PLANNING, PROVIDING, AND DOCUMENTING

Treatment in the Drug Medi-Cal, organized delivery system (DMC-ODS) environment

Person-Centered Recovery Oriented Care

Documentation Training Goals

Objectives

- Review the Intake/Assessment process and identify the documentation critical for a "valid" admission to services
- Improve the ability to translate ASAM data into patient-centered problem statements and goals that address Medical Necessity
- Identify the elements each treatment plan must include
- Describe how to efficiently and effectively meet requirements for clinical documentation, from Intake to Discharge/Transfer

Title 22 establishes **regulations for the Treatment Process**. . .

DMC and DMC-ODS **services elements:**

a) **Intake-** Establish eligibility, Medical Necessity, and complete admission process
b) **Treatment Planning-** Initial, Periodic Reviews, and Updating
c) **Program Services** - Providing and documenting services supporting the plan
d) **Justification for continuing services** beyond regulatory limits; and
e) **Discharge** from treatment- Completing a Discharge Plan and Summary.

Services must be provided by or under the direction of a physician:

Admission to Treatment
Eligibility

What **Eligibility for SUD benefits** must be verified by the provider, every month of service prior to billing services for that month. This includes:
- Validating Residency
- Validating Medi-Cal Eligibility

Individuals who have eligibility but not "active" benefits at time of assessment may be provided services under "case management" while program assists them in activating or transferring enrollment (see page 42, provider manual)

Who **Provider staff.**

When **At Intake**

NOTE: Notes documenting any intake/admission information should be maintained in the Client Record

Part 1 - Admission to Treatment
INITIAL SCREENING

What **ASAM Criteria Screening** (Youth or Adult) using the standardized Fresno County Substance Use Disorder (SUD) screening tool

Who **Access Line providers, Urgent Care/Youth Wellness Center, or providers (LPHA; Counselor,** Certified or Registered)

When Prior to admission

Note: Screening is used to determine an appropriate level of care for the individual and to facilitate a successful referral and linkage treatment

Part 1 - Admission to Treatment
INTAKE/ASSESSMENT

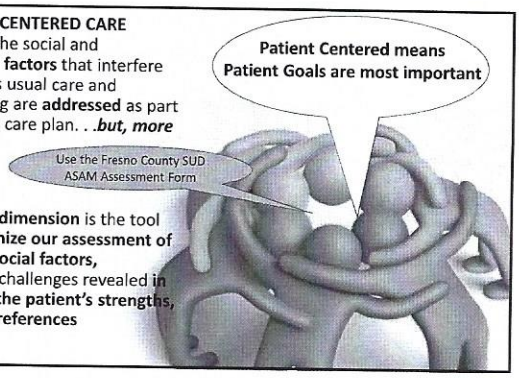
What
- **Assess if applicant meets admission criteria**
- **ASAM Criteria Assessment** (ASAM- Youth or Adult) to include: **6 dimensions with risk ratings and appropriate level of care [LOC] determination; *Personal History*** (Family; Social/Recreational; Employment; Education; Criminal; Legal Status); ***Medical History*** (Medical; Psychiatric/Psychological); ***Substance Use History*** (Drug/Alcohol History; Treatment History). . .

Who **LPHA; Counselor** (Certified or Registered)

When Intake Session: You have **10 calendar days from Referral screening** to provide intake session (**24 hrs if Urgent** admit; 3 days for OTP/NTP).

Note: Assessments need to be updated on a regular basis—OP/OPT every 90 days (youth after 90 days, then every 30); Residential every 30 days– all treatment, **when there are changes in the patients status**; and, **at every care transition**.

- In a **PATIENT-CENTERED CARE ASSESSMENT** the social and **environmental factors** that interfere with a patient's usual care and decision-making are **addressed** as part of the patient's care plan. . .***but, more importantly***



- **The ASAM 6 dimension** is the tool we use **to organize our assessment of the biopsychosocial factors,** examining the challenges revealed **in the context of the patient's strengths, abilities, and preferences**

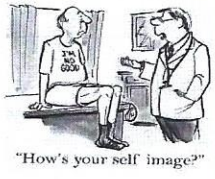
Part 1 - Admission to Treatment
Diagnosis and **Medical Necessity**

What **Review of the Admission Assessments and intake information to determine DIAGNOSIS; establish MEDICAL NECESSITY; and, apply ASAM CRITERIA**

Should be done at intake or as soon as possible thereafter

When-

- **OP; OPT**- Within 10 days from admission Date
- **RES; WM** – Within 3 days of admit



Who does this review?- **LPHA** and includes a face-to-face with counselor; then ***Documents***

- ***DSM-V diagnosis***
- ***basis for diagnosis*** (writes a narrative summary based review of intake information
- Verifies **Medical Necessity** – impairment focus
- Applies ASAM Criteria

Note: Youth <21 years without a SUD diagnosis may "at risk" and receive appropriate services

Some Notes on MEDICAL NECESSITY

The CORNERSTONE of Admission

A simple way to look at when services are MEDICALLY NECESSARY. . . .

1. There is a **SUD diagnosis** (**DSM-V** diagnosed, must have at least one diagnosis; youth <21 years may be **"at risk" by ASAM** Criteria)
2. There are **impairments**—functional and diagnostically related (**ASAM-** Treatment services are consistent with standard treatment of the condition; **meet ASAM Criteria**)
3. It can be reasonably expected that **treatment will improve functioning** (**ASAM-** Services are required for other than convenience)

See 22 CCR §51303; 42 CFR §438.210(a)(4) and, ASAM Criteria (2013)

Part 1 - Admission to Treatment
Physical Exam

For Admission into a DMC SUD Treatment Program a **Physical Exam* is required** in one of the following ways:

a. They have had a Physical Exam within the past 12-months. Obtain copy and place in patient record; **or**

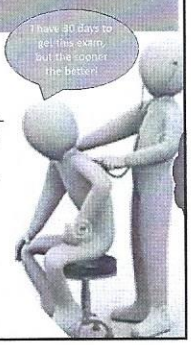
b. Perform a **new physical exam** (by a physician, PA, or LNP)

OR, if neither (a) or (b) has been performed,

c. Include the goal of obtaining a physical exam in the **Treatment Plan. . . .**

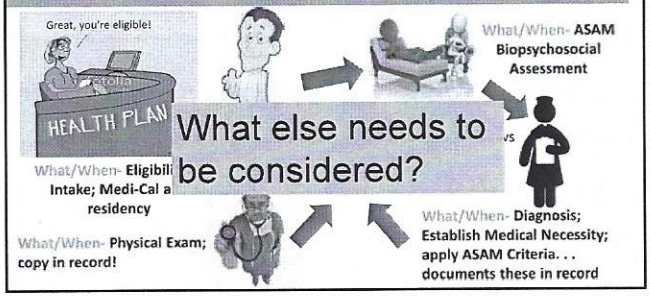
--The Physical Exam must be reviewed by a physician. . .

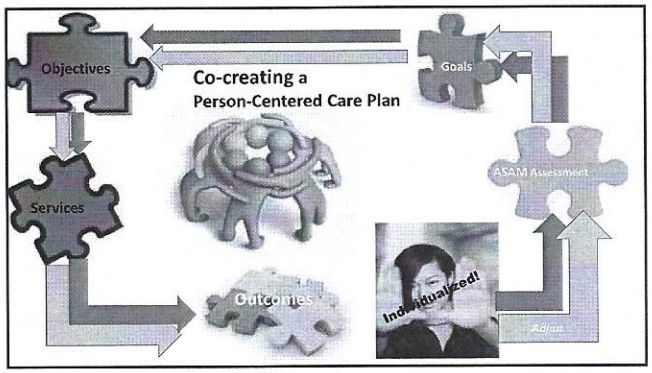
*Perinatal Treatment is limited to pregnant and post partum women, medical documentation of pregnancy and the last day of pregnancy must be in the client record



TITLE 22 AND DMC-ODS - Admission to Treatment
Eligibility; Assessment; Physical Exam

***This is an Admission Work Task Flow**





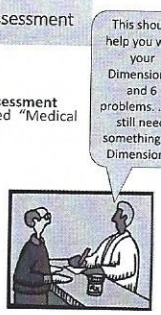
Part 2 - Treatment Plan: Individualized and Base on Assessment

By Title 22 and DMC-ODS Waiver, Treatment Plans **must be:**

- **Individualized** and **Patient-Centered**
- **Based on the information obtained during the intake and assessment process**- Reflect the appropriate treatment for the documented "Medical Necessity"...

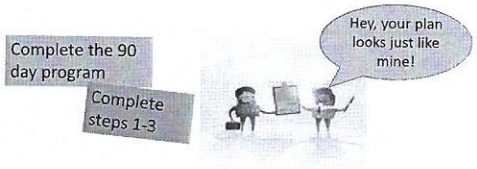
1. Acute Intoxication/withdrawal potential
2. Biomedical Conditions and complications
3. Emotions, Behavioral, or Cognitive Conditions
4. Readiness to Change
5. Relapse, Continued Use Potential
6. Recovery and Living Environment

When signed by the Physician or LPHA, the Treatment Plan becomes A Prescription directing Treatment Services. . .



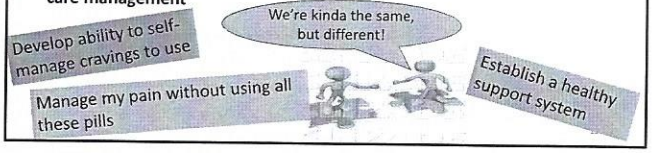
Program-Driven Plans

- ❑ Services and anticipated length of stay are determined primarily by the **philosophy, design,** and **model** of treatment— offer a **fixed length of stay** from which patient's **graduate** and say, **"I completed my treatment"**
- ❑ Problems are more "generic"—Not "wrong", they just fall short of recognizing and addressing individual strengths, needs, abilities, or preferences (SNAP)



Individualized Patient-Centered Plans

- ❑ **Services** are those determined to best **address the individual treatment needs of the patient**
- ❑ **Length of stay** is based upon the patient's response to treatment
- ❑ **Treatment plans link** problems link directly **to issues relevant the patient and identified in the assessment** (ASAM and others)
- ❑ Plan often includes a wide variety of services available from the community's resources and continuum of care—**Reflects comprehensive, chronic disease care management**



Part 2 - Treatment Plan: **Other Requirements**
Patient-Centered and with all the right stuff. . .

1. **Statement of problem(s)** clearly linked to issues identified in the assessment (ASAM)
2. **Goals to be reached** that address each problem
3. **Action steps**- Specific activities and interventions
4. **Target dates** to complete action steps/interventions
5. **Description of services- type** and **frequency**
6. Assignment of Primary **counselor- name**
7. **DSM diagnosis**
8. **Signatures**- counselor, patient, and LPHA (Typed/Printed names) and **date(s) signed**.

Always type/print names next to signatures

TIMELINES - TREATMENT PLANS

WHEN-
OP/IOT/RES- Complete within **10 days** signed (Counselor and Patient*); reviewed and approved as "medically necessary" by LPHA within 7 days of counselor signature

NTP/OTP- Complete within 28 days; Supervising Counselor and Medical Director review/sign within 14 days after counselor signature

Who- Completed by LPHA or Counselor; Reviewed and signed by LPHA

***If Patient refuses to sign the treatment plan, document** Patient's reason for refusal and your plan to increase their participation

Part 2 - Treatment Plan: **Updates and Revisions**

Treatment Plans must be reviewed and updated as follows:

a) No later than **90 calendar days after the counselor's signing the initial/ previous treatment plan**, OR

b) **When a change** in problems identification or focus of treatment **occurs**

The Counselor signs upon completion; Patient signs within 30 days of counselor

Updated treatment plans must be reviewed for medical necessity of services and signed/dated by the LPHA within 7 calendar days of signature by the counselor;

Part 2 - Treatment Planning: Medical Issues and Case Management

If Patient did not have a current physical exam or there are significant Biomedical Conditions or Complications, TREATMENT PLAN must include:

1. Obtaining a Physician Exam
2. Goal of obtaining appropriate treatment for an identified significant medical illness

Case management services are especially important among patients with chronic health problems, co-occurring disorders, or justice system involvement.

Problem: Patient has lost several teeth recently and experiences frequent, significant oral pain. Absence of dental care in over 7 years
Goal: Get a dental check up and develop a care plan with dentist

IF THE ASSESSMENT IDENTIFIES case management needs, a case manager must discuss the results and collaborate with the patient to **develop an individualized treatment plan that includes the patient's case management needs.**

PART 3- Documenting Case Notes in the Patient Record

Progress notes serve three major functions:

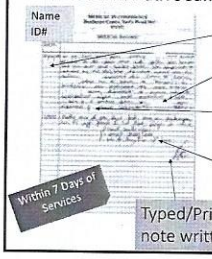
1. **Document all services rendered** during the course of treatment (ARE THE BASIS FOR BILLING);
2. Provide **a record of all significant clinical data** experienced during the treatment episode
3. **Describe response to treatment**—how services provided impacted impairments and functioning

They are critical basis for reviewing and adjusting treatment plans.

Progress notes for group & individual sessions may follow various formats: SOAP; GIRP; SIRP; DAP; BIRP . . .be consistent when documenting Clinical treatment sessions.

Part 3 - Documentation- Progress Notes Outpatient, NTP/OTP, and Recovery Services

For each individual or group session, the **counselor who conducted** that **session** shall **record a progress note** for each participant. Must be a legible, individual narrative summary and include the following information:



- Topic of Session
- Description of progress: toward goals, new issues
  - Type of support, interventions offered
- Date, Start, and End Time of each Service
- Document if face-to-face or electronic; if in community, location of service and how confidentiality was ensured
- Typed/Printed Name of LPHA or Counselor, signature, and date note written – MUST BE WITHIN 7 DAYS OF THE SESSION

Part 3 - Documentation- Progress Notes
Intensive Outpatient Treatment and Residential Treatment

The **counselor shall** record **one progress note (at a minimum) per calendar week for each participant**. Must be a legible, individual narrative summary and include the following information:

- Topic of each Session
- Remember to chart within the following week of summary
- **Description of progress**: toward goals, new issues
  - Type of support, interventions offered
- Date, Start, and End Time of each Service; Record of participants attendance
- Document if face-to-face or electronic; if in community, location of service and how confidentiality was ensured
- Typed/Printed Name of LPHA or Counselor, signature, and date

Part 3 - Case Management Notes

Case manager shall record one progress note for each case management activity and shall include:

- Beneficiary's name and Unique ID Number
- Purpose of the service and description of how service relates to the treatment plan (goals, objectives, action steps, referrals)
- Date with start/end time; documentation time; and travel time
- Identify if services were provided in-person or electronically, include where services were provided and, if in community, how confidentiality was maintained
- Case manager's name (typed/printed), signature, and date note written (**within 7 days of week of service**)

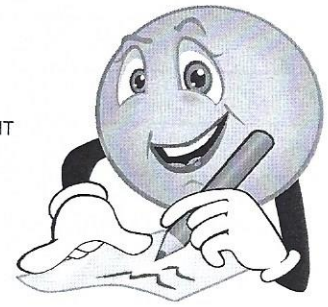
Part 3 – Physician Consult, MAT & Withdrawal Management (WM) Progress Notes

For medical progress notes, the physician or LPHA working within their scope of practice that provided the service shall record a progress note with the following:

- **Beneficiary Name and Unique Identifying Number;**
- **Purpose of the Service;**
- **Date with Start/End times of each service; and,**
- **Identify if services were provided face-to-face, by electronic means (telephone or telehealth)**
- **Physician/LPHA sign and date the progress note within 7 days of the service**

Let's discuss progress notes. .....

How do we consistently chart PROGRESS TOWARD TREATMENT PLAN GOALS AND OBJECTIVES?



Part 3 – Documentation Sign-In Sheets: DON'T FORGET GROUP SIGN IN SHEETS!!!

Maintain a group counseling sign-in sheet for every group counseling session which includes:

Topic of Session

Date, **Start**, and **End Time** of the session

Typed/printed names of each participant with their individual signature next to name. . .

Typed/Printed Name of LPHA or Counselor with signature

Part 4 - Program Services, Outpatient

Definitions- Outpatient services (OS) are non-Residential services which include:

- Group Sessions and/or Individual Sessions, Intake, Treatment Planning, Crisis, Collateral Session, and Discharge, Individual counseling, Family Therapy, Medication Services, and Patient Education.
- Sessions may be face-to-face or by telehealth and are not restricted to certified sites
- Client's 17 years of age or younger may not participate in a group with older, 18+, clients unless at a certified school site.

Beneficiaries attend up to 9 hrs/week (adults); up to 6 hrs/week (youth)

Minimum attendance (2 session/30 days) requirement waived only if:

- Fewer contact are clinically approved, and
- The beneficiary is making progress towards treatment plan goals

Exceptions or waivers must be noted, signed and dated by the physician and placed in the client's treatment plan

Part 4 - Program Services, Intensive Outpatient Treatment (IOT)

Service Definitions, IOT- Non-Residential services provided **9-19 hrs/week** (adults) or 6-19 hrs/week (youth)

The Components of Intensive Outpatient are (see Outpatient Services for definitions):

i. Intake
ii. Individual and/or Group Counseling
iii. Patient Education
iv. Family Therapy
v. Medication Services
vi. Collateral Services
vii. Crisis Intervention Service
viii. Treatment Planning
ix. Discharge Services

Part 4 - Program Services: Frequency of Service, Residential

Service definition, Residential Services (Res)- non-institutional, 24-hour non-medical, short-term residential rehabilitation services

The daily structure of activities is intended to restore cognitive functioning and build behavioral patterns within a community. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care

Services include those services described in OS and OPT, and:

I. Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication

II. Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment

Residential Treatment – Length of Stay and Treatment Authorizations

Initial Authorization for Residential Services - **Authorization** for residential treatment is **required** and is **based on medical necessity as identified by the ASAM Assessment.** The Administrative Service Organization (ASO) will process authorizations within 24 of request.

Length of Stay – Residential Treatment service is limited to two non-continuous episodes/year, for a maximum of 90 days per episode for Adults, 30 days for youth. One 30 day extension is permitted. Perinatal and criminal justice involved clients may qualify for longer lengths of stay.

Requests for continuing authorization: The ASO also ensures beneficiaries are continually assessed throughout treatment and prior to the end of the authorization period. Requests for continuing authorization must be submitted at least 5 days before the expiration of the initial authorization. **Required documentation includes:**

- Completed Continuing SUD Treatment Authorization Request (C-STAR);
- Copy of most recent Treatment Plan; and,
- A Reassessment

Part 4 – Program Services: Withdrawal Management

Withdrawal Management (Levels 1, 2, 3.2, 3.7 and 4 in ASAM) services are provided when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with an individualized client plan.

Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements.

The components of withdrawal management services are:

a) Intake: Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
b) Observation: The process of monitoring the beneficiary's course of withdrawal.
c) Medication Services
d) Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

Part 4 – Medication Services and Physician Consult

Medication services include the prescription, administration, or supervised self-administration of medication related to SUD Treatment, other necessary medications, or the assessment of their side effects.

- Services must be conducted by staff lawfully authorized to provide such services;
- Medication services are provided face-to-face and are available all levels of care
- Must be documented in the patient record (miscellaneous note format may be used)

Physician Consult – Physician consult services include physicians' consult with an approved addiction medicine physician, addiction psychiatrist, or clinical pharmacist. When documented as a progress note, the following shall be included:

- Beneficiary's Name and ID Number
- The purpose of the service
- Date, Start/End time of each service
- Identify if services were provided face-to-face or by electronic means
- Signed and dated by LPHA providing the service

Part 4 – Case Management

Case management services are services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care.

Providers shall conduct an initial screening of each beneficiary's ancillary needs, within thirty (30) calendar days of the effective date of admission

Services include:

- Assessment, periodic reassessment and care planning of case management needs;
- Transition in Level of Care assistance;
- Communication, coordination, referral, advocacy, and related activities;

For both residential and outpatient programs, a progress note is required for each case management interaction in the beneficiary's chart. Services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided as a field-based service, as long as confidentiality can be ensured

Part 4 – Recovery Services

Recovery services are important to the beneficiary's recovery and wellness as they transition into community-based recovery. Recovery services emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary.

- Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse.
- Recovery services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community

Part 4 – Important notes about Services

1. Counseling Services –
   a) With the exception of Crisis Services, counseling sessions (including Education Session) shall be provided based upon medical necessity and individualized needs as described in the patient's current treatment plan.
   b) Group Counseling sessions require a min 2, max 12 clients. The group content must address a need related to the substance use that help the beneficiary towards achieving her/his treatment plan goals.
   c) Multiple Services - In order to facilitate the correct placement for beneficiaries, **DHCS will allow a beneficiary to receive more than one service per day by various providers**. Counties will not be required to use a multiple billing override code when submitting their claim for reimbursement.

A beneficiary may receive different services on the same day from the same provider, and at the same time, could receive other services on the same day from a different provider. . . think treatment plan and medical necessity

Part 5 - Continuing Services- Authorizations

Continuing Service Justification- **Medical Necessity qualification for ongoing receipt of DMC-ODS services is determined at least every six months (annually for NTP's). This is accomplished through the reauthorization process by the LPHA**

Review by: LPHA

When: After 5th month; before 6th month

What must be Documented before Continuing Services can be authorized: A Review of,

- **Beneficiary's personal, medical, SU history**
- **Most recent physical exam**
- **Progress notes and TP Goals**
- **Counselor's recommendation**
- **Beneficiary's prognosis**

Part 6 - Discharge/Transfer Planning

It is said that "**discharge planning begins at admit**"—that means we should always be **planning for the continuing care of our patients**. A thorough discharge plans should include:

- Describe **relapse triggers; the patient's plan** to avoid relapse when confronted with each trigger;
- the patient's recovery support plan, including referrals
- Beneficiary's comments

Transition to and appropriate higher/lower level of care including Recovery Support Services needs to be a part of each Discharge Planning process

Part 6 - Discharge from Treatment: Discharge Summary

Every beneficiary, regardless of their length of stay and reason for discharge shall have a **Discharge Summary** completed.

The **discharge summary** must be **completed and documented** (counselor/LPHA) **within 30 calendar days of the last face-to-face** treatment contact and it must include :

- The duration of the treatment episode;
- The reason for discharge
- A narrative summary of the treatment episode
- The beneficiary's prognosis

NOTICE: INTERPREATION FROM DHCS. . .NEW INFORMATION/CLARIFICATION

The **FAIR HEARING RIGHTS** requirement refers to "eligibility and benefits."

A provider is only required to provide written notification at least 10 days prior to the effective date of the intended action to terminate or reduce services IF IT RELATED TO A BENEFICIARY'S MEDI-CAL ELIGIBILITY AND/OR BENEFITS.

To resolve any confusion, check with you county and see their regulations (under the waiver) for managing termination or reduction of program services you are providing to DMC-ODS clients. . .

DMC-ODS RESOURCES

DHCS website http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx

- FAQ's, Fact Sheets & Information Notices
- Implementation Matrix
- Resources for Counties
- Training Opportunities (CIBHS)
- Proposed Evaluation

ASAM Criteria Resources
https://www.asam.org/resources/the-asam-criteria/resources-and-training