ODS Waiver SUD Treatment Documentation

A high level overview of
DMC-Organized Delivery System (ODS) Waiver
documentation requirements

Overview

- Expanded Service Delivery
- Definition of LPHA
- Intake
- Physical Examination
- Diagnosis
- Medical Necessity
- Treatment Planning
- Progress Notes
- Discharge

Expanded Service Delivery

- Case Management
- Telephone
- Telehealth
- Physician Consultation

- All methods utilized must be documented by whomever provided the service under their scope of practice

Licensed Practitioner of the Healing Arts (LPHA)*

LPHAs include:

- Physician
- Nurse Practitioner
- Physician Assistant
- Registered Nurse
- Registered Pharmacist
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Clinical Counselor
- Licensed Marriage and Family Therapists
- License Eligible Practitioner working under the supervision of licensed clinicians

* Intergovernmental Agreement, (III. Program Specifications, A.1.i.a.)

Beneficiary Admission

Who can Document?

- ✓ LPHA
- ✓ Counselor (certified or registered by certifying organizations)

Timeframe

As needed

What Must be Documented?

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

Intake

Who can Document?

- ✓ LPHA
- ✓ Counselor

Timeframe

Due within thirty (30) calendar days from the beneficiary's admission to treatment.

What Must be Documented?

- Drug/Alcohol History
- Medical History
- Family History
- Psychiatric/Psychological History
- Social/recreational History
- Financial Status/History
- Educational History
- Employment History
- Criminal History, Legal Status
- Previous SUD Treatment History
- American Society of Addiction Medicine (ASAM) Criteria

Physical Examinations

Who can document?

- ✓Physician
- ✓Registered nurse practitioner
- ✓Physician's assistant (physician extenders)

Timeframe

Within thirty (30) calendar days of the beneficiary's admission to treatment date

What Must be Documented?

- Copy of physical examination completed within prior 12 months in beneficiary record, OR
- The beneficiary's initial and updated treatment plans include a goal to obtain a physical examination, until this goal has been met.

Diagnosis

Who can document?

- ✓ Medical director
- ✓ LPHA

Timeframe

Within 30 calendar days from admission to treatment

What must be documented?

- Basis of diagnosis must be based on DSM 5 criteria
- Documented separately from the treatment plan

Medical Necessity

22 CCR § 51303

SUD Treatment Services that are reasonable and necessary to:

- Protect life
- Prevent significant illness or significant disability
- Alleviate severe pain through the diagnosis or treatment of a disease, illness or injury

42 CFR § 438.210(a)(4)

Place appropriate limits on a service -

- On the basis of criteria applied under the State plan, such as medical necessity; or

For the purpose of utilization control, provided that –

- The services furnished can reasonably achieve their purpose
- Must ensure that the services are sufficient in amount, duration or scope to reasonably achieve the purpose for which the services are furnished.

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

Treatment Planning

Who can document?

- ✓ LPHA
- ✓ Counselor

Timeframe

Within 30 days from admission to treatment

What must be documented?

- Statement of problems
- Goals
  - Physical exam, if needed
  - Goal of obtaining treatment for an identified significant medical illness
- Action steps
- Target dates
- Type & frequency of counseling/services
- Diagnosis
- Assignment of primary therapist or counselor

Progress Notes

Specific to outpatient services, Naltrexone treatment services, and recovery services

Who can document?

- ✓ LPHA
- ✓ Counselor

Timeframe

Within seven calendar days of the counseling session

What must be documented?

- The topic of the session
- A description of the beneficiary's progress towards treatment plan goals
- Date of each treatment service
- Start and end time of each treatment service
- Typed or legibly printed name of LPHA or counselor, signature and date progress noted was documented
  - Adjacent to each other

- **Must identify if service was in-person, by telephone, or telehealth**
- **Must document location of service and how confidentiality was ensured if in community**

Progress Notes Cont...

Specific to intensive outpatient treatment, and residential treatment services

Who can document?

- ✓ LPHA
- ✓ Counselor

Timeframe

Within the following calendar week

What must be documented?

- At a minimum, one per calendar week
- A description of the beneficiary's progress towards treatment plan goals
- Record of beneficiary attendance
- Date
- Start and end time of each treatment service
- Topic of session
- Printed or typed & signed name of LPHA or counselor
  - Adjacent to each other

- **Must identify if service was in-person, by telephone, or telehealth**
- **Must document location of service and how confidentiality was ensured if in community**

Progress Notes Cont...

Specific to case management services

Who can document?

- ✓ LPHA
- ✓ Counselor

Timeframe

Within seven calendar days of the service

What must be documented?

- Beneficiary's name
- Purpose of the service
- A description of how the service relates to the beneficiary's treatment plan
- Date
- Start and end time of each service
- Printed or typed & signed name of LPHA or counselor
  - Adjacent to each other

- **Must identify if service was in-person, by telephone, or telehealth**
- **Must document location of service and how confidentiality was ensured if in community**

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**

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

Discharge Planning

Who can document?

- ✓ LPHA
- ✓ Counselor

Timeframe

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

What must be documented?

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

Discharge Summary

Who can document?

- ✓ LPHA
- ✓ Counselor

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

QUESTIONS?

Questions

An email account dedicated to external and internal stakeholders asking questions about the DMC-ODS Waiver.

Contact address -

DMCODSWAIVER@dhcs.ca.gov