. Facilitators assisted group in discussing alternative coping strategies to reduce angry responses and impact of SUD (and resulting anger) on interpersonal relationships. R: Client participated in the group when directly asked but did not volunteer much on his own. Seemed distracted and had trouble focusing on the topic. P: Client will continue to attend groups to gain increased understanding of the impact of substance use on relationships. Will work with client on developing more effective and less destructive ways to cope with stress.	1/18/17
				Donald Duck	
				Donald Duck, LAADC	
1/18/17	Collateral	2:15p to 2:50p	7	B: Counselor met with client's wife due to her concerns about client's continued substance use. Client signed a Release of Information on 11/30/16 allowing counselor to discuss client's treatment. Client's wife shared that client uses substances every day and does not appear to be slowing down. She shared that he is very difficult to be around and that she has thoughts of leaving him. I: Counselor spoke at length to client's wife, discussing ways she can provide support when he relapses; for example how to set appropriate boundaries with client, when to encourage client to contact his sponsor, to encourage client to share his feelings of sadness at groups. Counselor shared some of the coping mechanisms and stress relieving techniques client is working on in groups (listening techniques, reducing reactivity, alternative behaviors). R: Client's wife thanked counselor for advice on ways to provide support for client and how to set boundaries with him when he is drinking. Client's wife agreed to try some of these techniques and would contact counselor the following week to discuss progress. P: Based on client's wife reports, client continues to demonstrate significant impairment due to daily use of substances. Client continues to struggle with stress management and may be taking out work related stress at home.	1/22/17
				Donald Duck	
				Donald Duck, LAADC	
1/22/17	Group	6p to 7:20p	1	B: Client discussed still feeling angry about his previous day at work. Shared having a difficult time waking up and that he had a drink (beer) immediately upon waking. I: Client attended Mindfulness Group. Facilitators encouraged participants to recall previous times in their lives when they had success managing stress and anger without using substances. Group members linked this to their current situation and identified specific ways they can use these in their current position. R: Client appeared despondent and unfocused. He left the group about 10 minutes early stating he was getting tired and had to take the bus home. P: Client will continue to attend groups to gain increased understanding of the impact of substance use on relationships. Will work with client on developing more effective and less destructive ways to cope with stress.	1/23/17
				Donald Duck	
				Donald Duck, LAADC	

Services Types: **Counselor or Therapist is required to legibly print their name, sign and date EACH note.**

Intake/Individual-I	Group=G	Crises=C	Collateral=CO	Case Mngt=CM	Tx Plan=TP	Transport=TR	Medication=M	Discharge Plan=DP	Other=O

Index #s: 1) Substance Use Disorder 2) Mental Health 3) Physical Health 4)Employment/Education 5) Financial/Housing 6) Legal 7) Psycho-Social /Family 8) Spirituality To Be Added=TBA Not Applicable=N/A

The date of the counseling session may be different than the date note is signed. Notes must be legibly printed, signed and dated by the counselor/therapist the day of service or no later than 7 calendar days from the date of the counseling session.

DMC Minimum Contact Requirements

All reasons for non-compliance.

- For ODF and Naltrexone Treatment Services, the record must document at least two face to face sessions per 30 day period
  - If client does not meet this requirement, document close of services
  - There are two exceptions to this regulation if documented:
    - Fewer contacts are deemed clinically appropriate
    - Client is progressing toward treatment plan goals
    - Source: 22 CCR § 51341.1 (h)(4)(A)
- For IOT attendance requirements see prior slides & SUD-IOT Requirements Doc.
  - Source: 22 CCR § 51341.1 (b)(8)
- Narcotic Treatment Programs

  - Client shall receive a minimum of 50 minutes of counseling per month
    - The Medical Director may adjust or waive this requirement and document the clinical rationale behind the waiver
  - Source: 22 CCR § 51341.1 (h)(4)(B)

Collateral Services

- Are face to face sessions with the SUD therapists (or SUD counselor) and any significant persons in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms or supporting the achievement of the beneficiary's treatment goals.
- Significant persons are individuals that have a personal relationship(family member, non-paid advocate, sponsor, etc.), AND not an official or professional relationship (CWW, Probation Office, Teacher, etc.) with the beneficiary.
- Must be indicated in Tx Plan with frequency (2x/month).

SUD Group Treatment

SUD Groups

- SUD groups must be between 2 and 12 participants — reason for non-compliance
  - Groups larger than 12 participants must be broken into two separate groups with different SUD Counselors.
  - Group size updated by: CA State Plan Amendment (SPA) 15-012 Substance Use Disorder Services Expansion and Definition Changes
- A client that is 17 years of age or younger can not participate in group counseling with any participants who are 18 years of age or older—reason for non-compliance
- However, a client who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site

Source: 22 CCR § 51341.1 (b)(11)

Group Sign-In Sheets

All reasons for non-compliance.

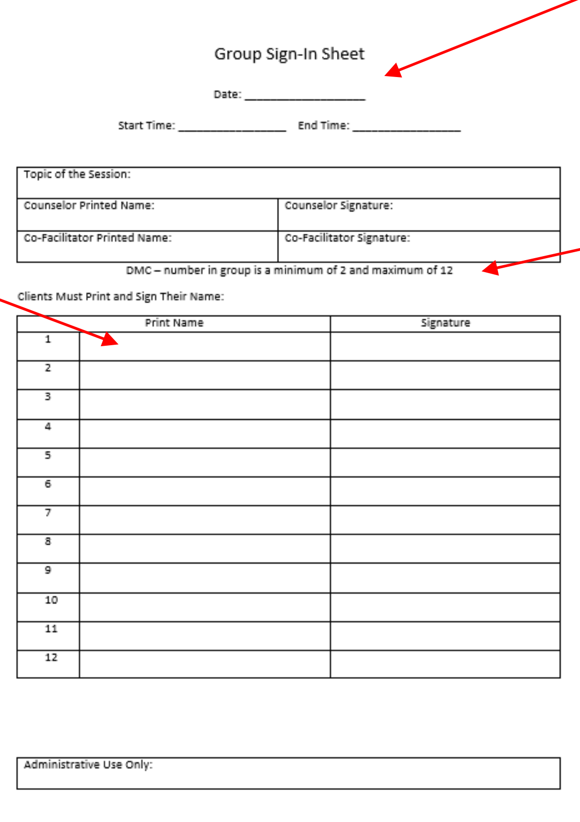
- Improper handling of group sign-in sheets was a frequent cause of non-compliance during prior SUD audits

- Required parts of group sign-in sheets include (22 CCR § 51341.1 (g)(2)):
  - Date of the group session
  - Topic of the group
  - Start and End Times of the group
  - Typed or legibly printed names of the participants (this can be pre-typed)
  - Signature of each participant (must be clear that it matches the name—if not legible due to client's writing inability, counselor must indicate.)

- Group sign-In sheets should be kept separate from the chart as it contains multiple clients' PHI and provided to BHCS whenever a chart is audited

Group Sign-In and signatures

Make sure members print their names legibly and sign their names.



Group Sign-In Sheet

Date: ______________

Start Time: ______________ End Time: ______________

Topic of the Session:	
Counselor Printed Name:	Counselor Signature:
Co-Facilitator Printed Name:	Co-Facilitator Signature:

DMC – number in group is a minimum of 2 and maximum of 12

Clients Must Print and Sign Their Name:

	Print Name	Signature
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Administrative Use Only:

Facilitators must enter **date** of group and **start/end times** to be in compliance. (Recommend they also type, legibly print names of clients.)

DMC SUD groups must be between 2 and 12 members

Keep sign-in sheets separately in order to maintain HIPAA compliance and confidentiality

When charts are requested for audit, remember to provide all corresponding sign-in sheets, otherwise the auditor is unable to confirm group compliance.

Discharge Summary
&
Discharge Plan

Discharge: Summary v. Plan

--see highly recommended compliant forms--

- A discharge plan is a plan to support client's discharge from the program
  - A plan is developed in conjunction with the client and is intended to transition client from treatment services
  - Can be claimed when completed face-to-face with client
  - Discharge plans should be prepared (discussed and signed with client) within 30 days prior to the last face-to-face treatment with client in order to be claimed
- A discharge summary is a summary of treatment services, progress, and prognosis—this is required when contact is lost with the client.
  - Must be completed within 30 days of last face-to-face service
  - Can be claimed if completed with the client face-to-face
  - Otherwise, should be non-billable

Source: 22 CCR § 51341.1 (h)(6)

Discharge Plans

- Recent SUD Audit indicated that client discharges are not being documented or completed according to DMC requirements
- When provider has lost contact with client, a discharge plan is not required, but the circumstances should be documented in a non-billable note & Discharge Summary.
- Must document that client was provided (or offered and reason for refusal) a copy of their discharge plan at the last face-to-face. - Source: 22 CCR § 51341.1 (h)(6)(A)(iii)

"Client discharged from the program" Is not a discharge plan!

Discharge Plans

--Form Highly Recommended--

- Discharge plans MUST include:
  - Description of each client's triggers and a plan to assist the client to avoid relapse when confronted with triggers
  - A support plan
  - Complete signature of therapist or counselor
  - Client's legibly printed name, date, and signature

Source: 22 CCR § 51341.1 (h)(6)(A)(i)

Discharge Summary Required when Client Contact Lost

--Form Highly Recommended--

- Discharge Summary MUST include:
  - Duration of treatment (admission date to date of last service)
  - Reason for discharge and if discharge was involuntary or successful completion of SUD services
  - Client prognosis
- If the discharge summary was not completed face-to-face with client, it must be disallowed
- Source: 22 CCR § 51341.1 (h)(6)(B)

Drug Medi-Cal Eligibility

- Check Medi-Cal Eligibility the first week of each month (if any services are being claimed to Medi-Cal).
  - If client loses Medi-Cal for a given month, or no longer meets Medi-Cal criteria (such as for Perinatal IOT in Residential).
    - Close case to Medi-Cal with D/C Summary and provide client with Fair Hear Notification. Continue to serve client as if Medi-Cal is being claimed.
  - If Medi-Cal is regained—provide note in client's chart that Medi-Cal case is reopened.

Alameda County BHCS requirement

Sources / Resources

- CA CCR Title 22: http://bit.ly/2hwel56
- https://www.sfdph.org/dph/files/CBHSdocs/SUD-Treatment-Provider-Manual.pdf
- http://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/Enclosure%204_15_30.pdf