DMC-ODS Service Code & Progress Note Training

Santa Cruz County Behavioral Health
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Training Goals & Objectives

Goals

- Learn the new service codes for each program service activity (Unplanned and Planned) & how to document appropriately.

Objectives

✓ You will be able to identify the new service codes for each program service activities (medical necessity driven)

✓ You will know the necessary requirements for documenting DMC-ODS services in Avatar

✓ You will become familiar with the progress note requirements and format for outpatient and residential service notes

Who can provide client services -

Licensed Practitioner of the Healing Arts (LPHA) - must have current good standing license/registered status.

- Physician
- Nurse Practitioner
- Physician Assistant
- Registered Nurse
- Registered Pharmacist
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Eligible Practitioner working under the supervision of licensed clinician (ASW, AMFT, APCC)

Registered SUD Counselor (must complete certification process within the 5 year requirement)

Certified SUD Counselor (must have current good standing certification status)

* All direct service staff (master program "trainees", volunteers, or other groups) must be a Registered SUD Counselor at a minimum to provide direct client services.

Services & Codes

Level of Care (LOC) unique codes

“Unplanned” & “Planned” Services

Unplanned: Prior to developed Treatment Plan & unpredictable services

1. Assessment & Reassessments
2. Treatment Planning
3. Crisis Intervention Services
4. Case Management Services

Planned: Treatment Services identified on Treatment Plan

1. Individual Counseling
2. Group Counseling
3. Case Management
4. Family Counseling

Client receives unplanned services during assessment phase: from date of admission to the finalization of the signed treatment plan (Final TP due: 72 hrs. for WM, 10 days for Residential, 30 days for IOS/OP & 28 days for NTP).

Order of Service Code review –

ADULT Population 21+ & 18-20 y/o

1. WM 3.2 – Withdrawal Management - Janus Detox
2. Residential 3.5 - Janus Main
3. Residential 3.1 - Encompass SCRR & SPP, Janus Main, Janus Perinatal Res
4. IOS Intensive Outpatient - Sobriety Works, Janus, Encompass Alto North & South
5. OP Outpatient – Sobriety Works, Encompass Alto North & South, Janus OP
6. NTP & MAT – Janus NTP Methadone clinics, IMS MAT services @ Janus & Encompass Residential

YOUTH Population <18 (U21 Codes)

1. IOS Intensive Outpatient – Encompass Youth
2. OP Outpatient – Encompass Youth

➢ **County SUDS Service Coordinator Team: Adult & Youth OP Population**

Service Codes – Level Of Care (LOC) & Age

Per Level of Care:

- ❖ linked to each program's ASAM LOC
- ❖ Janus has both 3.1 & 3.5 codes.

Per age:

21+ = Adult codes (A1xxx)

18-20 year old adults = U21 codes (A2xxx)

<18 = U21 codes (A2xxx)

Alert:

- ❖ Adult Programs need to identify the admissions that are 18-20 years old and use the appropriate U21 codes.
- ❖ Opened Charts have age at top under client's name.
- ❖ Adult Programs: Groups with 21+ and U21 –
  - Use the 21+ code for group
  - Send County a Service Correction spreadsheet with the identified U21 group participants by 15th of following month.

Assessment Codes & Documentation

SUD Counselors & LPHA staff can utilize the Assessment Service code to write a progress note that summarizes the client's ALOC Assessment and Diagnosis, including dimensional strengths, challenges and any identified referrals needing immediate attention (i.e. referral to PC for physical exam).

Assessment Service Codes – unique to level of care

OP Adult = A1411

OP Youth = A2411

IOS Adult = A1211

IOS Youth = A2211

NTP (Adult only) = A1311

Residential 3.1 = A1511

Residential 3.3 = A1611

Residential 3.5 = A1111

Withdrawal Management 3.2 = A1711

Trackable non-billable service code: Also can use A001

Treatment Plan Codes & Documentation

SUD Counselors and LPHA staff can utilize the Treatment Planning Service code to write a progress note that summarizes the Treatment Planning session – client's goals, strengths, challenges and any identified referrals needing immediate attention (i.e. referral to PC for physical exam).

Treatment Planning Service Codes – unique to level of care

OP Adult = A1420

OP Youth = A2420

IOS Adult = A1220

IOS Youth = A2220

NTP (Adult only) = A1320

Residential 3.1 = A1520 (non-billable)

Residential 3.3 = A1620 (non-billable)

Residential 3.5 = A1120 (non-billable)

Withdrawal Management 3.2 = A1720 (non-billable)

(Youth Res 3.1 = A2520) (non-billable)

Case Management Services – All LOC

Case Management is a separate service code available at all levels of care, including Residential. 15 minute increments for F2F or phone. SUD Counselor & LPHA appropriate.

A1480 = OP Case Management - Adult
A2480 = OP Case Management – Under 21
A1280 = IOS Case Management – Adult
A2280 = IOS Case Management – Under 21
A1380 = NTP Case Management –Adult
A1580 = RES 3.1 Case Management – Adult (A2580 for 18-20 y/o)
A1680 = RES 3.3 Case Management – Adult (A2680 for 18-20 y/o)
A1180 = RES 3.5 Case Management – Adult (A2180 for 18-20 y/o)
A1780 = 3.2 WM Case Management – Adult (A2780 for 18-20 y/o)

Start & End time of service applies to CM Services. Staff MUST complete note within 7 calendar days of service. Note describes purpose of CM service & how it relates to the client's treatment goals.

IOS/Intensive Outpatient Services: like OP:

Intensive Outpatient Services are now a per service Progress Note. 15 minute increments. (no longer a block of time rate)

Service Type	21+ Age Code	U21 Age Code
Initial Assessment	A1211	A2211
Treatment Planning	A1220	A2220
Case Management	A1280	A2280
Individual Counseling	A1230	A2230
Group Counseling	A1260	A2260
Collateral	A1240	A2240
Family Counseling	A1238	A2238
Crisis Intervention	A1270	A2270
Discharge Services	A1239	A2239

OP/Outpatient: Outpatient Progress Notes are a per service progress note. 15 minute increments.

Service Type	21+ Age Code	U21 Age Code
Initial Assessment	A1411	A2411
Treatment Planning	A1420	A2420
Case Management	A1480	A2480
Individual Counseling	A1430	A2430
Group Counseling	A1460	A2460
Collateral	A1440	A2440
Family Counseling	A1438	A2438
Crisis Intervention	A1470	A2470
Discharge Services	A1439	A2439

DMC-ODS NTP Services – Services in 10 increments & CM @ 15 min.

DMC-ODS Available Services:

1. **A1311/A2311** = Assessment code (linked to indiv counseling HCPC – 10 min)
   a. Includes LPHA/MD medical necessity note and continuing service justification note
2. **A 1320/A2320** = Treatment Planning (Indiv HCPC – 10 min)
3. **A1334/A2334** = Individual Counseling (10 min)
4. **A1339/A2339** = Discharge planning (linked to Indiv HCPC – 10 min)
5. A1364/A2364= Group Counseling (10 min)
6. **A1380/A2380** = Case Management (**15 min**) (**New Code**)
7. **A1390/A2390** = Methadone dosing – daily rate
8. A1306/A2306 = Physician Consultation (**15 min**) (**New Code**)
9. A1350, 1351, 1352, 1353 = Recovery Services – pending (**15 min**) (**New Code**)
10. **A400** = No Show (non-billable code)
11. **A001** = non-billable info note code (Can be used for medical necessity justification note)

Progress Note Requirements

Outpatient Service Notes – ODF, IOT & NTP

Residential Weekly Notes

Notes! – Another Paradigm Attitude shift

Small Picture Attitude~

Notes are:

- Busy work
- A bothersome requirement
- Not central to client care. F2F contact seems more important and/or satisfying
- Pointless – no impact on client's care
- Adds compliance stress and frustration

Big Picture Attitude ~

Notes are:

- Opportunity to reflect on session, your role and work with client & the client's progress or barriers to progress.
- Big Picture: Clinical review of treatment effectiveness and path.
- Antidote to the cycle of reactivity: (responding to latest crisis w/out the foundation setting that may prevent future crisis, repeating past mistakes or doing what has always been done.
- Move from client unsuccessful to program's services need adjustment.

Medical Necessity's "Golden Thread"

- "Unplanned Services" – The services not listed on Treatment Plan

1. Assessment & Diagnosis
   - *Evaluation and Establishing Medical Necessity*

2. Treatment Planning
   - *Authorized Collaborative Treatment Plan*

3. Crisis Intervention Services – *imminent risk interventions to stabilize crisis*

4. Case Management Services *to link client to immediate services*

- Planned Services – The services identified on Treatment Plan
  - Individual & Group Counseling, Collateral, Family Counseling, and Case Management

DMC-ODS Progress Note: **Required details**

1. Start and End time of service session (not including documentation time)
2. Avatar Duration = Real Time:
   a. Face-to-Face time: service time with client
   b. "Other" time:
      1. *Avatar form completion and/or progress note writing time*
      2. *Case Management time (without client)*
      3. *Medical Director note when there is no direct client time*
3. Required: At least 2 Evidence-Based Practices identified in PN that were used with client (add to Intervention narrative + click EBPs in PN form)
4. D-I-R-P format – linking focus of service to TP goal and/or action step progress
5. All Notes need to be entered within 7 calendar days of Date of Service (DOS), DOS counts as day 1.
   - Residential weekly summary notes to be entered within 7 calendar days of the last treatment day of the week.

Intake Assessment, Medical Necessity Determination & Treatment Plan

Review separate “Assessment & Treatment Plan” training material for more details

ALOC Documentation & Assessment Progress Notes

SUD Counselor note & LPHA/MD Medical Necessity note

OP/IOS/NTP SUD Counselor: Progress note captures F2F time with client conducting the ALOC, "other" documentation time for ALOC form and progress note writing time.

Note Content: Identified areas of significant impairment or distress within the last 12 months must be documented.

1. **What are the client's "significant impairments or distress" identified within each ASAM dimension?**
2. **What are areas that need immediate referrals (medical, psychiatric, financial)?**

- **Medical/Physical exam need**: Referral to PCP for exam; Referral to Alliance for PCP assignment; Follow up with PCP office to obtain medical exam summary if has been completed with 12 months of admission date.

LPHAs: **Note needs to indicate that medical necessity for program admission has been met.**

- Summarize case presentation in Progress Note (review clients medical, psychiatric, family and substance history, referral source, ALOC, Dx form, UA results) to determine if medically appropriate for recommended level of care.

Medical Necessity – Cont.

Who Can Document?

- ✓ Medical Director
- ✓ LPHA

Timeframe

Within 30 days from admission to treatment

What Must be Documented?

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

Medical Director's notes

General Progress Note or Med Service Note

Service Code options:

Assessment Service Code (non-billable code in residential level) **.....**

- Documentation that determines medical necessity of LOC and services based on client's diagnosis, reviewed medical, psychiatric and substance use records, and consultation with treating primary SUD Counselor and/or LPHA.
- SAMPLE Template from AVATAR Med note (next slide)

OR

A001 = Non-billable informational note that indicates the review of physical and medical records

Sample Medical Director Template

[Based on my review of the client's personal, medical, substance use history, and most recent physical exam, I have determined she/he has the following unmet medical needs:______(fill in as indicated on questionnaire/exam) or ________ (indicate that the client doesn't have any unmet medical needs).

I have evaluated this client's current presentation and determined she/he meets medical necessity for Drug Medi-Cal services under the DSM 5 diagnosis of ________________, based on the following impairments: __________________(list evaluated impairments).]

Example: LPHA note to determine Medical Necessity

"Based on review of the primary counselor's assessment and recommendations, and review of the client's personal, medical, psychiatric and substance use history, most recent health questionnaire, and current ASAM assessment, I have determined this client to meets medical necessity for Drug Medi-Cal services under the diagnosis of Heroin Dependence Dx., based on the following impairments: increased use of heroin; poor insight of substance use triggers/craving; reports negative consequences of use as removal of child/CPS involvement; demonstrates minimal coping skills for recovery; and is at high risk for continued use without external prompts and interventions.

Progress Note – Initial Treatment Plan

D (Client Presentation) – Staff and client met to discuss treatment goals and identified specific action steps to achieve goal. Client presented as insightful and creative with identifying goals and steps.

I - Staff met with client to develop treatment goals. Staff utilized motivational interviewing skills to engage client in progress and offered psychoeducation interventions regarding how co-occurring problems impact overall wellness and recovery.

R – Client was forthcoming with goal priorities for sobriety and housing. Client receptive to learning more about co-occurring focus and the importance of a physical exam for self-care.

P – Staff to follow up with client next week with written treatment plan to ensure accuracy and signed agreement.

Progress Note – Updated Treatment Plan

D (Client Presentation) – Staff provided case management service to monitor clients treatment progress towards goals and action steps.

I - Staff met with client to review current treatment goals, successes and outstanding action steps to determine if there has been significant changes that may require a change in treatment plan and services.

R – Client was forthcoming with current status and identified areas of improvement and continue struggle. Client and staff determined that client met key action step by securing a sponsor and obtaining use daily basis. Client identified new triggers for cravings and new actions steps focused on relapse prevention strategies.

P – Staff to follow up with client next week with updated treatment plan to ensure accuracy and signed agreement.

Case Management

Case Management Services – All LOC & age

- Case Management is a separate service code available at all levels of care, including Residential & NTP. 15 minute increments for F2F or phone. SUD Counselor & LPHA appropriate. (21+ & U21 code available)
- Start & End time of service applies to CM Services. Staff MUST complete note within 7 calendar days of service. Note describes purpose of CM service & how it relates to the client's treatment goals.
- Components of Case Management activities:

❖ *Comprehensive assessment and periodic reassessment of client's need for continuous CM services*

❖ *Monitoring treatment progress – (ASAM reassessment)*

❖ *Client advocacy and linkage to services*

❖ *Monitoring transitional needs to a higher or lower level of SUD care (ASAM reassessment)*

❖ *Monitoring service delivery to ensure access to services and service delivery system*

Case Management Services – Examples

1. Contacting PCP office or Alliance office to secure a PCP appointment for client to attend to needed physical exam or identified health concern.
2. Link to or coordinate care with MH Counselor or Psychiatrist
3. Coordinate medical appointment needs
4. Coordinate with legal/probation services on treatment status update
5. Outreach SLEs for information on available housing
6. Contacting County Service Coordinator for possible assistance on clothing needs
7. Assessing current level of care and anticipated discharge transfer to another LOC
8. Coordination of access to MAT treatment services
9. Assist in coordinating discharge from hospital/jail or higher level of care
10. Reassessment of ASAM dimensional needs, including CM needs

CM services – 15 minute increments, including residential & NTP

D – Data: What the purpose of service, who was involved and how related to TP goal progress. Plus start and end time and method – in-person meeting or phone

I – describe what CM service was provided as related to TP

R – outcome of service as related to TP

P- follow up items/plan

Program Levels of Care – Progress Notes

WM – Withdrawal Management

3.5 Residential – specialized population

3.1 Residential, including Perinatal (general population)

Withdrawal Management 3.2 - Janus

Medically necessary detox services provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Average length of stay is 5-8 days.

The components of WM services include:

- **Intake:** The process of admitting a beneficiary into a substance use disorder(SUD) treatment program. Intake includes the evaluation or analysis of SUD, the diagnosis of SUD, the assessment of treatment needs, and may include a physical examination and laboratory testing necessary for SUD treatment.
- **Observation**: The process of monitoring the beneficiary’s course of withdrawal as frequently as deemed appropriate for the beneficiary. This may include, but is not limited to, observation of the beneficiary’s health status.
- **Medication Services**: The prescription or administration related to SUD treatment services, and/or the assessment of the side effects and results of that medication.
- **Discharge Services**: Preparing the beneficiary for referral into another level of care, post treatment return, re-entry into the community, and/or the linkage of the individual to community treatment, housing, and human services.

WM – 3.2 (Janus) Service Codes

1. **A1711** Assessment Code = Intake Admission ALOC + other assessment tools (non-billable)
2. A1711 = LPHA's/MD Medical Necessity justification note (part of the assessment phase)
3. **A1700** = Treatment Day rate
4. **A130** = Board & Care rate (not just for perinatal housing as code says)
5. A1720 = Treatment Planning code (**optional non-billable code**) TP development time documented in progress note that identified TP goals. TP competed within 72 hours.
6. **A001** = non-billable progress note every 2-3 days (details next slide)
7. **A1780** = Case Management Code (ASAM reassessment & linkage/coordination)
8. **A1791 MAT code** = Prescriber direct client services **IF prescriber is prescribing**, ordering, monitoring medications. Can include medical necessity justification note.
9. A1706 = Physician Consultation - Prescriber to SUD Consultant service = 2 medical scope staff

WM Non-billable Progress Note – A001

General Progress Note form – Weekly Residential Note – A001 Non-billable

Item's to capture (Template in Avatar)

1. Progress with detox stabilization and treatment goals. A documented service for each day to be reimbursable.
2. Individual Counseling sessions need to indicate Start and End time of session and at least 2 Evidence Based Practices used as interventions with client and addressing treatment goals. Identified referrals or items that need CM follow-up.
3. Group names attended, start and end times and summary of how client participated in groups.
4. Discharge planning with client, including possible step-down referrals and/or community resources.

Prescriber Services: Physician Consultation, additional MAT, Withdrawal Management Progress Notes

Progress Notes Cont…

Specific to physician consultation services, additional medication assisted treatment, and withdrawal management

Who can document?

- ✓ Medical Director
- ✓ LPHA

Timeframe

Within seven calendar days of the service

What must be documented?

- Beneficiary's name
- The purpose of the service
- Description of how the service relates to the beneficiary's treatment plan
- Date, start and end times of each service
- Printed or typed & signed name of **Medical Director or LPHA**
  - Adjacent to each other

– Must identify if service was in-person, by telephone, or telehealth

WM Progress Note Example

Identify week of treatment dates: ***<u>Must have a documented service each day for daily rate reimbursement.</u>***

DIRP format for overall narrative:

- D - **Data:** Summary of Client's detox stabilization presentation during the week (symptoms, behaviors, impairments justifying continued stay
- I - **Intervention:** Interventions and support client received from staff and identifying at least 2 evidence based practices used by staff in service with client. (MI, Seeking Safety,…). Include any Treatment planning or discharge planning activities
- R - **Response:** Description of client's specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals
- P- **Client's plan** (including new issues or problems that affect treatment plan). Identify discharge plan.

Summary of week's Individual services & Group participation: Topic, Date, Start & End time, Focus and relation to TP

Residential 3.5 (Janus) 21+ & 18-20 y/o [U21 -A2xxx]

1. **A1111**/A2111 Assessment Code = Intake Admission ALOC + other assessment tools (non-billable)
2. A1111/A2111 = LPHA's/MD Medical Necessity justification note (part of the assessment phase)
3. **A1110**/A2110 = Treatment Day rate
4. **A130** = Board & Care rate (not just for perinatal housing as code says)
5. A1120/A2120 = Treatment Planning code TP development time documented in progress note that identified TP goals. TP competed within 10 calendar days. (optional non-billable code)
6. **A001** non-billable progress note every week (details next slide)
7. **A1180**/A2180 Case Management Code (ASAM reassessment & linkage/ care coordination
8. **A1191 MAT code** = Prescriber direct client services **IF prescriber is prescribing**, ordering, monitoring medications. Can include medical necessity justification.
9. A1106/A2106 = Prescriber to SUD Consultant service = 2 medical scope staff

Residential 3.1 (Encomp SCRR & SPP) & Janus

1. **A1511**/A2511 Assessment Code = Intake Admission ALOC + other assessment tools- non-billable)
2. A1511/A2511 = LPHA's/MD Medical Necessity justification note (part of the assessment phase)
3. **A1500**/A2500 = Treatment Day rate
4. **A130** = Board & Care rate (not just for perinatal housing as code says)
5. A1520/A2520 = Treatment Planning code TP development time documented in progress note that identified TP goals. TP competed within 10 calendar days. (optional non-billable code)
6. **A001** = non-billable progress note every week (details next slide)
7. **A1580**/A2580 = Case Management Code (ASAM reassessment & other CM activities)
8. A1591 = Encompass is a pending MAT certified provider
9. A1506/A2506 = Prescriber to SUD Consultant service = 2 medical scope staff

Residential Weekly Notes

Who can Document: Registered/Certified SUD Counselors & LPHA

Timeframe: Progress Note is required for services. At a minimum: one (1) weekly note that captures all details. **Finalized in Avatar within 7 calendar days of the week's services.

Method: Note must identify if service was in-person or by telephone.

Location: Must document where the services was provided, i.e. Office. IF in the community, **MUST** document how confidentiality was ensured by staff.

What must be documented (required):

1. Start & End time of each treatment service
2. Date of Service(s) & Topic(s) of Service (for each treatment day to be reimbursable)
3. Description of the client's progress towards treatment plan goals (link PN to TP goals)
4. Group Topic(s) and attendance record
5. Identifying at least 2 evidence based practices used by staff in service with client
6. Printed and signed name of Counselor or LPHA

❖ Discharge planning with client, including identifying relapse prevention strategies for triggers, possible step-down referrals and/or community resources

Residential Notes – A001 non-billable

Identify week of treatment dates: ***Must have a documented service each day for daily rate reimbursement.***

DIRP:

- D - **Data:** Summary of Client's presentation during the week (symptoms, behaviors, impairments justifying continued stay
- I - **Intervention:** Interventions and support client received from staff and identifying at least 2 evidence based practices used by staff in service with client. (MI, Metrix, Seeking Safety…). Include any Treatment planning or discharge planning activities
- R - **Response:** Description of client's specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals
- P- **Client's plan** (including new issues or problems that affect treatment plan)

Summary of week's Individual services & Group participation: Topic, Date, Start & End time, Focus and relation to TP

Transportation

Transportation is not a Medi-Cal billable treatment service.

Time transporting clients to appointments while in residential setting is part of the residential day rate.

Program Levels of Care – Progress Notes

IOS – Intensive Outpatient Services (Adults: 9+ hrs./wk.)

OP – Outpatient Services (Adults: 8 or less hrs./wk.)

NTP – Methadone clinics (+ MAT services)

Adult IOS (Sobriety Works, Alto South, Janus)

Billing changes: Like OP

1. **Per Service** billing/progress note
2. **15 minute increments** or fractions (use real time)
   a. Face-to-Face
   b. Other time
3. Use of Group Note form
   a. Multiple service code group clients
   b. Combo of sequestered and consented group members
4. A400 = No Show
5. A001 = non-billable info note

Billable Service Codes:

A1211/A2211 = Assessment Code

A1220/A2220 = Treatment Code

A1230/A2230= Individual Counseling

A1260/A2260 = Group Counseling

A1280/A2280 = Case Management

A1270/A2270 = Crisis Intervention

A1239/A2239 = Discharge Planning

A1238/A2238 = Family Counseling

A1206/A2206 = Physician Consultation

Recovery Codes - pending

IOS General Progress Notes

Who can Document: Registered/Certified SUD Counselors & LPHA

Timeframe: Progress Note is required **per service** . Finalized in Avatar within 7 calendar days of the service.

Method: Note must identify if service was in-person or by telephone.

Location: Must document where the services was provided, i.e. "Office". IF in the community, **MUST** document how confidentiality was ensured by staff.

What must be documented (required):

1. Start & End time of each treatment service
2. Date of Service & Topic of Service (service code)
3. Description of the client's progress towards treatment plan goals (link PN to TP goal)
4. Group Topic and attendance record
5. Identifying at least 2 evidence based practices used by staff in service with client
6. Printed and signed name of Counselor or LPHA

IOS A1230 Indiv. Counseling - Example

Data: IOS Individual Counseling session: **Start time is 10:00 am and end time is 11:00 am.** Treatment Plan goal addressed is improve trigger identification to prevent relapse. Client reports "I saw my family over the holiday and wanted to drink within an hour. Thankfully, I used the mindfulness skills and realized the tone of my dad's voice scares me inside, which makes me want to numb out. I was able to find a meeting and went. Overall, I'm feeling pretty proud of myself for not relapsing."

Intervention: Staff reviewed client's comments with client to identify successes towards goal of trigger identification. Staff used Motivational Interviewing with client and reviewed mindfulness strategies to explore reaction to father's voice and response to feelings to use. Psychoeducation on how holidays can be triggering due to dynamics and acknowledgement of strength to go to family activity and use of stress ball and meeting.

Response: Client able to recognize positive choices and that he could manage the uncomfortable feelings sober. Client expressed new awareness that physical activities and mindfulness strategies are helping his trigger management.

Plan: Staff will schedule another session to review current ASAM scoring and talk with client about planning for discharge to ODF services.

OP (Sobriety Works, Alto North & South)

1. Per Service billing/progress note
2. 15 minute increments or fractions (use real time)
   a. Face-to-Face
   b. Other time
3. Use of Group Note form
   a. Multiple service code group clients
   b. Combo of sequestered and consented group members
4. A400 = No Show
5. A001 = non-billable info note

Billable Service Codes:

A1411/A2411 = Assessment Code

A1420/A2420 = Treatment Code

A1430/A2430 = Individual Counseling

A1460/A2460 = Group Counseling

A1480/A2480 = Case Management

A1470/A2470 = Crisis Intervention

A1439/A2439 = Discharge Planning

A1438/A2438 = Family Counseling

A1440/A2440 = Collateral (client + significant non-professional person)

A1406/A2406 = Physician Consultation

Recovery Codes pending

OP General Progress Notes

Who can Document: Registered/Certified SUD Counselors & LPHA

Timeframe: Progress Note is required **per service**. Finalized in Avatar within 7 calendar days of the service.

Method: Note must identify if service was in-person or by telephone.

Location: Must document where the services was provided, i.e. "Office" IF in the community, **MUST** document how confidentiality was ensured by staff.

What must be documented (required):

1. Start & End time of each treatment service
2. Date of Service & Topic of Service (service code title but can add more specifics)
3. Description of the client's progress towards treatment plan goals (link PN to TP goal)
4. Group Topic and attendance record
5. Identifying at least 2 evidence based practices used by staff in service with client
6. Printed and signed name of Counselor or LPHA

OP & IOS Group Notes

Groups shall be conducted with no less than two and no more than 12 clients at the same time. Ninety minutes equals one unit of service. Fractional units of service are not allowed.

Document Group # & Start and End time in Intervention section of note.

For group counseling, one or more therapists treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service. Counties should calculate the units to submit on a claim using the following formula:

Number of minutes for the group/number of beneficiaries = Total minutes per beneficiary.

Groups with 21+ and U21 participants – use 21+ service code. (*Provider admin will send County code correction list to County to fix before claims go to State.)

Reference: DHCS DMC Provider Billing Manual _June 2017 version

(Nancy Mast will offer trainings on Avatar Group Notes if interested.)

OP A1411 Assessment - Example

Data: ALOC assessment session: **Start time is 10:00 am and end time is 11:00 am.** Staff met with client to complete ASAM level of care assessment to identify multi-dimensional treatment needs. Client presented with no withdrawal risk, identified use trigger of anxiety and stress and reports eager to start treatment to address current alcohol misuse.

Intervention: Staff interviewed client on current ASAM dimension areas and identified needs for a more recent physical exam and coping skills for use preventions when anxious or feeling stressed. Staff used MI and solution focused interventions throughout interview.

Response: Client able to comprehend questions and express feeling and thoughts on current self-rating. Client reports not having a current PCP and would like help getting an appointment.

Plan: Staff will schedule another session with client to develop a treatment plan that related to assessment needs and client's treatment goals, including getting linked to a new PCP for an appointment. Staff will f/up with contacting client's medical insurance to assist with coordinating a PCP assignment.

NTP Services – Services in 10 or 15 min increments or fraction

DMC-ODS Available Services:

1. A1311 = Assessment code (linked to indiv counseling HCPC – 10 min)
    a. Includes LPHA/MD medical necessity note and continuing service justification note (DMC-ODS)
2. A 1320 = Treatment Planning (Indiv HCPC – 10 min)
3. A1334 = Individual Counseling (10 min)
4. A1339 = Discharge planning (linked to Indiv HCPC – 10 min)
5. A1364 = Group Counseling (10 min)
6. A1370 = Crisis Intervention service (imminent risk of relapse or relapsed)
7. A1380 = Case Management (**15 min**) (**New Code**)
8. A1390 = Methadone dosing – daily rate
9. A1306 = Physician Consultation (**15 min**) (**New Code**)
10. A1350, 1351, 1352, 1353 = Recovery Services – pending (**15 min**) (**New Codes**)
11. A400 = No Show (non-billable code)
12. A001 = non-billable info note code

NTP – General Progress Notes

Who can Document: Registered/Certified SUD Counselors & LPHA

Timeframe: Progress Note is required per service in 10 minute increments. Finalized in Avatar within 7 calendar days of the service.

Method: Note must identify if service was in-person or by telephone.

Location: ex. Office.

What must be documented (required):

1. Start & End time of each treatment service
   a. "Face-to-Face" time for Indiv or Grp service
   b. "Other" time for Case Management activity & documentation time
2. Date of Service & Topic of Service (Topic tends to be service code name but can write in more, such as "collateral meeting with indiv and sponsor"
3. Description of the client's progress towards treatment plan goals (link PN to TP goal)
4. Group Topic and attendance record
5. Identifying at least 2 evidence based practices used by staff in service with client
6. Printed and signed name of Counselor or LPHA

NTP A1320 Treatment Planning - Example

Data: Treatment Planning session: **Start time is 10:00 am and end time is 11:00 am.** Staff met with client to develop treatment plan based off ASAM assessment needs and client's goal. Client presented on time, alert and reports eager to start treatment to address current heroin misuse.

Intervention: Staff interviewed client on current identified areas of treatment needs and prioritized goals. Client's recent physical exam indicated the need for f/up on dental care so staff encourage a medical care goal. coping skills for use preventions when anxious or feeling stressed. Staff used MI and solution focused interventions throughout interview.

Response: Client agreed with medical care goal as well as wanting more education on how to be successful with NTP services when homeless. Client expressed concerns for not staying motivated. Staff used MI techniques and psycheducation to support client's process.

Plan: Staff scheduled another session with client to offer more psychoeducation and strategies to successful engagement. Client doesn't have a dentist so staff will f/up with researching this resource for linkage.

U21 Codes: Under 21 yrs
Youth services to age 17 & adult 18-20 y/o

OP:

A2411 = Assessment
A2420 = Treatment Planning
A2470 = Crisis Intervention
A2480 = Case Management
A2430 = Individual Counseling
A2460 = Group Counseling
A2438 = Family Counseling
A2440 = Collateral
A2439 = Discharge Planning/Services
A2450, 2451, 2452, 2453 = Recovery (P)
A2406 = Physician Consultation

IOS Codes:

A2211 = Assessment
A2220 = Treatment Planning
A2270 Crisis Intervention
A2280 = Case Management
A2230 = Individual Counseling
A2260 = Group Counseling
A2238 = Family Counseling
A2240 = Collateral
A2239 = Discharge Planning
A2250, 2251, 2252, 2253 = Recovery (P)
A2206 = Physician Consultation

A400 = No Show
A001 = non-billable info note

County Service Coordinators – OP services

CM activities:

1. Contacting PCP office or Alliance office to secure a PCP appointment for client to attend to needed physical exam or identified health concern.
2. Link to or coordinate care with MH Counselor or Psychiatrist
3. Coordinate medical appointment needs
4. Coordinate with legal/probation services on treatment status update
5. Outreach SLEs for information on available housing
6. Contacting County Service Coordinator for possible assistance on clothing needs
7. Assessing current level of care and anticipated discharge transfer to another LOC
8. Coordination of access to MAT treatment services
9. Assist in coordinating discharge from hospital/jail or higher level of care
10. Reassessment of ASAM dimensional needs, including CM needs

Billable Service Codes:

Non-billable A001 & A400

A1411/A2411 = Assessment Code

A1420/A2420 = Treatment Code

A1430/A2430 = Individual Counseling

A1460/A2460 = Group Counseling

A1480/A2480 = Case Management

A1470/A2470 = Crisis Intervention

A1439/A2439 = Discharge Planning

A1438/A2438 = Family Counseling

A1440/A2440 = Collateral (client + significant non-professional person)

A1406/A2406 = Physician Consultation

Recovery Codes pending

Other Documentation

Continuing Services

Discharge Services – See “Discharge Services” Training for more details.

Continuing Services – LPHA responsibility

Continuing Services

Who can document?

✓ Medical Director

✓ LPHA

Timeframe

No sooner than 5 months and no later than 6 months

What should be documented?

- Review of the following:
  - Beneficiary's personal, medical, substance use history
  - Most recent physical exam
  - Progress notes & treatment plan goals
  - LPHA's/counselor's recommendation
  - Beneficiary's prognosis

LPHA writes a Case Management Progress Note that captures the review of all the required elements and determination of medical necessity for ongoing services at current LOC .

If not medically necessary, then client is ready for discharge.

Discharge Planning: Anticipated Discharge Planning

Discharge Planning

Who can document?

- ✓ LPHA
- ✓ Counselor

Timeframe

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

What must be documented?

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

For Now:

1. Capture info in Progress Note using Discharge Planning Service Code or identified in Res note.

2. Avatar Discharge Plan located in SUD Tx Plan form. See "Discharge Services" Training material.

Discharge Summary: Loss of Client Contact

Discharge Summary

Who can document?

- ✓ LPHA
- ✓ Counselor

Timeframe

Within 30 days of last face-to-face

What must be documented?

➢ Unexpected lapse in treatment services for 30+ days
- Duration of the treatment episode
- Reason for discharge
- Narrative summary of the treatment episode
- Prognosis

For Now:

1. Complete "Treatment/Discharge Summary" Form. These requirements listed in note section.

2. Document treatment DC summary in Progress Note using A001 Code if "loss of contact" or Residential note.

Non-Reimbursable Services

- ❖ Reviewing a chart for assignment of therapist.
- ❖ Any documentation after client is deceased.
- ❖ Preparing documents for court testimony.
- ❖ Voicemail, texting, or email message
- ❖ Mandated reporting such as CPS or APS reports
- ❖ No service provided: Missed visit. Waiting for a "no show"
- ❖ Documenting that a client missed an appointment.
- ❖ Traveling to a site when no service is provided due to a "no show"
- ❖ Leaving a message on an answering machine
- ❖ Personal care services
- ❖ Transportation
- ❖ Purely clerical activities
- ❖ Recreation
- ❖ Socialization
- ❖ Academic/Educational
- ❖ Vocational services
- ❖ Multiple Staff in Case Conference:
- ❖ Supervision: BBS
- ❖ Utilization management, peer review, or other quality improvement activities
- ❖ Interpretation/Translation only

No Faxing or Emails

No Recreation

No Translation

No Transportation

No internet Research

No Voicemails

No Texting

Recovery Services: Pending Use – Avatar

Recovery services address the needs identified in the ASAM Dimension 6 Recovery Environment Criteria; as well as during the transfer/transition planning process as part of the individual's continuum of care.

Occurrence: **When a client has successfully completed their course of treatment whether they are triggered, have relapsed or as a prevention measure to prevent relapse.**

3 types:

1. Outpatient counseling to stabilize the client and then reassess if there is need for further care;
2. Recovery Monitoring: Recovery coaching, monitoring via telephone
3. Case Management services

Confidentiality

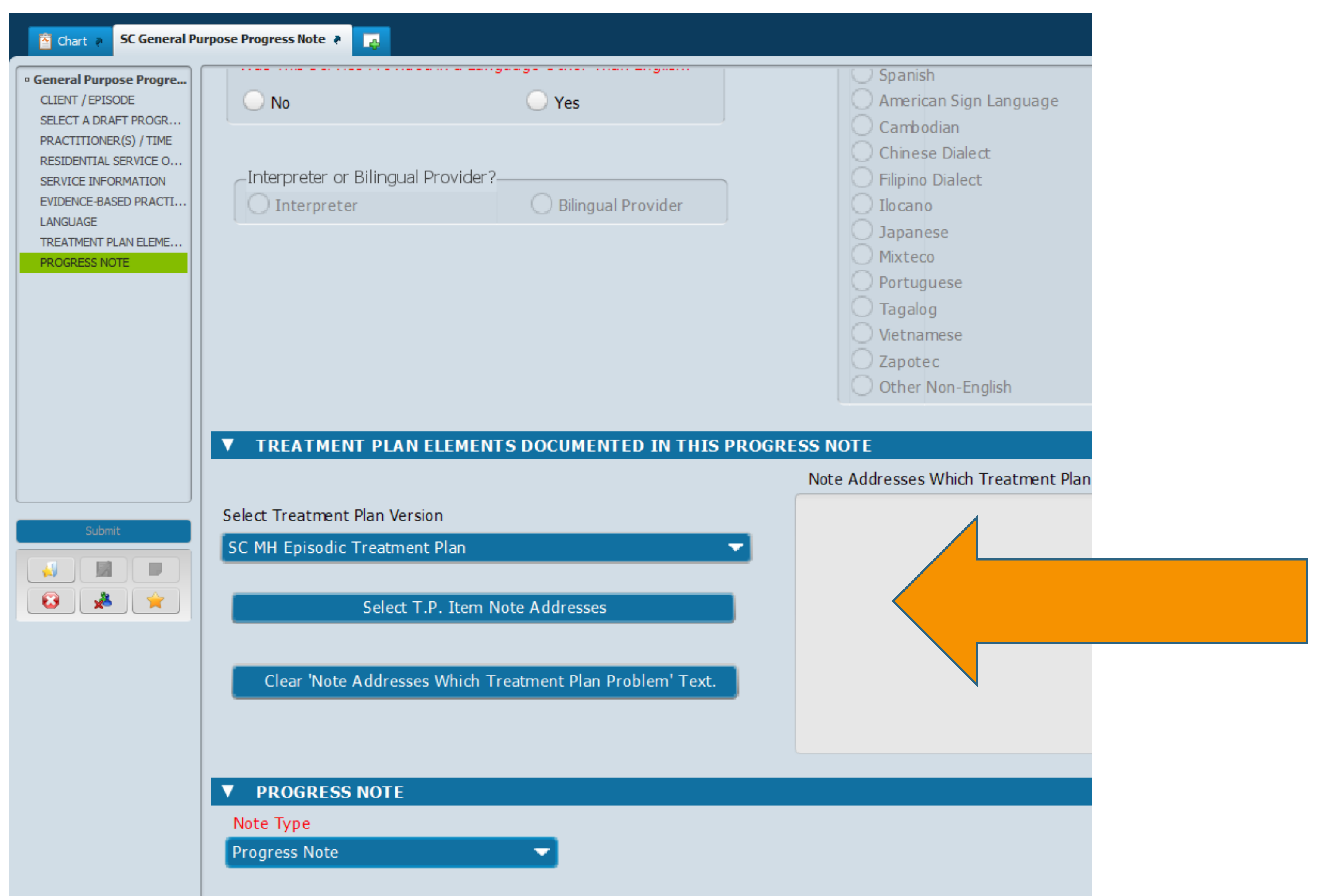
Because we must protect client confidentiality, and because the medical record is a legal document that may be subpoenaed by the court, please observe the following standards in completing progress notes:

- Do not write another client’s name in client’s chart
- Names of family members should be recorded only when needed to complete assessment, registration and financial documents.
- On progress notes and most assessments, refer to the relationship - mother, husband, friend, but do not use names.
- Use a first name or initials of another person only when needed for clarification.

Avatar Progress Note

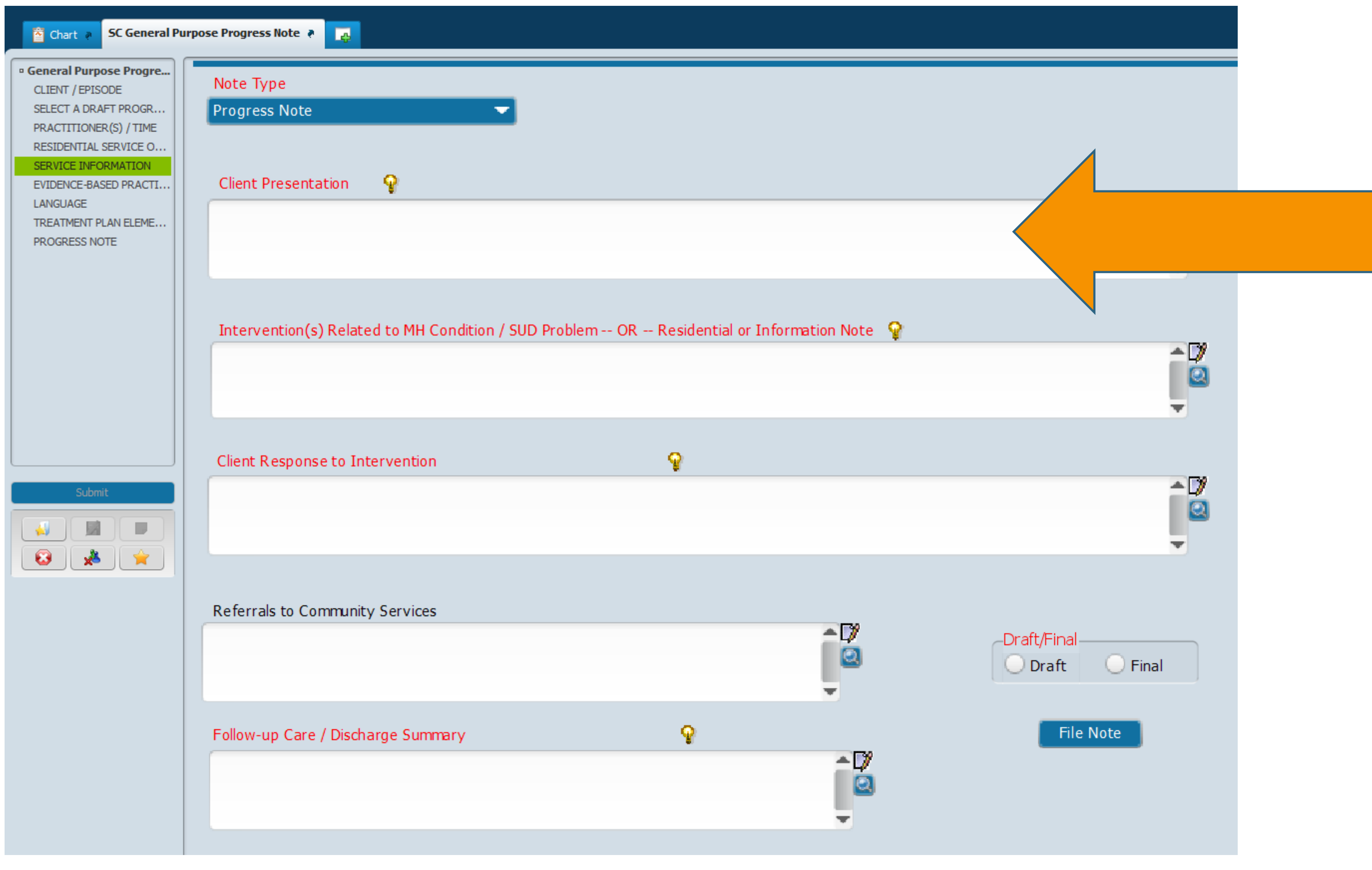
Form Snap Shots

Avatar Reminder: Progress Note



Tx Plan Reference: Identify which Treatment Plan Goal is related to the service provided.

Client Presentation/ Data



Client Presentation "Data"

D-I-R-P Progress Note Format

Client Presentation = Data.

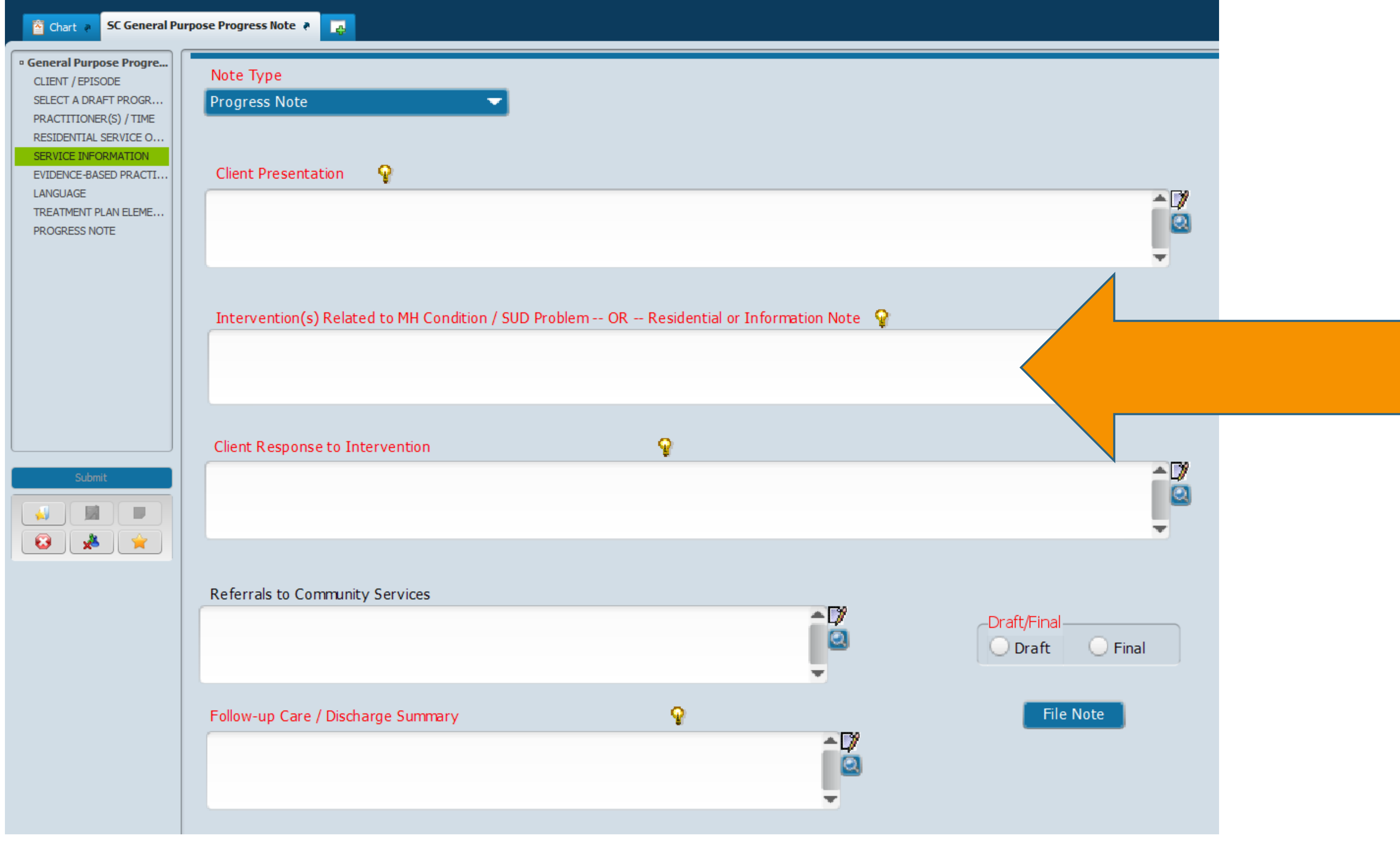
1. **Enter Start and End time of service here**

2. **Enter current focus of session and how related to TP goals.** (Current progress today and/or since last session; any current risk factors any new problems.)

Add "time includes travel" as appropriate.

Location should match the Location Code.

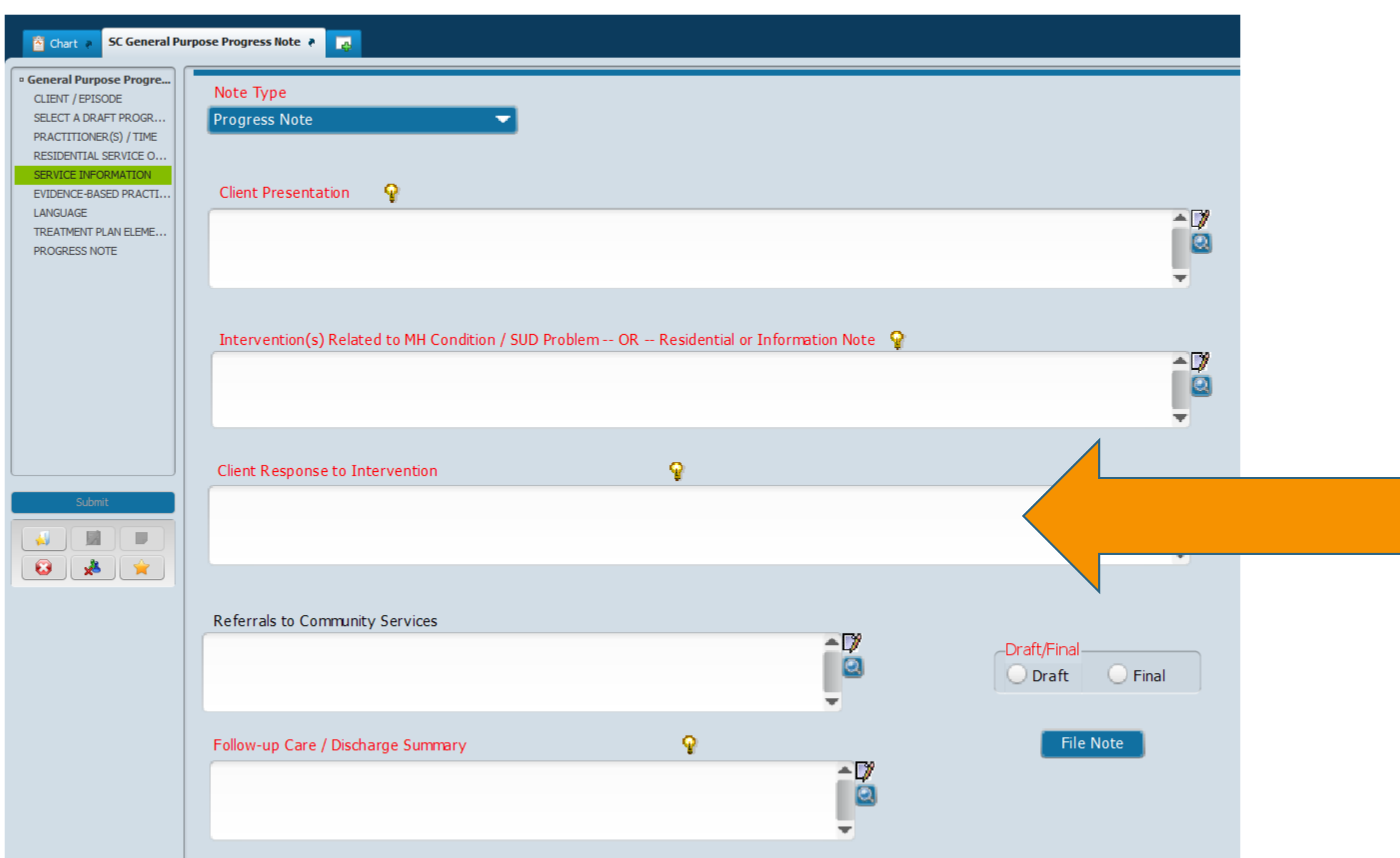
Interventions



Individual & Group Counseling Intervention:

1. Focus primarily on symptom reduction as a means to minimize functional impairments; and
2. Skill building to improve, maintain, or restore functioning.
3. ID Evidence-based practices used with client.
4. Give details of skills discussed in the session related to the treatment plan and tools/assignments provided geared towards treatment goals.
5. “supporting”, “reinforcing”, and “providing feedback” are not stand-alone interventions.

Client Response

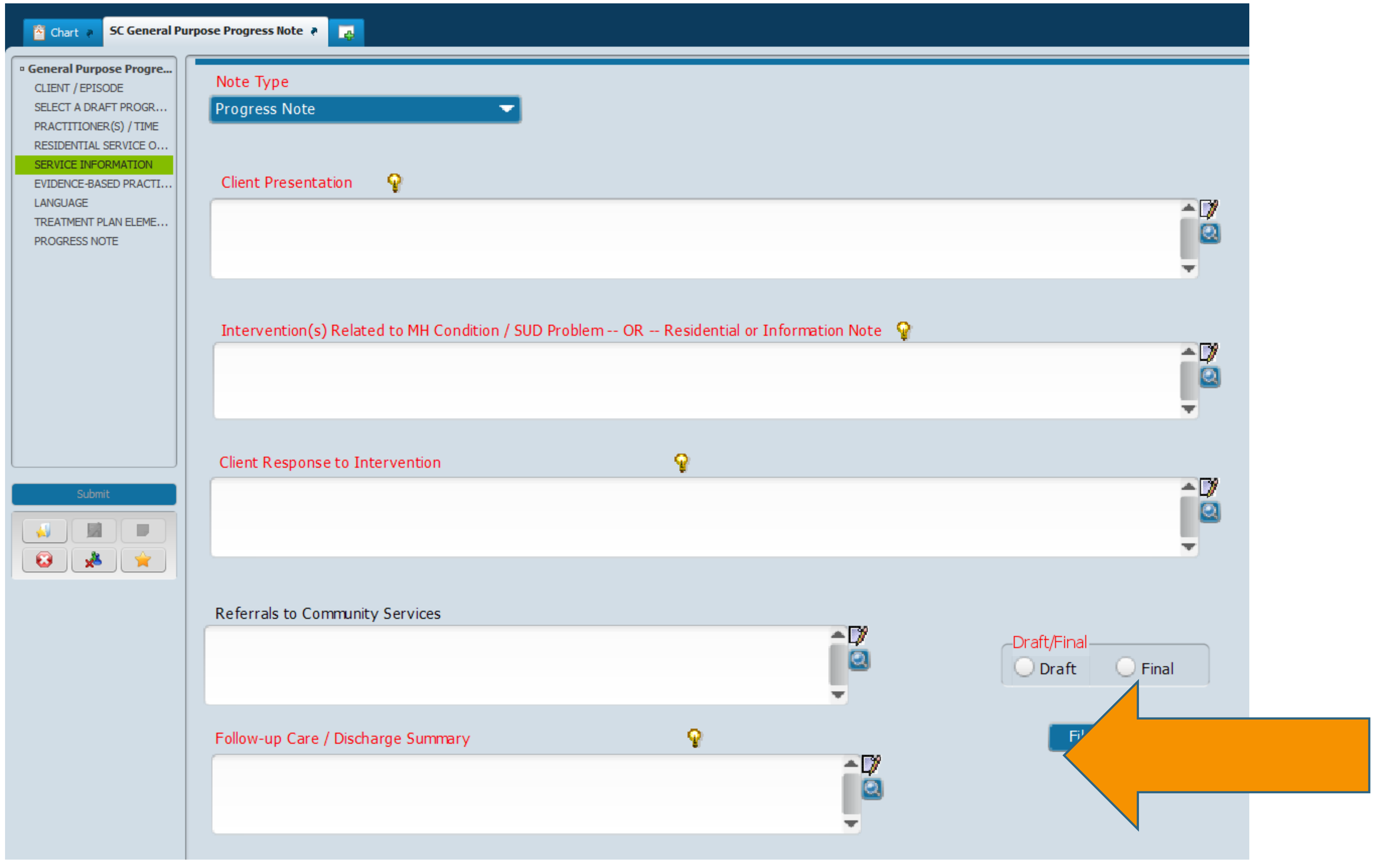


Client Response

Describe the client's RESPONSE to the intervention
or the outcome or result of the service.

"N/A" should only be used in the Client Response section on a very limited basis (CM) and never if is there is direct contact.

Follow-Up Care



Follow-Up Care

Continued frequency and type of services indicated; proposed tasks for next session

Ex 1: Meet next week for individual counseling to continue building on relapse prevention plan for each identified trigger.

Ex 2: Contact PCP office to share signed ROI and request copy of physical exam summary.

Thank You