CLINICAL DOCUMENTATION FAQ

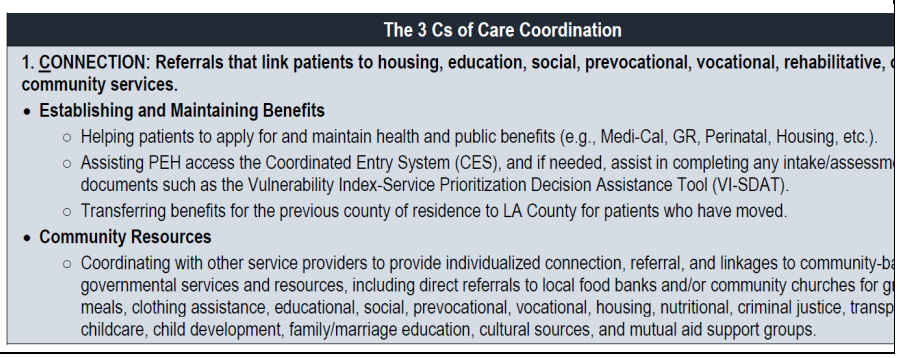
This document is a compilation of questions various Divisions of SAPC have received in meetings, trainings, and/or by email. This document will be updated periodically as new items arise, guidance and/or policy changes, or items are no longer relevant. The FAQ is broken down into sections to help users navigate the document with ease. Lastly, several responses include reference documents and links to where additional information on the topic can be found.

Progress Note:

Assessment

Assessment Questions	Answers
What are the documentation requirements for the 90792 code? Is a SOAP note sufficient or does it need to be an entire form, or series of other assessments (e.g. CIWA, COWS, etc.) in addition to a note? Can you provide an example of the expected documentation to help support the implementation of these services.	A SOAP note is fine, as long as the key elements of a psychiatric evaluation (CC, HPI, Psychiatric/SUD/Medical History, Allergies, Meds / Med Trials History, Social, Mental Status Exam and any other physical exam components that were collected, Formulation/Dx, Assessment/Plan) are documented in this format.
How should we document a physical exam?	For services to be billable to SAPC, the note documents that include a physical exam need to include an SUD diagnosis and the plan of care (including any applicable medications) for the SUD. For FY 24/25: • Residential Settings may use H0034R to bill for this service. • Non-residential, H0034 is allowable, as are 99202-99205 (depending on the time of the medical visit).

Care Coordination

Care Coordination Questions	Answers
Can care coordination be rendered without the patient present?	Yes. With payment reform the presence of the patient is required for almost all services, the general exception is Care Coordination. When patient is not present in care coordination services, providers should include the rationale of providing the services without the patient and why it is clinically appropriate in the progress note.
Is linking patients with community resources (such as toys for their children) considered Care Coordination? The lack of resources during the holiday season is highly stressful to our participants and this connection would be very helpful for their emotional well-being.	The Provider Manual mentions that connecting to community resources is a type of care coordination. Another consideration when it comes to care coordination is whether it's medically necessary. If connecting specific patients to this community resource will help their SUD recovery and it is medically necessary, then that service would be considered as care coordination. Make sure documentation reflects why it is medically necessary in the progress note.
What Care Coordination activities need to be included in the Problem List and does this need to be added before providing the service?	Services provided should be tied to the patient's Problem List. The Problem List can be updated at any time so if a need arises during session, provide the Care Coordination and update the Problem List afterward to identify the new area that needs to be addressed.  **The 3 Cs of Care Coordination** **1. CONNECTION: Referrals that link patients to housing, education, social, prevocational, vocational, rehabilitative, community services.** • **Establishing and Maintaining Benefits** ○ Helping patients to apply for and maintain health and public benefits (e.g., Medi-Cal, GR, Perinatal, Housing, etc.). ○ Assisting PEH access the Coordinated Entry System (CES), and if needed, assist in completing any intake/assessm documents such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SDAT). ○ Transferring benefits for the previous county of residence to LA County for patients who have moved. • **Community Resources** ○ Coordinating with other service providers to provide individualized connection, referral, and linkages to community-b governmental services and resources, including direct referrals to local food banks and/or community churches for g meals, clothing assistance, educational, social, prevocational, vocational, housing, nutritional, criminal justice, transp childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

Collateral Services

Collateral Services Questions	Answers
I could not find anything on the Rate Matrix re: collateral calls with social workers, DCFS, or outside providers regarding client's treatment. Would these types of calls that last 30 minutes be billable as a care coordination service?	The use and term of "collateral" has changed under payment reform. Per DHCS CalAIM BH Initiative FAQ "Collateral services" is no longer defined as a unique service component of the DMC-ODS service modalities. In accordance with SPA 21-0058 and as described in BHIN 24-001, the concept of including a collateral in a member's substance use disorder treatment has been incorporated into assessment services, individual counseling, and family therapy. Assessment services may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. Additionally, individual counseling services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals. Finally, family therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the member's recovery as well as the holistic recovery of the family system. Family members can provide social support to the member and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the member is not present during the delivery of this service, but the service is for the direct benefit of the member. SPA 21-0058 and BHIN 24-001 detail which DMC-ODS service modalities include assessment services, individual counseling services, and family therapy as billable service components. Connecting with other individuals as part of treatment, may be billable as care coordination if what you are communicating with them meets the standard of care coordination. Administrative tasks, such as calling and leaving a voicemail, should be documented; however, it would not be billable.

Discharge

Discharge Questions	Answers
When should staff enter a Progress Note with "Discharge Planning/Summary"?	A progress note should be completed whenever a session was spent discussing matters related to planning a patient's discharge, such as preferences and needs upon discharge from current level of care, plan of care for discharge, and patient's goals achieved at discharge. Provide can enter a progress note with "Discharge Planning/Summary" throughout all stages in treatment as long as services provided are related to discharge planning. A progress note should be completed when an encounter is had with the patient and to document work being done for the patient if the patient is not present. The Provider Manual discusses the requirement of completing the Discharge and Transfer form as part of the discharge process, which should have an accompanying note so you could bill.

Fields for Billing

Fields for Billing Questions	Answers
Why do we need to have the Service Start and End Times?	The Service Start and End Times are used for auditing purposes and note identification by the Sage Helpdesk when requesting a records modification. During a SAPC audit, the Start/End times used to verify if the practitioner was working during the stated hours per their timecards. Please note the Start and End fields account for the time spent with the patient, but not necessarily the time providing a direct service which is what is billable.
If the billing code has to be changed, does the progress note procedure code need to be updated?	Best practice would be to request a modification record request to revert the document to draft and update the Service Type and/or Procedure Codes (CPT/HCPCS) field as appropriate. However, if SAPC provides mass guidance for rebilling a code to a different code, then using the Append function would be accepted. An example would be when SAPC instructed Residential Facilities that billed E&M codes for MAT assessments that resulted in all the services denied by the State. In this case, SAPC instructed providers to rebill using a different code.
If the same provider sets up morning visit and afternoon visit, do they combine notes into one- for billing purposes.	It depends. If the same practitioner renders two or more of the SAME service (exact procedure), to the same patient, on the same day then it is up to provider protocols whether these should be documented in one or more progress notes. SAPC will accept both, however Secondary Provider EHR configurations may require note entry to be done in a specific way if it is tied to directly creating claims. Generally, if 2+ of the same service is rendered to the same patient, on the same day, by the same practitioner then when the service is billed it has to be "rolled-up" into a single billed service for the duration of both services. Roll up billing exemptions:

Fields for Billing Questions	Answers
	• Group/Patient Education groups • Procedure codes (mostly CPT) with duration ranges. Example if the description says 21-30 minutes. • Procedure code with 1-unit maximums.

Location

Location Questions	Answers
When do we use office?	Office (11) is defined by the State as a location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnoses, and treatment of illness or injury on an ambulatory basis. For accuracy of place of service: • Outpatient providers should use: Non-residential Substance Abuse Treatment Facility (57) • Residential providers should use: Residential Substance Abuse Treatment Facility (55) • OTP providers should use: Non-residential Opioid Treatment Facility (58) • Field Based Service providers: see the FBS Standards and Practices
What location code should be used when a patient is not present, such as a care coordination medical team conference?	Typically, the location refers to where the patient is during the service. When there is no patient, use the code that best describes the site location (Non-residential Substance Abuse Treatment Facility, Residential Substance Abuse Treatment Facility, Non-residential Opioid Treatment Facility).
We are a campus provider, what site should be documented on the progress note? We know that the billing will go through the main DMC site.	For patients in residential services, enter the site location where the patient sleeps. For patients in non-residential LOCs, use the site where the service was rendered. Campus providers: Use an NPI from a site in the agency that provides the same LOC. http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm# http://publichealth.lacounty.gov/sapc/docs/providers/sage/finance/office-hour/Billing-Office-Hours-091224.pdf
What are the steps for documenting travel time to and from a Field Based Service location?	Only approved Agencies may provide FBS. Travel time should never include time from the staff's home to a site location or from the site location to the staff's home, as that is not reimbursable.

Location Questions	Answers

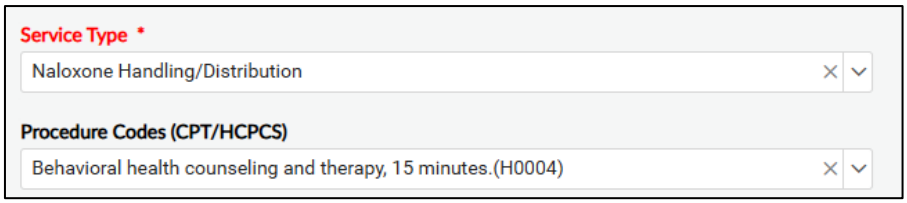
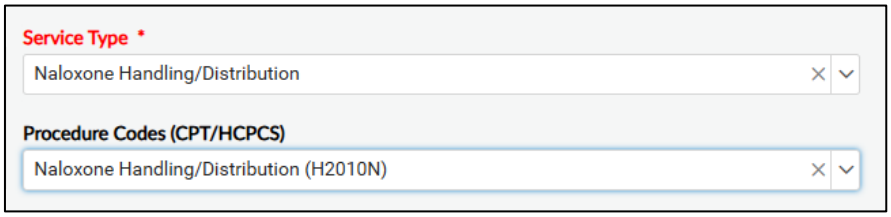
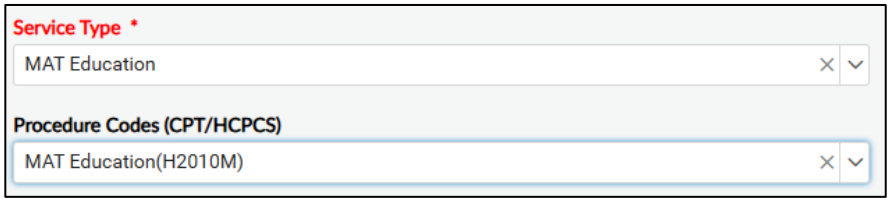
	Scenario 1: Practitioner starts shift at an FBS-approved location.
	• Start time and End time **to the destination** should match the Service Start time.
	• If another service follows at the same location, then Start and End time **from the destination** should match the Service End time.
	
	Scenario 2: Practitioner travels from office to FBS location for patient A, then goes to a second FBS location for patient B.
	• **Start time to destination** should reflect the exact time the provider left to go to the first FBS location. **End time to destination** should be the arrival time at the FBS location.
	  ○ There are two options for documenting End time from destination:
	Time from Destination: Start and End time should match the **Service End Time.** Scenario 3: Practitioner sees multiple patients at the same location.
	• The **Time to Destination** field should reflect the travel to the FBS location for the first patient seen.
	  ○ For the **Time From Destination,** it should match the **Service End Time**
	• For the last patient seen, fill in the **Time to Destination** to match the **Service Start Time.**
	  ○ For the **Time From Destination**, include the time to return to the office or another FBS location. This does not apply if traveling home.
	• If there are additional patients, then still indicate it was a field-based service, but the **Time to and Time From** fields should match the **Service Start and End Times**.

How do I determine which location code to use, if the location type does not match exactly?	Although there's no exact match for some FBS site(s), try to choose the best location code that matches closest based on the site. If you need assistance, please email: DPH-SAPC_ASOC@ph.lacounty.gov

Mandated Reporting

Mandated Reporting Questions	Answers
Would making DCFS/APS reports also be considered a billable care coordination service?	When it comes to mandated reporting, there are tasks that are required, but not necessarily billable. Filling out a CPS/APS report form would fall under the administrative category which is not billable. However, the time spent talking to person who is taking the report could be billable and depending on how it is written and if the patient was part of the conversation.

MAT Services/Naloxone/MAT Edu/Safeguarding

MAT Questions	Answers
How do we document the incentives MAT Education (H2010M) and Naloxone Handling/Distribution(H2010N) to get the incentives?	The incentive is based on billing code, not on the type of note selected on the progress note. MAT Education and Naloxone Handling/Distribution are not standalone services and are conducted while rendering another service such as counseling, group, or care coordination. For the H2010N/M incentive codes, a separate progress note is NOT required by SAPC. Example, if naloxone was provided during a counseling visit then H0004 can be claimed when there is a progress note substantiating the counseling visit, and H2010N can ALSO be claimed in addition to H0004 against that same note. For primary providers who are relying on the Progress Note Status Report for billing, agency staff may file a separate naloxone "tracker note" to assist billing staff with visibility on naloxone distribution at a counseling session. However, this is not required for H2010N to be claimed and agencies can operationalize an alternative workflow for the purposes of claiming H2010N or H2010M. Example of a Sage Progress Note when including both services in one record:  Example of a H2010N "tracker note":  SAPC added an additional service type of MAT Education to clarify the services:  http://publichealth.lacounty.gov/sapc/Sage/Communication/SAPC-Sage-Provider-Communication-021425.pdf
Does H2010S require any face-to-face interaction or additional documentation outside of logging in the medication into PCNX?	For H2010S the patient has to be present for the time that is billed. A medical safeguarding note can be written for the time the staff spend coordinating medications without the patient, but the time spent without the patient is not billable.

MAT Questions	Answers
Can you clarify what is meant by H2010S is a "stand alone?"	Stand-alone refers to a service not needing to be associated or provided in combination with another service. ○ *If an eligible practitioner handles 2 medications for Patient A and 10 medications for Patient B during a morning pill-call, there would be <u>one</u> H2010S service billed for <u>each patient</u>. If that same practitioner handles an evening pill-call service for these same patients, there would an additional H2010S service billed for each patient.* ○ *No other service other than handing of medication was rendered.* H2010M and H2010N are NOT stand-alone services and are provided in conjunction with another service such as counseling or care coordination.
Can you confirm that H2010S can be used more than once a day for the same patient. If so, is there any written documentation you can provide stating this.	Yes, it can. This was addressed that this in the All Provider Meeting in the Clinical Services Division update on 11/5/2024: http://publichealth.lacounty.gov/sapc/providers/treatment-provider-meetings.htm which has the instruction in writing. ○ *If an eligible practitioner handles 2 medications for Patient A and 10 medications for Patient B during a morning pill-call, there would be <u>one</u> H2010S service billed for <u>each patient</u>. If that same practitioner handles an evening pill-call service for these same patients, there would an additional H2010S service billed for each patient.*
With the changes recently announced that MAT services are no longer a standalone service, can you give direction on how we are to document? For example, if a counselor sees a client for an individual session for 60 minutes and then conducts a MAT education and referral session for another 60 minutes, are they to write one note in PCNX labeled as an individual counseling session but with the content of that note to reflect both services and therefore the total service time is 120 minutes? Or are they to continue to write 2 separate notes and then when we bill, we tally up the service time and submit once?	H2010M/N are not standalone service because these billing codes are codes for tracking incentives, and they are $0 claim codes. The amount of direct service provided to the patient should be accounted for in the reimbursable service code. In the example provided the full 120 minutes (8 units) would be billed for the individual session and this would get billed to the State. The units and duration billed against the $0 H2010 M/N will not count toward treatment hours as these are simply tracker codes and the duration is accounted for with the billed service. So, when billing H2010 M/N the unit can also reflect the time specific time spent for that service, in this case 4 units. The documentation of using one note or two notes is up to Agency workflows, but SAPC does not require two 2 separate notes. However, the Note narrative should include a description of the counseling session including what was done in providing MAT Education.
Can you please confirm that we (.5, 1.0 LOC) do not need to submit a treatment plan for MAT services?	Only OTP level of care (LOC) requires a Plan of Care (formerly called Treatment Plan). In other words, MAT in non-OTP outpatient settings does not require to complete Treatment Plan Form.

MAT Questions	Answers
We were in another meeting and told that if a treatment plan was not submitted, MAT services would not be reimbursed.	However, care planning is still an integral part of treatment. Collaborating with patients to identify the next steps in treatment and recording these next steps in the "Plan" part of each progress note is required. You can find out more about care planning in non-OTP settings in the newest SAPC Provider Manual 9.0 pp. 52, 193-196.
We are seeking clarification on which CPT code an LVN would use to provide services that include injections for both MAT medications and non-MAT medications in residential and outpatient programs.	DHCS accepts both H0033 (even though it says oral in the description) and H0034 for injections; you can use either. You can use H0033 to bill for administration of any medically necessary medications, even if they aren't FDA approved to treat substance use disorders, as long as the medical/psychiatric condition being treated is documented on the problem list and the progress notes describe how the medication treatment supports the patient's recovery from the diagnosed SUD(s).
What are the available medication service codes for our staff, as well as program type/licensure requirements for providing these services at both IMS designated sites as well as non-IMS sites.	H0033 is for medical staff administering medication, which requires a medication administration note and for the site to have IMS. H2010S is for any DMC-ODS practitioners to handle/store medications for patient self-administration. It does not require IMS. The Rate and Standards Matrix, released per Fiscal Year will indicate which services are reimbursable by provider discipline.
We are seeking clarification on the correct CPT or HCPCs code to use when non-MAT services are provided by a MD/DO, NP or PA to a client in our IMS Certified Residential Facility. For example, a client may need anxiety medication in order to successfully remain in SUD treatment sees the NP and is prescribed a medication.	SAPC does not pay for psychiatric or other medication services delivered to a patient that does not also include the treatment of the substance use disorder. Our information notice 24-01 (link) on Page 2 describes these standards: *Medication services billed to SAPC require documentation of the eligible (non-tobacco) SUD diagnosis. The documentation must also describe the medication services provided to address each applicable SUD. Agencies shall offer tobacco use disorder treatment, including with medications appropriate for the patient, when tobacco use disorder is present alongside a non-tobacco SUD. For tobacco use disorder treatment services offered on-site alongside treatment of non-tobacco SUD(s), the applicable (non-tobacco) SUD(s) should serve as the diagnosis listed on the claim. Other problems treated by the licensed prescribing clinician (for example, psychiatric care and general medical care) can also be included alongside addiction medication services if the eligible (non-tobacco) SUD was documented as a focus of the visit (it does not need to be the only focus of the visit). Medication services associated with documentation where there is no mention of an eligible (non-tobacco) SUD and no mention of treating the SUD are not billable to SAPC.* In your example, if a patient with a substance use disorder condition also requires psychiatric management, one strategy is for the psychiatric clinician to document the SUD (for example, alcohol use disorder) and their medical decision making around the treatments for alcohol use disorder offered to the patient (including all of the medications FDA approved for alcohol use disorder described within SAPC-IN Attachment B) along with the anxiety condition and psychiatric management of anxiety being considered. Treating anxiety (and other psychiatric and medical conditions) alongside SUD is entirely permitted as long as the SUD diagnosis and

MAT Questions	Answers
	related medical decision making is document in the note. What would not be permitted is a psychiatric note omitting discussion of the SUD and the medical decision making regarding the medication treatments appropriate for that patient's SUD.
Is Recovery Services excluded from the use of H2010N and H2010M and calculation of the incentive deliverable percentage of clients with AUD/OUD? On the one hand this would make sense to me because RSS clients do not have access to MAT services, but of course in providing quality care we provide MAT education and distribute Narcan as needed.	We use the H2010M and H2010N code for our incentives tracking, and this includes patients receiving recovery services.
Is H0034 for non-MAT medical Services such as a physical exam?	H0034 (and the 992**) codes are billable when the medical services, like physical exam, included an SUD diagnosis and a plan of care for that SUD. So, the physical exam is part of the medication visit, but notes documenting a physical exams that don't mention an SUD diagnosis or plan of care for the SUD aren't billable. When the SUD diagnosis is included, and plan of care is discussed H0034 is billable for the service that includes a physical exam.
What if medication service is NOT MAT related? What procedure code should be used?	The medication service must include an SUD diagnosis and a plan of care for the SUD to be billable to SAPC. Non-MAT medication services documented within the same note as the SUD diagnosis and plan of care for the SUD diagnosis ARE billable to SAPC, but SAPC doesn't pay for stand-alone medication services that don't also include and SUD diagnosis or plan of care for the SUD diagnosis.

Medical Necessity

Medical Necessity Questions	Answers
What code is used for medical necessity?	The State did not identify a specific code for “medical necessity.” However, with the expansion of the payment reform they did give LPHAs an outlet to more specifically bill for their time. Diagnosing is something that can only be done by select (LE) LPHA and is part of establishing medical necessity, so we identified 90885 as a way for LPHAs to capture their time. As a reminder, supervision activities are not reimbursable by the State.
Do you know of any other way I can learn if our Medical Necessity notes " meets the criteria for 90885 (Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes)"?	Manual review of the historical notes is really the only way to determine if the content meets the level of 90885. The duration of the note should not change, and the billers should bill the time appropriately.

Medical Necessity Questions	Answers
What LPHAs can approve the medical necessity note?	Practitioners whose scope of practice allow them to diagnose a substance use disorder may finalize the medical necessity note. This is limited to: • Registered and Licensed: Clinical Social Workers, Marriage and Family Therapists, and Professional Clinical Counselors. • Psychological Associates and Licensed Psychologists • Prescribers: Physicians, Physician Assistants, Nurse Practitioners Practitioners who may **NOT** finalize a Medical Necessity note include counselors, registered nurses, licensed vocational nurses, medical assistants, peers, licensed occupational therapists.
How does one expand on symptoms which may be either chronic or acute in a way that supports medical necessity?	Providers should include detailed description of patient's presentation/symptoms as well as functional impairments, and/or biopsychosocial factors contributing to patient's substance use and relapse risk. For example: • Instead of stating "patient is experiencing psychosis", provide specifics such as "patient reports ongoing intermittent auditory hallucinations, command, and paranoid type. Per Pt, 'the voices tell me I should leave because someone here wants to hurt me'". • Instead of stating "patient is experiencing legal issues" provide specifics such as "Pt has ongoing legal issues including being on summary probation and having open DCFS case. Pt's next DCFS court date is 3/1/25 and Pt reports if she loses her children she is going to "give up" because 'what is the point'". • For medical issues instead of only stating "Pt has a history of seizures", provide specifics such as "Pt has a recent history of ETOH withdrawal related seizures, with last seizure 6 weeks prior to admission. Pt is non-compliant with prescribed medications and states 'I forget to take my medications when I'm drinking"'. • For behavior preventing lower LOC participation and requiring higher LOC, instead of stating "Pt presents agitated", provide specifics such as "Pt presented as agitated and aggressive at time of screening, evidenced by pressured and rapid speech, threats to staff, and postured stance. Pt required IV sedation and requires 24 hour 1:1 nursing for safety and medical observation for medication management."
What are the aspects/categories that need to be covered in a medical necessity note?	Specify patient's drug of choice, quantity/frequency of use, date of last use, how use has resulted in functional impairments, current relapse risk factors, co-occurring diagnoses, and/or biopsychosocial elements impacting or interacting with Pt's SUD, as applicable. For Withdrawal Management: include current withdrawal symptoms, be as specific as possible to justify the level of WM being requested. Unstable medical or psychiatric issues. Need for medication management that requires medical observation.

Peer Support Services

Peer Support Services Questions	Answers
How to correctly document the P in a PIN Note for group or individual peer support note? We are creating a Plan of Care for each patient. When these patients attend a group that is led by a PSS, the PSS is documenting the group for billing purposes. The question is what PIN format to use for Group notes by a PSS.	The Plan of Care, Interaction, Next Steps (PIN) format for documentation is not mandatory but only a suggested format. Your agency is free to continue to utilize the PIN documentation format if you find it useful, otherwise you are welcome to use whichever documentation format you currently use. The PIN format was just an example that another county's providers had found useful. http://publichealth.lacounty.gov/sapc/docs/providers/trainings/SAPC-Peer-Support-Services-Guide.pdf pg. 6
How to document Peer Support Service Plan of Care? Where is Plan of Care documented?	SAPC does not require a separate Plan of Care form, instead the Plan of Care should be evident throughout the service episode in the body of the clinical progress notes.
What service type/procedure code do we use for a Peer Support Service Plan of Care?	Service Type: Peer Support Service – Plan of Care Procedure Codes (CPT/HCPCS): H0038.
Do we have to create a plan of care for all encounters with patients or just patients that we will continue to work with on a regular basis?	Yes, assume all patients would continue services (i.e. After conducting an intake) and therefore would need a Plan of Care. It is best clinical practice to have that Plan of Care in place for treatment purposes, but also so that the treatment team can begin to work with the patient in the event the patient does stay in treatment. Whether the patient would continue to services or not is of course a clinical matter and something that the patient and your treatment team would discuss.
Is there a requirement to complete a session within three (3) days of the completion of the Plan of Care?	Since the plan of care for Peer Support Services is documented in a progress note, the documentation should be completed within 3 business days. That would also include all required signatures, such as the author and LPHA/Peer Supervisor. Please refer to SAPC Information Notice 23-04 page 6 for details and additional timeframes.
If the PSS who creates the Plan of Care and is our agency PSS Supervisor, is it okay to have only his electronic signature?	Yes. If the PSS Supervisor is the author, only their signature is required.
In PCNX, when the PSS creates the Plan of Care, it is then sent to the PSS Supervisor who approves and finalizes it in PCNX. Since the PSS Supervisor is not an LPHA at our agency and the Plan of Care is a Progress Note and not a Form like the Problem List, when the PSS Supervisor Finalized the Plan of Care, it seems like it only captures the PSS Supervisors Electronic Signature. In the Finalized Plan of Care, it still shows the name of the PSS who created the Plan of Care, but when I print the document, at the top it only shows the PSS Supervisors information that I understand is the Electronic Signature. Please advise.	With Document Routing of the Progress Note, the Console Widget Viewer will show both the Author and Supervisor signature on the last page once all signatures are obtained. If the note is left in draft by the PSS and the PSS Supervisor goes into the draft note to finalize, the Progress Note Printout will show both the Draft and Final electronic signatures/timestamps. SAPC recommends using the Document Routing process when needing a co-signature.

Residential

Residential Questions	Answers
What are the required components of a Residential Daily Summary	Residential Daily Summaries must summarize all services and activities the patient engages in over the course of a day. Residential Daily Summaries must include details about the service or activity, how it supports the patient's progress toward care goals, attendees, start and end times of both the service/activity and the documentation, and any relevant information about the patient's response. Patient response should be captured for each service or activity. Progress Notes must be signed or initialed by the LPHA or counselor responsible for the service, with signatures placed adjacent to each other when both are required.

Screenings

Screening Questions	Answers
Treatment Providers- what to do if they screen and person didn't show for the intake. What to document?	If the screen was conducted via Sage, with the ASAM CO-Triage or Youth and Young Adult Screener, then the corresponding Service Connections Log (SASH, CENS, CORE) or Referral Connection form (Treatment providers) needs to be completed, along with a Progress Note, to bill. The "No Show" can be documented in a progress note. If the Intake was scheduled with a provider different from who conducted the screening, and the patient is not enrolled with your agency, you should attempt to contact the individual for rescheduling.
Where and how are initial screenings documented and what code is used for billing?	**CENS:** (1) Conduct either ASAM CO-Triage or Youth and Young Adult Screener. (2) Complete Referral Connection Form. (3) If individuals need referral to SUD treatment services, please use H0049-CN for billing. If screening results indicate individuals do not need SUD treatment services, please use H0049-N for billing. **DMC-ODS Treatment Services Providers:** Conduct either ASAM CO-Triage or Youth and Young Adult Screener. **If patients are not admitted to your agency:** Complete Referral Connection Form. Providers should use H0049-N for billing. Please submit PAuth for screening billing. For more information about Screening billing and PAuth submission, please refer to the Sage Claiming for Screening Job Aid on the SAPC website: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/ClaimingSUDScreeningInstructions.pdf **If patients are admitted to your agency:** Upon completion of ASAM CO-Triage or Screener of Youth and Young Adult, complete a progress note for the screening session. Providers should use H0049 for screening services when admitting patient directly after screening.

Assessment

Assessment Form Questions	Answers
What is the ASAM requirement for RI-CM?	For initial enrollment and reauthorization, if there was an existing ASAM that was completed within the past 12 months, no additional ASAM will be needed unless the agency determines a new ASAM is appropriate. As of **October 1, 2024**, (for Auths with start date 10/1/24 and after), providers will be required to submit a newer ASAM completed within 30 days from the readmission date for all readmissions if client dropped out from outpatient and RI-CM services. However, no new ASAM is required if (1) the client continued with outpatient services but dropped out from RI-CM services, (2) the existing ASAM completed within the past 12 months contains a qualifying SUD dx and (3) client's condition has not changed. There is no change for initial and reauthorization. The purpose of this update is to reflect the ASAM requirement for RI-CM readmissions to align with the State's BHIN 24-031. Here is the link to the BHIN for your reference: BHIN 24-031 Updated Guidance for the Recovery Incentives Program: California's Contingency Management Benefit
Is a new ASAM for a client who we discharged, but returns and wants services again required? We did the discharge and Cal-OMS discharge already for the client.	Please see the ASAM Assessment Requirements document on the SAPC website that explains when a new ASAM is required http://publichealth.lacounty.gov/sapc/docs/providers/asam/ASAM-Assessment-Requirements-LOC-Transitions.pdf
DHCS 5103 Client Health Questionnaire and Initial Screening Questions is required if Incidental Medical Services (IMS) are provided. What should administration of this form be considered – assessment or care coordination?	Code Type: Assessment Sage Service Code Description: Administration of patient- focused health risk assessment instrument (96160)
Are Health Questionnaires and Physicals required for admission to all LOCs?	A Health Questionnaire is required by CA Code of Regulations § 10567 (focused on Resident Health Screening) and CA AOD Certification 7020 (page 27) which require collection of the information referenced on DHCS Form 5103. DHCS Form 5103 is one (but not the only) option to maintain compliance with this requirement, and an additional avenue for compliance is to have a qualified health care practitioner (physician, physician assistant, advanced practice nurse) conduct a physical examination to identify any health problems or conditions which require medical attention, or which are of such a serious nature as to preclude the person from participating in the program.

Assessment Form Questions	Answers
	SAPC's provider manual sections: "ASAM XX: Service Requirements" references "Treatment services at this LOC include... completing the health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam at each LOC." Landing page for the most recent Provider Manual
Who can complete a health questionnaire?	Health Questionnaire's need to be reviewed and signed by an LPHA or by a registered/certified counselor who is operating under supervision of an LPHA.

Diagnosis:

Diagnosis Questions	Answers
Which ICD 10 code does GHB fall under?	The convention is to use F19.20 other psychoactive substance dependence for GHB use disorder, but if this code isn't available, then the recommendation is F13.20 sedative, hypnotic or anxiolytic dependence.
What is the difference between an admission and updated diagnosis?	Based on the Sage configuration, patients only ever have one (1) episode per agency, therefore they should only ever have one "Admission" diagnosis per episode. Subsequent diagnosis(es) should be marked as "Update." All patients require a diagnosis for billing otherwise it will be denied.
Can someone other than the diagnosing practitioner complete the Diagnosis form?	Yes. There is a field on the form where the "Diagnosing Practitioner" can be selected. However, there needs to be documentation in the Progress Note from the diagnosing practitioner that they made the diagnosis identified on the Diagnosis form.

Problem List

Problem List Questions	Answers
MAT referrals aren't appropriate for everyone, why is the explanation field required, can we just indicate N/A?	Per SAPC IN 24-01, providers must discuss and offer MAT as a treatment options with patients who meet the criteria of opioid, alcohol, and/or tobacco use disorder. SAPC also recommends discussing and offering MAT as a treatment option with patients who meet the criteria for cannabis use disorder, stimulant use disorder (methamphetamine type), and cocaine use disorder. Providers should provide psychoeducation to patients who meet criteria of the above substance use disorders. The explanation field should indicate why a referral was not made, such as the patient declined those services, or they are already enrolled. If a referral was made, the field can contain when they were referred or who they were referred to, if there is a pending evaluation.
We're aware MAT should be considered for every SUD patient, but for the purposes of documentation, as on the problem list, we're wondering if "referred" generally means "discussed," "linked to an appointment," "linkage	For the MAT referral field on the Problem List/Treatment Plan form, click "yes" in situations when an actual referral is made such as setting up a MAT appointment or providing MAT referral sources to patient. Click "no" when no referral is made, this includes patient refused MAT referral after providing MAT education, or patient is already receiving MAT services.

Problem List Questions	Answers
attempts made," or something else. What's the best document to reference?	
When is the provider fills out the Problem List and a Z-code is used in the Problem Description, do we include "As reported by" or is that only if we are adding anything other than z codes for example in need of annual physical?	If it is within the scope of practice for the provider to directly add Z55-65 codes to the Problem List, there is no need to include "as reported by" in the problem description. In general, these are the items that need to be completed within the practitioner's scope of practice. 1. Problem 2. The date of the problem added 3. The name, credential, and title of the practitioner adding the problem 4. The date that the problem was resolved a. The name, credential, and title of the practitioner who identified the problem as resolved
The progress note has to be submitted within three (3) business days of the service; do we also have (3) business days to create the treatment plan/problem list?	When developing a Problem List (PL) with patient, it would require to (1) complete a progress note for the service rendered (developing a PL) and (2) finalizing a Problem List in the Problem List/Treatment Plan form. There are separate "clocks" for the completion of these two types of documentation. The progress note documenting the PL development session should be completed within 3 business days from the date of service rendered. The Problem List, which is documented in the Problem List/Treatment Plan form, has to be finalized according to the timeline outlined in Table 16 of Provider Manual 9.0. The finalization of the PL does not follow the 3 business days rule for progress notes. However, it is highly recommend having a LPHA to finalize a Problem List within 7 days when counselors complete a Problem List, as this is considered as good clinical practice. Regarding to the "Date Created" on the Problem List/Treatment Plan form, this date would be the date that counselors/practitioners start working on the Problem List with patient. Sometimes it may take more than one session to develop Problem List. For example, a counselor met with patient to develop a Problem List on 8/5/24 and 8/7/24. • The counselor would enter 8/5/24 for "Date Created" on the Problem List/Treatment Plan form, as 8/5/24 was the date that they start developing the Problem List with the patient. • Then, the counselor would also write two separate progress notes, one dated on 8/5/24 and another one dated on 8/7/24 to document the two separate Problem List/Treatment Plan

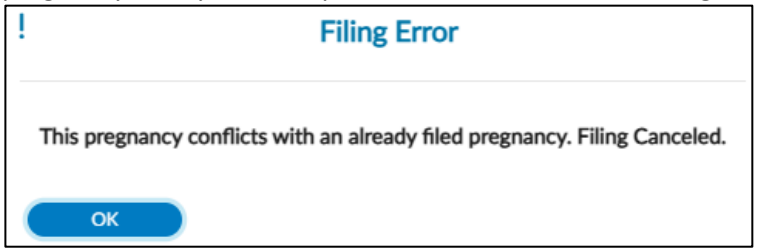
Problem List Questions	Answers
	Development sessions. The finalization of these two progress notes would be within 3 business days. The finalization timeline would depend on the Level of Care and if the patient is under 21 and/or experiencing homelessness.
For Contingency Management (CM), is a Problem List required both for when one provider is rendering CM and another is rendering Outpatient (OP)?	Yes, a Problem List is required for both the Outpatient and Contingency Management providers. http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/23-06/SAPCIN23-06CM.pdf
Is a Problem List required for Recovery Services?	Standalone Recovery Services require a Problem List. See Table 16 of Provider Manual 9.0 for details regarding timelines.

Release of Information

ROI Questions	Answers
Can agencies use their own ROI?	Providers must use the SAPC approved Release of Information (ROI) from the SAPC website or in Sage to ensure the required CFR 42 part 2 language is present and met. http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm#clinical

Women's Health History

Women's Health History Questions	Answers
Do all patients require a Women's Health History form?	The Women's Health History (WHH) form is required to be completed in Sage by PPW providers for patients who are pregnant or within a 1-year postpartum period. Both Primary and Secondary Sage Users are required to complete the WHH form. Not completing this form for pregnant and postpartum patients will result in State denials. The following items are required to submit the form: • Add, Edit or Delete a Record • Client ID • Episode Number • Selected Record [conditionally required] • Assessment Date • Date of Last Menstrual Period (2300-DTP-03) [needed for billing purposes] • Pregnancy Start Date [needed for billing purposes] • Expected Due Date • Pregnancy End Date [should be entered for existing record to close out the pregnancy period and for patients who enter treatment within the 1-year postpartum period] • Initial treatment Date (2300-DTP-03) [needed for billing purposes]

Women's Health History Questions	Answers
Is this something that needs to be completed with changes in LOC/site?	No. The WHH form is completed at the agency level not the site level. It should be completed per pregnancy and edited as appropriate, such as updating to include the end date of pregnancy.
If the patient leaves and returns to treatment does a new Women's Health History form need to be completed?	It depends. The WHH form must be completed for every unique pregnancy. If a patient returns to treatment during the course of the same pregnancy, the system will prevent a new record from being filed.  If the pregnancy ends during the course of treatment, providers will need to update the WHH and enter a "Pregnancy End Date." If the patient returns to treatment and is experiencing a new pregnancy, the provider must enter the end date of the patient's previous pregnancy in the existing WHH form. *Even if the patient is new to your agency, the WHH allows access to pregnancy records entered by other agencies for continuity of care, State billing, and Medi-Cal eligibility aid code updates specific to pregnancy/1 year post postpartum period. However, it will not be known what agency completed the other WHH entry.* Once the previous pregnancy is end dated, the provider will be able to file a new WHH for the patient's current pregnancy.
What is the difference between the Women's Health History and Reproductive Health form?	The Women's Health History form indicates perinatal status and must be completed for all patients who are pregnant or within a 1-year postpartum period. This information is required for claims to the state when using the perinatal HD modifier. The Reproductive Health form is available for providers to screen for reproductive health needs and refer to appropriate services. Providers are encouraged to complete this form for all clients of reproductive age, not just those who are pregnant or postpartum. Before completing the Reproductive Health form, providers must first attend SAPC's Pregnancy/Parenting, Attitudes, Timing, and How Important (PATH) training. This is a pregnancy intentionality training that reviews the form, referral process for services, and other key reproductive health topics.

Women's Health History Questions	Answers
	(Note: Sexual and Reproductive Health Specialists are *required* to attend the PATH training and complete the Reproductive Health form for all appropriate clients.) Both forms are completed in Sage by Primary and Secondary Sage Users.

Secondary Provider Requirements

Secondary Provider Req Questions	Answers
What should we do if we just got into contract with a new EHR vendor?	During the approval process to become a Secondary Sage User, form templates should be provided to the Associate Medical Director for approval. The goal would be to have templates approved prior to the official transition as a Secondary Sage User. However, if this does not occur, providers can use downtime procedures form until the EHR forms are approved. Email form templates to email: SAPC.QI.UM@ph.lacounty.gov with subject line: [Agency Name] Secondary Provider Form Approval Request Forms requiring approval: • Progress Note • Treatment Plan (OTP) • Problem List
We are currently a Secondary Sage User, but are planning to switch vendors, do we have to do anything with our forms?	Similar to the Primary to Secondary Sage conversion process, form templates should be provided to the Associate Medical Director for approval. If the EHR transition occurs prior to getting approval, providers should use downtime procedures forms. Email form templates to email: SAPC.QI.UM@ph.lacounty.gov with subject line: [Agency Name] Secondary Provider Form Approval Request Forms requiring approval: • Progress Note • Treatment Plan (OTP) • Problem List
Our agency is Residential LOC 3.1, 3.5, and 3.2, and IMS certified. We employ a MD for IMS/MAT services, which take place on-site at our program locations. Our agency's employed MD also has a private practice with his own EHR system. Is our employed MD able to document SAPC through his private practice EHR system? And if so, do we simply upload that EHR note as a PDF to PCNX attachments in order to be in compliance with SAP-C documentation requirements? Are we required to also enter a progress note into PCNX in order to bill for MD services?	At this time SAPC would not be able to connect directly to the MD's private practice EHR. However, the MD can continue to document in their own system and either upload to Sage themselves or have one of your staff upload the document into Sage. For billing purposes, if your staff uses the progress note status report to track claims and bill, then we suggest having the staff enter a "tracking" progress note with the billing information so that it populates the to the progress note status report. The file attach naming convention should follow these examples: i. History and Physical: H&P-(MM-DD-YY)-Patient Initials-PATID

Secondary Provider Req Questions	Answers
	ii. Medication Services: MAT- (MM-DD-YY)-Patient Initials-PATID If you do not use the progress note status report for tracking billing, then we still suggest entering a non-billable progress note that points to the MD note in the file attach for tracking purposes and visibility. Additionally, for DMC services and documentation, we do have to ensure the progress notes meet minimum DMC/Title 22 standards. Please ensure that your MD notes meet these minimum requirements to avoid audit issues. SAPC QI and UM can assist in that process if you would like to send them a blank note template from the prescriber's EHR to review. Likely the requirements are present, but we need to verify.
Does there need to be any agreement or MOU in place between our agency and our employed MD's private practice if the MD is using his own EHR for documentation? Or is this not necessary as the MD is an employee of our agency?	No need for an MOU.
Can the Problem List be documented in our own EHR if we are a Secondary provider?	Yes, this is the correct workflow as long as your agency's Problem List has been approved by SAPC. Please see SPAC IN 22-19 p. 2 for details.
What forms still need to be completed in Sage when we have our own EHR.	This list is subject to change as new requirements come down from the State or through interoperability updates. • Admission (Outpatient) • Update Client Data • All Cal-OMS related forms • ASAM Assessment/Finalize ASAM Assessment (Co-Triage and Continuum) • Provider Site Admission • Referral Connections • Service Connections Log (CENS only) • Youth and Young Adult Screener • Financial Eligibility • Service Authorization Request • Diagnosis • Real Time Inquiry 270 Request and Posting of 271 Response • Discharge and Transfer Form • Recovery Bridge Housing Discharge • Women's Health History (PPW sites only) • Reproductive Health (PPW sites only)

Program Standards

Program Standards Questions	Answers
Can we combine our intake consents into one with a single signature page?	No, Consent for Services, Notice of Privacy Practices, Rights and Responsibilities, HIPPA Agreement, Electronic Communication Consent, Telehealth Consent, Advanced Healthcare Directive, and Group Services Contract are required to be signed individually, and cannot be grouped together. Each of these forms is a standalone form, so while you can compile them into a single packet, they can't sign a single document where that signature covers all of these components. They are individual consents for each service component.
What are the max number of hours for Recovery Services?	At a practical level, if a patient is receiving 9 or more hours consistently per week, it would raise the question as to whether that patient would require an IOP LOC or higher.
For Contingency Management (CM) if a client is already enrolled in SUD treatment, do they need to be re-screened for medical necessity in advance of starting CM treatment? Do they need a new ASAM and Problem List/Treatment Plan?	The CM provider is required to determine that CM is medically necessary for each client. In addition, the CM provider shall document StimUD on the problem list (or treatment plan for Narcotic Treatment Providers, NTPs) within a client's medical record. If there is an ASAM in the chart within 12 months of the CM admission, UM accepts that.
For Contingency Management (CM) If a client has a StimUD in remission can they qualify for RI-CM?	RI-CM services are available to patients with a StimUD in remission, as long as patient meets medical necessity. If a patient holds a StimUD and is in remission provider should document need for RI-CM despite remission diagnosis.
What forms is SAPC requiring for SUD clients in counseling that also need mental health therapy treatment (under SAPC); so, if we are to provide mental health services to our SUD clients who are already enrolled with us for SUD counseling services, what forms is SAPC requiring from us to provide them with MH services under SAPC?	There are not specific forms per say for mental health counseling/therapy/psychiatric services required by SAPC but would refer to your agency policies (or to develop best practices). However, the ASAM Continuum assessment (for adults 21 and over) and ASAM Assessment for Youth and Young Adults (ages 0-20) does cover mental needs and may assist with furthering the understanding of what if any psychiatric/mental needs your patient needs. As for what needs to be documented once it is discovered that the patient will be attending therapy or psychiatric services-there needs to be an indication of such on the Problem List in either Development or Update (please see Pg 52 of SAPC Provider Manual 9.0) It should also be noted that any time a patient whether or not they are in mental health services is experiencing symptoms of SI/SA and needs further evaluation please encourage LE/LPHA to utilize proper assessment tools such as the Columbia- Suicide Severity Rating Scale (C-SSRS) https://cssrs.columbia.edu/wp-content/uploads/Columbia_Protocol.pdf
Could you provide guidance on the EBP's SAPC is allowing LVN's to utilize? The provider manual does not provide specific guidance for LVN's in this area.	LVNs are able to provide the full range of services within their scope of practice under the direction of a physician or registered nurse (typically using standardized protocols). SAPC hasn't published LVN standardized protocols for the full list of possible LVN duties but have published our expectations for addiction medication services and draft P&Ps under SAPC Information Notice 24-01: let me know if you have any trouble locating this notice posted via

Program Standards Questions	Answers
	http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#bulletins