County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**SUPT**
	Policy Number	**SUPT-11-02**
	Effective Date	**08/10/21**
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Title: **Electronic Health Record & Documentation**	Functional Area: **Information Systems Management**

Approved By: **Signed version available upon request**

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BACKGROUND / CONTEXT:

An Electronic Health Record (EHR) is an electronic, real-time version of a client's treatment history that is available instantly and securely to authorized users. EHRs improve client care, care coordination, diagnostics and outcomes as well as increase practice efficiencies and cost savings. Substance Use Prevention and Treatment (SUPT) utilizes Avatar by Netsmart Software. Avatar is a cloud-based, web-accessible EHR system used for Sacramento County beneficiaries who receive substance use disorder treatment services. Avatar EHR includes Practice Management and Clinical Workstation modules.

All SUPT treatment providers are required to utilize an EHR system. SUPT highly recommends that treatment providers utilize the full Avatar EHR. In some situations, providers may be approved to use of an alternate EHR system. However, at a minimum, all SUPT treatment providers must utilize Avatar Practice Management and Service Requests and Assessments in the Avatar Clinical Workstation.

DEFINITIONS:

- **Avatar Clinical Workstation:** A module of the Avatar EHR, which includes the following electronic clinical documents, Service Requests, Substance Use Disorder (SUD) Assessments, Health Questionnaires, Treatment Plans, Progress Notes, and Order Connect.
- **Avatar Practice Management:** A module of the Avatar EHR, which includes claiming information, data reporting, and Perception Document Management.
- **Avatar Steering Committee:** Serves as the governing body of the Avatar system, which provides leadership, oversight, and strategic direction.
- **Avatar Team:** Comprised of County staff who provide project management, trainings, and technical assistance for the Avatar EHR system as well as preparing and submitting monthly claims to the California Department of Health Care Services.
- **Custodian of Record:** The individual or organization responsible for monitoring and maintaining both the integrity and confidentiality of health records, as well as the retention and destruction guidelines for a provider or program.

- **Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Requires all covered entities to prevent unauthorized access to protected health information.
- **Protected Health Information:** This term refers to a subset of confidential health information, including demographic information, collected from an individual.

PURPOSE:
The purpose of this policy and procedure is to outline SUPT guidelines, requirements, and timelines for Avatar Practice Management, Clinical Workstation, and hard copy and electronic document management.

DETAILS:
The Avatar Team provides project management, trainings, and technical assistance for the Avatar EHR system as well as preparing and submitting monthly claims to the State of California, Department of Health Care Services.

Avatar Email: Avatar@saccounty.gov
Avatar webpage: https://dhs.saccounty.gov/BHS/Avatar/Pages/Avatar.aspx

Avatar User Accounts
New Avatar users must submit a request to have an Avatar account created by the Avatar Team, which is unique to the user and shall not be shared with others. New Avatar users are required to complete Practice Management and Clinical Workstation trainings as applicable to the service provider/practitioner. To request a new user account, an *Avatar Account/User Training Form* should be completed and submitted to the Avatar Team. This form can be found on the Avatar training webpage:

Avatar Training/Registration Email: AvatarTrainingRegistration@saccounty.gov

Avatar Training Webpage:
https://dhs.saccounty.gov/BHS/Avatar/Pages/GI_Avatar_Training.aspx

The Avatar *Account/User Training Form* should also be completed and submitted to modify user accounts and to deactivate or reactivate an Avatar user account.

Please note: All Avatar users must comply with requirements as outlined in *P&P #QM-00-03* Avatar *Account Management and Password Protection.*

https://dhs.saccounty.gov/BHS/Documents/BHS-Policies-and-Procedures/PP-BHS-QM-00-03-AVATAR-Account-Management-and-Password-Protection.pdf

AVATAR PRACTICE MANAGEMENT
Practice Management (PM) was the first module of Avatar to be implemented by SUPT. PM contains client record management information including claiming information, data reporting, and Perception Document Management (to scan non-Avatar generated documents into the EHR).

Claiming: Billable and Non-Billable Service Codes

All SUPT county-operated and contracted providers are required to accurately enter billable and non-billable service codes into Avatar for all service activities provided to clients. Accurate entry of service codes based on type of service provided is the basis for tracking, claiming, and paying for reimbursable service provisions.

The "*SUPT Service Code Definitions and Training Guide"* includes all SUPT billable and non-billable service codes, which can be accessed at:

https://dhs.saccounty.gov/BHS/Documents/SUPT/GD-BHS-SUPT-Service-Codes-Definitions-and-Training-Guide.pdf

The tables below include codes to be used for non-billable service activities:

When a client	**Then use**
Fails to show for appointment and has not called	No Show Non-Billable Code: 90500
Calls to cancel an appointment prior to the appointment time	Cancellation Non-Billable Code: 90501

When staff	**Then use**
Fails to show for appointment and has not called	No Show Non-Billable Code: 90600
Calls to cancel an appointment prior to the appointment time	Cancellation Non-Billable Code: 90601
Attempts to engage client prior to provider start date (before first face-to-face)	Engagement Non-Billable Code: 22222
Performs administrative activities that cannot be reimbursed by Medi-Cal or other funding sources	Administrative Non-Billable Code: 11111

Data Reporting

Service providers should ensure accurate and timely entering of client information (e.g. CalOMS) into Avatar. Client data entered into Avatar is extracted and used for local, state, and federal data reporting requirements. Additionally, data entered into Avatar is used for monitoring and audit purposes.

Perception Document Management

To ensure a comprehensive electronic client chart, all paper clinical documents, non-Avatar generated paper records, and other key historical records (e.g. letters, hospital information, etc.) collected as part of ongoing care should be scanned into the client's Avatar EHR.

Service providers should designate a Custodian of Records who is responsible for monitoring and maintaining quality assurance standards, integrity of records, and confidentiality of Protected Health Information (PHI), including scanning records, verifying scanned records, and ensuring local, State, and Federal retention and destruction of records requirements.

Scanning of Records: The scanning of records must follow the designated, standard categories, and conventions established in Avatar. Documents should be scanned into the designated categories so that scanned records have a common convention and method to ensure that record retention and retrieval are not compromised. Examples of categories include, but are not limited to: System of Care Forms; Assessments; Client Correspondence; Court/Legal; Labs; Medication Consents; Labs; Hospital Discharge.

A comprehensive list of categories that are to be used when scanning is available: https://dhs.saccounty.gov/BHS/Documents/Utilization-Review/FM-BHS-QM-Sacramento_County_Scanned_Document_Management.pdf

Any new categories must be approved by the Avatar Steering Committee. New categories will be incorporated and ready for use only during established planned release cycles.

The staff member(s) performing the actual scan will:

- Ensure that all pages (front and back) successfully pass through scanner and that image displayed on the imaging software preview screen appear accurate.
- Affix a sticker at the top right corner of the page marked, "Scanned" and write the date the page was scanned on the sticker or initial and notate the date the document was scanned on the top right corner of the page.

The staff member(s) responsible for these records will have immediate access to the images, from their desktops, using the imaging software. They will have 90 days to use and review the images. If any problem is detected, the paper record should be retrieved and rescanned.

Upon scan completion, the Custodian of Records should:

- Verify that scanned documents are scanned into the correct episode.
- Verify that the scanned document is an exact replica of the original document in its entirety.

Once paper documents are scanned into the EHR and verified by the Custodian of Records, such documents may be confidentially destroyed (California Civil Code 56.101). Client records are to be destroyed to preserve and assure confidentiality of PHI in compliance with Health Information and Portability and Accountability Act (HIPAA) regulations.

Retention and Destruction of Records: Every agency/provider will have a written policy and procedure that addresses the retention and disposal of all PHI, including hard copy PHI, electronic PHI and/or the hardware or electronic media on which it is stored. The policy and procedure must also include procedures for removal of electronic PHI from electronic media before the media are made available for re-use. See Title 45 Code of Federal Regulations 164.310(d)(2)(i) and (ii).

Retention of EHRs will meet State and Federal requirements for client record retention. All adult EHRs will be maintained for 20 years after the date of discharge. EHRs of minors will be maintained at least one year after the minor has reached the age of eighteen. For psychologists, client records are to be maintained for 20 (twenty) years from the patient's discharge date, or in the case of a minor, 20 (twenty) years after the minor reaches 18 years of age. Sacramento County will retain records for a period of 20 (twenty) years from date of discharge.

Agencies/providers must determine the appropriate method for their agency to dispose of PHI while ensuring confidentiality of the PHI. Some possible options to dispose of PHI include:

- For PHI in paper records, shredding, burning, pulping, or pulverizing the records so that PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed.
- For PHI on electronic media, clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing or exposing the media to a strong magnetic field in order to disrupt the recorded magnetic domains), or destroying the media (disintegration, pulverization, melting, incinerating, or shredding).

Agencies/providers must ensure that all staff involved in the retention and disposal of PHI has been trained on the agency/provider policy and procedures. This includes staff that are responsible for the disposal of PHI as well as staff that supervise those responsible for the disposal of PHI as well as volunteers. Agency/provider retention and disposal of PHI policy and procedures will be reviewed and monitored during site monitoring visits and is subject to review during audits.

AVATAR CLINICAL WORKSTATION

The AVATAR Clinical Workstation (CWS) module was implemented ("Go-Live") for SUPT service providers on March 1, 2021. The CWS contains electronic Avatar-generated clinical documents, which includes Service Requests, SUD Assessments, Health Questionnaires, Problem Lists, Treatment Plans/Client Plans, Progress Notes, and Order Connect.

Please note: Data elements for each electronic document are included and described in the *SUPT CWS Required Data Elements*.

Service Request: All treatment providers (providers using Avatar as well as providers using other approved EHRs) are required to utilize the "Service Request Response 2.0" Form in Avatar when a client requests services. Completed Service Request Response 2.0 Forms are used to track:

1. Time from service request to first assessment
2. Time from first assessment to a first treatment service (the SUD Assessment and Treatment Plan should be completed prior to first treatment).

Service Requests Completed by System of Care (SOC)
When a client walk-in or calls the SOC, staff is responsible for completing the following the day the client requests services:

- Query Avatar to see if the client is already in Avatar.
- If the client is already in Avatar, SOC staff should complete the "Service Request Response 2.0" Form in Avatar to open an episode.
- If the client is not in Avatar, SOC staff should complete a Pre-Admit Form to add the new client and create an Avatar client ID.
- Once the client has an Avatar client ID, SOC staff should complete the "Service Request Response 2.0" Form in Avatar to open an episode and assign the service request to a SOC clinician.

Service Requests Completed by Providers
When a client requests services from a contracted provider (walk-in or calls the provider directly), the provider is responsible for completing the following the day the client requests services:

- Query Avatar to see if the client is already in Avatar. This is important to avoid duplicate EHRs the same client. Provider should confirm date of birth and the social security number of the client to avoid duplication.
- If the client is already in Avatar, the provider should complete the "Service Request Response 2.0" Form in Avatar to open an episode.
- If the client is not in Avatar, the provider should complete an Admit Form to add the new client and create an Avatar client ID. Once the client has an Avatar client ID, the provider should complete the "Service Request Response 2.0" Form in Avatar to open an episode and assign the service request to a clinician.
- Once the Service Request is completed, the provider can conduct the SUD Assessment.

Medical Necessity and Level of Care Determination

This section establishes Sacramento County SUD medical necessity and level of care determination parameters for the following populations:

- Adult Beneficiaries, ages 21 and older
- Child/Youth Beneficiaries, ages 0-21

The intent is to provide operational guidance for access to services for different levels of care and the conditions that determine medical necessity in accordance with W&I Code section 14059.5 and in accordance with DHCS BHIN-21-071.

Medical Necessity and DMC-ODS Access Criteria

Pursuant to W&I Code section 14184.402(a), all medical necessity determinations for covered SUD treatment services provided to Drug Medi-Cal (DMC) beneficiaries shall be made in accordance with W&I Code section 14059.5 and in accordance with the requirements set forth below.

Initial Assessment and Services Provided During the Assessment Process

Covered and clinically appropriate DMC-ODS services are reimbursable for up to 30 days following the first visit with a LPHA, as defined in the California's Medicaid State Plan, or registered/certified counselor, whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days for beneficiaries under age 21, or if a provider documents that the beneficiary is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over.

The DMC-ODS initial assessment shall be performed by an LPHA or registered or certified counselor. The assessment and services provided during the assessment process may be conducted by System of Care staff or contracted DMC-ODS network provider staff in the community or the home using the following methods:

1. Face-to-face
2. Telehealth ("telehealth" throughout this document is defined as synchronous audio and video)
3. Telephone (synchronous audio-only)

If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make and document the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by telehealth, or by telephone.

Narcotic Treatment Programs (NTPs) conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam of a NTP beneficiary conducted at admission qualifies for the purpose of determining medical necessity under the DMC-ODS.

DMC-ODS Access Criteria for Services After Assessment

a. *Beneficiaries 21 years and older:* To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older must meet one of the following criteria:
    i. Have at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
    ii. Have had at least one diagnosis from the DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
b. *Beneficiaries under the age of 21*: Covered services provided under DMC-ODS shall include all medically necessary SUPT services for individuals under 21 years of age as required pursuant

to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid (Medi-Cal) -coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered under Medi-Cal. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

Additional Coverage Requirements and Clarifications

Consistent with W&I Code 14184.402(f), clinically appropriate and covered SUD prevention, screening, assessment, and treatment services are covered and reimbursable Medi-Cal services even when:

1) Services are provided prior to determination of a diagnosis or prior to determination of whether DMC criteria are met, as described above;
2) The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or
3) The beneficiary has a co-occurring mental health condition.

Regarding (1), DMC-ODS services are reimbursable during the assessment process as described above in the "*Initial Assessment and Services Provided During the Assessment Process"* subsection. In addition, clinically appropriate and covered DMC services provided during the assessment process are covered and reimbursable even if the assessment later determines that the beneficiary does **not** meet criteria for DMC-ODS services. These changes do not eliminate the requirement that all Medi-Cal claims include a Centers for Medicare & Medicaid Services (CMS) approved International Classification of Diseases (ICD)-10 diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes).

Regarding (2), Forthcoming guidance from DHCS will provide clarification regarding new policies and criteria for DMC-ODS documentation standards and requirements. The existing documentation standards and requirements remain in effect until replaced.

Regarding (3), clinically appropriate and covered DMC-ODS services delivered by Sacramento County SUPT providers are covered and reimbursable Medi-Cal services whether or not the beneficiary has a co- occurring mental health disorder. Reimbursement for covered DMC-ODS services provided to a beneficiary who meets DMC-ODS criteria and has a co-occurring mental health

condition shall not be denied as long as DMC-ODS criteria and requirements are met.

Level of Care Determination

In addition to being medically necessary, all SUD treatment services provided to a Sacramento County beneficiary must be clinically appropriate to address that beneficiary's presenting condition.

In accordance with W&I Code 14184.402(e), providers must use the criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service for DMC-ODS beneficiaries. However, a full assessment utilizing the ASAM criteria is not required for a Sacramento County beneficiary to begin receiving covered and reimbursable SUD treatment services; an abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. As mentioned in the "*Initial Assessment and Services Provided During the Assessment Process"* subsection:

- For DMC-ODS beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with a LPHA or registered/certified counselor.
- For DMC-ODS beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM criteria shall be completed within 60 days of the DMC-ODS beneficiary's first visit with an LPHA or registered/certified counselor.
- If a DMC-ODS beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over.

Please note: Services shall be provided in the least restrictive setting, and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency.

SUD Assessments

The SUD Assessment is a tool used to determine medical necessity, diagnosis, and level of care for substance use disorders. SUD Assessments are to be conducted by a Licensed Practitioner of the Health Arts (LPHA) or ADS Counselor I/II. The SUD Assessment includes the six Dimensions of the American Society of Addiction Medicine (ASAM) Criteria, which includes:

Dimension 1: Acute Intoxication and Withdrawal Potential
Dimension 2: Biomedical Conditions and Complications
Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications
Dimension 4: Readiness to Change
Dimension 5: Relapse, Continued Use or Continued Problem Potential
Dimension 6: Recovery/Living Environment

For each of the six Dimensions, all of the questions should be answered, comments/descriptions should be included, and scored appropriately (0=None, 1=Mild, 2=Moderate, 3=Severe).

Resource: ASAM Criteria: https://www.asam.org/asam-criteria/about

SUD Assessments Completed by SOC Staff

- The SOC clinician accepts and reviews the Service Request and schedules and completes the SUD Assessment.
- Upon completion of the SUD Assessment, SOC staff copies and pastes the SUD Assessment into the "SOC Response Comment" area of the Service Request.
- The Service Request is submitted to a contracted provider based on level of care.
- SOC staff completes the "SOC Pre-Admit Discharge."

Note: The service provider can contact SOC staff to have the SUD Assessment completed by SOC staff be scanned and loaded into the service provider's episode in Avatar.

SUD Assessments Completed by Service Providers

SUD Assessments are reported to the Department of Health Care Services; therefore, **all treatment providers** must enter SUD Assessments into Avatar, including providers who are utilizing another EHR.

Initial SUD Assessment

The initial assessment shall be performed face-to-face, by telehealth (synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home. If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

Assessment periods for non-residential DMC-ODS services are as follows, with the first date of service counting as "day 1":

- Up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established OR
- Up to 60 days if the person in care is under age 21 OR
- Up to 60 days if a provider documents that the person in care is experiencing homelessness and therefore requires additional time to complete the assessment

If a person in care withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over.

SUD Re-Assessments
The assessment should be updated throughout treatment when there is significant information impacting the person's clinical presentation. Re-assessment shall be completed within the staff's clinical discretion (reasonable and in accordance with generally accepted standards of practice, stepping client up or down in level of care.)

NTP/OTP providers shall follow Federal guidelines (42 C.F.R. § 8.12 Section (F)(4)), which requires a re-assessment on an annual basis and when there is significant information/changes impacting the person's clinical presentation.

Standardized Assessment/Re-Assessment Requirements

- The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.
- The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.
- Assessments shall be updated as clinically appropriate when the beneficiary's condition changes.

Intra (within)-Agency Level of Care Transfer
When a beneficiary is transferred to a different level of care **within the same agency**, provider should:

- Complete Admin/Discharge CalOMS process.
- Document specifics of transfer within the introductory/intake progress note at the start of services and confirm the previous SUD Assessment dimension and needs indicated.
- Scan in the previous SUD Assessment and any relevant informing materials into the new episode. Update any necessary informing material and Release of Information.

Change of Insurance for All Levels of Care: In circumstances where insurance changes for the beneficiary, provider will determine if clinically appropriate to conduct a new assessment. Provider will enter previous assessment information into the Sacramento County SUD Assessment (utilizing the date that this change took place on the SUD and PN) within the EHR and ensure that the SUD Assessment completion and change is documented within the associated Progress Note.

Health Questionnaire (HQ)
The completed HQ is part of the EHR in the Avatar Clinical Workstation (CWS) as part of the beneficiary's chart.

The clinician/personal service coordinator or medication support staff are responsible for having a completed HQ as part of the EHR for all beneficiaries initiated upon admission.

Parents or caregivers may provide the clinician/personal service coordinator with information to complete the HQ. The provider shall review the HQ with the beneficiary and/or parent/caregiver to ensure that all areas are completed and accurate.

When current health concerns are evident, the provider refers the beneficiary to a Primary Health Care Provider or the attending Psychiatrist for physical evaluation and documents the details of this referral in the Progress Notes.

Required HQ Reporting Items:

The following items must be addressed in the HQ. These elements are part of the required CalAIM assessment domains.

- Relevant physical health conditions must be identified and updated as appropriate with referral to a Primary Care Physician as needed or appropriate.
- If the beneficiary and/or caregiver indicates that they currently do not have a Primary Care Physician (PCP), the provider must make efforts to provide information and support to ensure that linkage has been made. If the beneficiary has not had a visit with a PCP within the past twelve (12) months this should be included as an item on the problem list.
- Allergies and adverse reaction(s) to medications, or lack of known allergies.
- Women's Health History if the beneficiary is pregnant.

The HQ shall include the following information. All areas are optional unless identified as (required).

1. Date
   The date the form is completed. If it takes more than one day to complete the form, this date should reflect the date the form was started.

2. Gender
   This is pre-populated based on the beneficiary's identified gender assigned at birth in the, "Update Client Data" section of the chart. Based on this selection, applicable information will be pre-populated by Avatar.

3. Currently seeing a primary physician
   Identify with a "yes' or "no" if the beneficiary is currently seeing by a primary physician.

4. Last Doctor Visit
   Indicate the timeframe from the last doctor's visit as reported by the beneficiary. In addition, specify the reason for the last doctor visit.

5. ER visits
   Mark either "yes", "no" or "unknown" to identify any ER visits conveyed by the beneficiary in the preceding 12 months. Provide details for the ER visits.

6. Last Colon Screening
   Indicate the timeframe from the beneficiary's last Colon Screening or if they have never had a Colon Screening.

7. General Medical Conditions **(Required)**
   Identify any known medical conditions (past or present) that the beneficiary has ever experienced. Indicate the **onset** and **details** and describe the medical conditions and current treatment the beneficiary is receiving.

8. Gender specific questions
   Choose the beneficiary's gender specific questions. Provide information describing any existing health conditions, dates (to the best knowledge of the beneficiary/caregiver) and current treatments. The gender specific questions are generated based on the beneficiary's identified gender assigned at birth in the "Update Client Data" section of the chart.

9. Dental
   Indicate the timeframe from the last visit to the dentist and whether "yes", "no" or "unknown" if the beneficiary has any dental problems, ever had oral surgery or has any dental problems.

10. Hearing
    Indicate "yes", "no" or "unknown" if the beneficiary has any hearing problems. Provide details on the hearing problems. Indicate the timeframe from the last hearing test and provide details on the hearing test and hearing issues.

11. Vision
    Indicate "yes", "no" or "unknown" if the beneficiary has any visual problems, timeframe from the last exam and whether "yes", "no" or "unknown" if the beneficiary wears any type of corrective lenses/ contacts, and provide any details on vision problems.

12. Caffeine and Tobacco
    Indicate the beneficiary's caffeine intake and/or tobacco intake, select the beneficiary's smoking habits and identified tobacco products that the beneficiary uses. Solicit whether beneficiary is interested in a smoking cessation program. Provide detail on tobacco use.

Problem List/Client Plan

A Problem List shall be compiled for each beneficiary for all service modalities (except NTP/OTP) and when required for specific service types, a Client Plan must be completed. If a problem exists on the list and has not been end dated by a previous provider then you will not need to add this again to the problem list, however, document within your progress notes the areas of need indicated in the assessment. When discharging clients you want to consider if appropriate to apply an end date to specific problems, consider the severity and client's ability to function without BHS services.

Problem List: The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

1. The provider(s) responsible for the beneficiary's care shall create and maintain a problem list.

2. The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.
3. A problem should be identified during a service encounter, may be addressed by the service provider during that service encounter, and subsequently added to the problem list. We want to encourage client's voice and choice, including the beneficiary goals in their own words, and acknowledge their resiliencies and enhance their self-worth.
4. The problem list shall include, but is not limited to, the following:
    a. Diagnoses identified by a provider acting within their scope of practice, if any. (Include diagnostic specifiers from the DSM if applicable).
    b. Problems identified by a provider acting within their scope of practice, if any.
    c. Problems or illnesses identified by the beneficiary and/or significant support person, if any.
    d. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.
5. Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition. The problem list does not need to be updated within a specific time frame or have a requirement about how frequently the problem list should be updated after a problem has initially been added.
6. In addition to completing the problem list, for billing purposes, the diagnosis form in the EHR must also be completed.
7. To support consistency in documentation, please see attachment A for crosswalk for ICD-10/SNOMED and DSM Codes.

Client Plan: The use of a Problem List has largely replaced the use of client plans, except where federal requirements mandate a client plan be maintained. The following service type will continue to require a client plan:

Narcotic Treatment Program Client Plan: Services will be need to be documented into a client plan form.

Peer Support Services: For all levels of care must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

Discharge/Transition Plan – A discharge/transition plan should be developed when a beneficiary has achieved the goals of the care plan within a progress note.

a. This may include:
    i. Step down criteria considerations
    ii. Decrease in symptoms, behaviors and improvement in functioning
    iii. Decrease in risk factors and increase in safety
    iv. Decrease SUD Assessment Scores
    v. Stability in their living arrangement, economic needs, personal health care and social, cultural and spiritual needs

vi. Considerations and referrals for on-going mental health and/or substance use treatment

Progress Notes

Progress Notes are a description of direct and indirect service activities including billable and non-billable contacts. Progress Notes also convey information from collateral resources, consultation contacts, and coordination with other system providers and agencies. Progress Notes must support the applicable service but should be brief and succinct. Long narratives and lengthy descriptors should be avoided. County approved abbreviations may be used in Progress Notes (see BHS Abbreviations and Acronyms).

Providers shall create progress notes for the provision of all DMC-ODS services. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

Progress notes shall include:

- The type of service rendered.
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
- The date that the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time.
- Location of the beneficiary at the time of receiving the service.
- A typed or legibly printed name, signature of the service provider and date of signature.
- ICD 10 code.[3]
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation). Weekly summaries will no longer be required for day rehabilitation and day treatment intensive.

When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements listed above shall also be met.

Timeline for Progress Notes

- Progress Notes for all **Crisis Services** must be completed **within 24 hours**.
- Progress Notes must be completed within **3 business days for all service modalities except NTP/OTP.**
- Progress Notes must be completed within **7 business days for NTP/OTP services** of the service session.

Progress Notes are considered final once submitted into Avatar CWS and electronic health record systems. If critical content or information is left out, notes may be "appended" (Append Note function in Avatar CWS). The use of the "Append" feature to clarify or add information to support a claim will be **limited to 45 business days after the date of service and applies only to the following:**

- The addition of clarifying information (e.g., providing additional details that further support the service provided)

- To make a correction to inaccurate information (e.g., wrong date for follow up appointment,)

- The addition of information inadvertently omitted from the progress note (e.g., documenting providing client plan copy, language, cultural accommodation, adding a staff name or classification etc.)

- Once a claim has closed there will be no append option. If Progress Notes require an amendment exceeding 45 business days from the date of service, a separate progress note can be created with a non-billable service code (11111). See Information Letter: Update to Use of Progress Note Append Feature (7/13/2018) for more information.

- Corrections for a service that has not been claimed yet may be edited using the Edit Service Information function in Avatar. Corrections for open or closed charge services that have not claimed must be submitted to QM on the Open Charge Deletion Request (OCDR) form. Corrections for services already claimed must be submitted to DBHS Fiscal on the Claims Correction Spreadsheet. Refer to the *Instructions on How to Edit or Delete a Service* Document. In some cases, services may need to be re-entered as a non-billable activity so that documentation exists for completed service activities.

- Any Progress Notes that are hand written and not entered through an Electronic Health Record must be legible, including legible printed name, signature and professional classification, as well as include the date of service, amount of time taken to provide services and location that the service took place in order to be considered a complete progress note. The hand written progress note should be scanned in the Scanned Document Folder labeled, "Non Medication Progress Notes" or "Medication Progress Notes" depending on the type of service.

Progress Note Components

Date of Service: Enter the date the service occurred. Note that "entry date" is recorded in Avatar and electronic health record systems. Entry date is used to confirm timely submission of progress notes.

Service Charge Code: Enter or select the applicable Service Charge Code. See Sacramento County Service Code Definitions/Training Guide for updated list of Service codes, code definitions, and training information. A separate progress note must be written for each service billing (i.e. multiple notes may be needed for different service activities occurring during one client contact or session).

Service Location: Enter or select the applicable Service Location. Location options are predefined through Department of Health Care Services Client Services Information (CSI) data requirements.

Practitioner Name and Signature: Practitioner name and professional classification are automatically entered in Avatar CWS and electronic health record systems. The practitioner's signature or electronic signature is required on all notes and are automatically entered upon finalizing the progress note

Duration: Enter total duration of service time in minutes. Direct service time, Documentation time, and Travel time must be entered separately, if applicable. Documentation time includes the time it took to complete the progress note for the service. Travel time is the round-trip travel time from agency office to service location. Travel time can only be counted for services where a billable activity occurs.

Face-to-Face Service: Select "yes" or "no" as appropriate. Select "yes" if a service was provided to the client face to face.

Evidence-Based Practices (EBPs): At least two of the following EBPs must be used and pre-approved by Sacramento County SUPT: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Therapy, and Psycho-Education.

Service Strategies:
Service strategies used by SUPT include the following five evidence-based practices: Cognitive Behavioral Therapy, Relapse Prevention, Psycho-Education, Motivational Interviewing, and Trauma Informed Treatment.

Progress Note Type: Select the applicable Note Type (i.e. Standard, Medication, Intake, Discharge, Group Note, and Clinician Treatment Summary). Note Type should be "Standard" unless a specialized service that fits another category is provided. Note Type is independent of Service Code claimed and does not affect billing.

Language in Which Service Was Provided: Select the language the service was provided in. If multiple languages are spoken during a service please clarify in the progress note narrative.

Use of Interpreter: Select "yes" or "no" as appropriate. If the staff providing the direct service is

providing interpretation, “yes” should be selected.

Group Services: Group services must indicate the number of clients participating in the group. In Avatar CWS, “Number of Clients in Group” must be used to identify the number of participants so that duration can be accurately apportioned to each client. If a group is co-facilitated, the second facilitator can only bill and be identified as “Co-Practitioner” if his or her non-duplicative role is defined in the narrative of the note. **Note:** “Preparation time” is not accepted as billable time for group services.

Discharge Notes: The Discharge Note Type should be selected and the applicable Service Charge Code used for the service is selected. Discharge notes are billable only if a billable service is provided in that final contact (i.e. case closed with final Individual Therapy service). If no contact has been made with the client for an extended period then the Discharge note is considered “administrative” and the Non-billable Service code (11111) should be selected. See Policy and Procedure QM-10-28 Discharge Process for more information.

Clinical Introductory Progress Note: Written at the first face to face contact, or very soon thereafter, providing an overview of the client and his/her SUD condition. A complete note includes, but is not limited to: the identity of the client, including age, ethnicity, and other significant demographic information, the referral source, presenting condition, including symptoms, behaviors, and level of functioning, need for services/medical necessity and level of care justification, client strengths, supports, and a plan for subsequent services. If a client indicates a primary language other than English, or a physical disability, the provider will offer an accommodation to provide culturally and linguistically competent services and note this in the clinical introductory progress note. If a client refuses such accommodation, this refusal will be documented in the clinical introductory progress notes or such items may be present within the SUD Assessment within the EHR.

Other Items to Include in Progress Notes

- **Cultural and Linguistic Accommodations**: Must be offered to the client and on behalf of the family/caregiver. This must be documented in every note when a language other than English is indicated. If the provider is trained and proficient in English and the target language then the progress note must specify the language spoken during the session. When an interpreter is necessary the progress note shall include the following: the language the session was conducted in, language services offered, the name of the interpreter, how interpretation was conducted. If a provider is using a client’s family member for interpretation, document the emergency situation and circumstances where no other means of interpretation or communication was available. Should the client elect a family member as the interpreter, there must be documentation of the clinical decision to make that decision and documentation demonstrating efforts to offer an independent interpreter. Sacramento County prohibits the use of children as interpreters under all circumstances. See Cultural Competence & Ethnic Services Policy and

Procedure “Procedure for Access to Interpreter Services” for more information.

- **Interventions:** A description of the interventions used, client’s response to the interventions and progress made toward treatment goals/ objectives by the client and family (when applicable) must be reflected in the notes. Progress notes should document relevant clinical decisions, when decisions are made, and alternative approaches for future interventions. Each progress note claimed must demonstrate how services provided reduced impairment, restored functioning or prevented significant deterioration in an important area of life functioning, allowed a child to progress developmentally as individually appropriate or for clients under the age of 21, corrected or ameliorated the condition. Each progress note claim must relate to the qualifying diagnosis and identified functional impairments as well as should be medically necessary.

- **Adminstrative Discharge Summary:** Should include a written summary of the treatment episode including duration of treatment, reason for discharge, and recommendations for follow-up care and referral. This type of summary should be used when discharge is unplanned, administrative or treatment is incomplete within progress note.

There are two types of Residential Progress Notes:

Residential providers must document all services provided at a minimum of 20 hours per week with at least one individual counseling session per week based on medical necessity. At a minimum, residential providers must complete a Daily Progress Note each day (Minimum of 5 hours of billable clinical services per week). An independent Progress Notes (for non-billable, non-clinical services) can be used in addition to the Daily Progress Note. For services provided to a 3.5 or higher LOC, it would be clinically appropriate to provide additional clinical and care coordination per week to beneficiaries based on medical necessity.

Reimbursable daily service activities are:

• Intake
• Individual Counseling
• Group Counseling
• Patient Education*
• Family Therapy
• Collateral Services
• Crisis Intervention Services
• Treatment Planning
• Transportation Services*
• Discharge Services

*The other structured activities that are available in residential treatment, including patient education, are not considered clinical interventions, and are not subject to a limitation in regard to the number of participants.

* Provision of or arrangement for transportation to and from medically necessary treatment. Transportation service alone does not justify billing for a daily rate.

1. **Clinical Services:** Individual narrative summaries that describe the beneficiary's progress as identified in the problem list/treatment planning, including challenges, goals, interventions and strategies, and/or referrals. The first clinical service of the day is billed under the day rate. All subsequent services of the day would be documented under the same note or filed under a separate independent note. Group counseling must include 2-12 participants in order to meet the criteria for a clinical service.

2. **Non-Clinical Services:** A daily summary of non-clinical educational activities or services. Non-clinical services include:
    - Patient Education*: Meditation, life skills, social skills, community enrichment, exercise, etc.
    - Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment (transportation service alone does not justify billing for a daily rate).

*Patient Education is a reimbursable service and can still generate the daily rate. Patient Education is a non-clinical service and not subject to a limitation in the number of participants. Patient education can count towards the 20-hour weekly service requirement but cannot count towards the weekly clinical service requirement of 5 hours 3.1 ASAM LOC or 3.5 ASAM LOC.

Services Provided By Two or More Practitioners at One Point in Time
When services are being provided to a client by two or more persons at one point in time, each person should document his/her own individual progress note including service code, service time, documentation and travel time. There must be documentation of each persons' involvement in the context of the client's needs and describe how each role was separate, distinct, and medically necessary.

Appending/Correcting Progress Notes: If critical content or information is left out of a Progress Note, the note may be "appended" (Use Append Note function in Avatar CWS (within 45 days) in order to justify the service code or time claimed. Corrections for open or closed charge services that has not claimed must be submitted to Behavioral Health Quality Management on the Open Charge Deletion Request (OCDR) form. Corrections for services already claimed must be submitted to the Department of Health Services Fiscal Services on the Claims Correction Spreadsheet. Refer to the Instructions on How to Edit or Delete a Service Claim Document. In some cases, services may need to be re-entered as a non-billable activity so that documentation exists for completed service activities.

Telehealth Consent
If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or

telephone service, in writing or verbally at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary:

- An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in person, face-to-face visit;
- An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future;
- An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted
- And the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider
- The provider must document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

REFERENCE(S) / ATTACHMENTS:

Avatar Email: Avatar@saccounty.gov
Avatar webpage: https://dhs.saccounty.gov/BHS/Avatar/Pages/Avatar.aspx

Avatar Training/Registration Email: AvatarTrainingRegistration@saccounty.gov
Avatar Training Webpage:
https://dhs.saccounty.gov/BHS/Avatar/Pages/GI_Avatar_Training.aspx

Scanned Documents Management
https://dhs.saccounty.gov/BHS/Documents/Utilization-Review/FM-BHS-QM-Sacramento_County_Scanned_Document_Management.pdf

SUPT Service Code Definitions and Training Guide
https://dhs.saccounty.gov/BHS/Documents/SUPT/GD-BHS-SUPT-Service-Codes-Definitions-and-Training-Guide.pdf

ASAM Criteria: https://www.asam.org/asam-criteria/about

SUPT CWS Required Data Elements

CalMHSA Documentation
BHIN 22-019, Attachment A

RELATED POLICIES:

SUPT-03-01 DMC-ODS Overview
QM-00-03 Avatar Account Management and Password Protection
QM-10-25 Client Plan
QM-10-27 Discharge Process
QM-10-30 Progress Notes

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X	SUPT Administrative Support Staff	X	BHS Avatar Team
	SUPT Options for Recovery	X	BHS Quality Management

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