Washington State Department of Social & Health Services

Transforming lives

ISSUE DATE: 02/01/18
NEXT REVIEW DATE: 02/01/19

DBHR Guidance Document #01-18
Opiate Treatment Program Documentation Standard

The HCPC Code H0020 does not allow reporting dosing encounters as "episodes" any longer. Because HCPC Code H0020 requires minutes for encounters, it is important that minutes reported for this type of encounter be as accurate as possible.

Typical dosing encounter for opiate treatment program (OTP) would generally be accurate as:

- H0020 for 3 minutes with Provider Type '01'

Take-home dosing should only be encountered for the time it takes to dispense the take-home medication on the day it is dispensed to the client in the facility.

H0020 should only be used for dosing. All other services (individual treatment, group treatment, assessment, etc.) should be coded as such.

OTP dosing records are part of an individual's electronic clinical record and include the following data elements:

- Patient ID/name/DOB/age/Medicaid #/ID#/intake date/address/alerts or restrictions
- Medication
- Dose date/Pour date/Hand out date
- Date and time administered
- Dose type and amount
- Staff member name and credentials

In addition to the Washington State Board of Pharmacy, federal Drug Enforcement Administration, and DBHR, federal accreditation bodies also may conduct on-site surveys of all OTP programs to ensure dosing records accurately reflect this type of clinical intervention. We expect to update the SERI to reflect these expectations.

OTP clinicians will document additional clinical services, such as individual and group treatment, in accordance with the Medicaid and SERI documentation standards. All services must be included in the individual service plan which shall be reviewed and updated in accordance with WAC 388-877B-0420.

BHOs are allowed flexibility when it comes to the reporting of dosing encounters for courtesy dosing, based on the contractual arrangements they have with clinics outside of their region and agreement with that region's BHO. With out-of-BHO courtesy dosing, the home BHO is responsible for submitting the native transaction, however it is allowable for the regional BHO to submit the dosing encounter.

If you have questions about OTP services please email Jessica Blose at: Blosejk@dshs.wa.gov
If you have questions about coding services or the SERI, contact Richard VanCleave at vanclrl@dshs.wa.gov

WAC 388-877B-0420

Substance use disorder opiate substitution treatment services—Clinical record content and documentation requirements.

In addition to the general clinical record content requirements in WAC 388-877-0640, an agency providing substance use disorder opiate substitution treatment services must maintain an individual's clinical record.

(1) The clinical record must contain:

(a) Documentation the individual was informed of the federal confidentiality requirements and received a copy of the individual notice required under 42 C.F.R. Part 2.

(b) Documentation that the agency made a good faith effort to review if the individual is enrolled in any other opiate substitution treatment and take appropriate action.

(c) Documentation that the agency:

(i) Referred the individual to self-help group(s).

(ii) Addressed the individual's vocational, educational, and employment needs; and

(iii) Encouraged family participation.

(d) Documentation that the individual received a copy of the rules and responsibilities for treatment participants, including the potential use of interventions or sanction.

(e) Documentation that the individual service plan was completed before the individual received treatment services.

(f) Documentation that the individual service plan was reviewed:

(i) Once every month, for the first ninety days in treatment;

(ii) Once every three months, for every two years of continued enrollment in treatment; and

(iii) Once every six months, after the second year of continued enrollment in treatment.

(g) Documentation that individual or group counseling sessions were provided:

(i) Once every week, for the first ninety days:

(A) For a new individual in treatment;

(B) For an individual readmitted more than ninety days since the most recent discharge from opiate substitution treatment.

(ii) Once every week, for the first month, for an individual readmitted within ninety days since the most recent discharge from opiate substitution treatment; and

(iii) Once every month, for an individual transferring from another opiate substitution treatment program, when the individual had received treatment for at least ninety days.

(h) Documentation of progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur, or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.

(i) Documentation when an individual refuses to provide a drug testing specimen sample or refuses to initial the log containing the sample number. The refusal is considered a positive drug screen specimen.

(j) Documentation of the results and the discussion held with the individual regarding any positive drug screen specimens in the counseling session immediately following the notification of positive results.

(k) Justification for the change in the level of care when transferring an individual from one certified treatment service to another within the same agency, at the same location.

(l) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:

(i) The individual's demographic information; and

(ii) The diagnostic assessment statement and other assessment information to include:

(A) Documentation of the HIV/AIDS intervention.

(B) Tuberculosis (TB) screen or test result.

(C) A record of the individual's detoxification and treatment history.

(D) The reason for the individual's transfer.

(E) Court mandated, department of correction supervision status or the agency's recommended follow-up treatment.

(F) A discharge summary and continuing care plan.

(m) Documentation that a staff member(s) met with the individual at the time of discharge from the agency, unless the individual left without notice, to:

(i) Determine the appropriate recommendation for care and finalize a continuing care plan.

(ii) Assist the individual in making contact with necessary agencies or services.

(iii) Provide and document the individual was provided a copy of the plan.

(n) Documentation that the discharge summary was completed within seven working days of the individual's discharge from the agency, which includes the date of discharge and a summary of the individual's progress towards each individual service plan goal.

(o) Documentation of all medical services. See WAC 388-877B-0440 and 388-877B-0450, regarding program physician responsibility and medication management.

(2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:

(a) Be personalized to the individual's unique treatment needs;

(b) Include individual needs identified in the diagnostic and periodic reviews, addressing:

(i) All substance use needing treatment, including tobacco, if necessary;

(ii) The individual's bio-psychosocial problems;

(iii) The treatment goals;

(iv) Estimated dates or conditions for completion of each treatment goal; and

(v) Approaches to resolve the problem.

(c) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.

(d) Document that the plan has been reviewed with the individual.

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-877B-0420, filed 6/15/16, effective 7/16/16. Statutory Authority: RCW 43.20A.550, 70.02.050(3), 70.96A.040(4), 70.96A.155, [70.96A].157, 71.24.035 (5)(m), 74.04.050(1), 74.08.090, and chapters 70.02 and 71.24 RCW. WSR 14-06-093, § 388-877B-0420, filed 3/4/14, effective 4/4/14. Statutory Authority: Chapters 70.02, 70.96A, 71.05, 71.24, 71.34, 74.50 RCW, RCW 74.08.090, 43.20A.890, and 42 C.F.R. Part 8. WSR 13-12-053, § 388-877B-0420, filed 5/31/13, effective 7/1/13.]