# Clinical Documentation FAQ

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# General Service Questions

This section is comprised of generalized questions related to required aspects of services, but not limited to specific forms.

## Assessment

| Assessment Questions | Answer |
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| What services are considered "Assessment"? | Assessment services include both initial assessments and subsequent assessments. Subsequent assessments can be conducted according to a client's clinical needs and generally accepted standards of practice. Assessment |

| Assessment Questions | Answer |
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| | services entail meeting with clients to determine diagnosis(es), gather information to ensure clients receive the right service, at the right time, and in the right place. This includes but not limited to the completion of ASAM Continuum or ASAM Assessment Tool – Youth (Paper Version), and clinical interview. Please refer to BHIN 24-001 Assessment section for details. |
| What needs to be documented for someone who is screened for services but did not show up for the intake? | If the screening 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 Connections form (Treatment Providers) needs to be completed, to bill for the screening.<br><br>If the client was given an intake appointment following the screening, the outcome of the intake appointment needs to be documented in the Appointment and Referral Disposition form, effective September 1, 2025. Whether the client shows or no-shows to the appointment, it is documented on this form. It is the receiving (or admitting) provider that completes this form.<br><br>*Note: If the screening provider is the same provider that admits the client, that provider completes both the Referral Connections form, and the Appointment and Referral Disposition form. If the screening provider refers the client out to another SAPC provider, the screening provider completes the Referral Connections form and the receiving provider completes the Appointment and Referral Disposition form.*<br><br>If a client is screened, but no appointment is made (e.g., client refused referral), then only the Service Connections Log (SASH, CENS, CORE) or Referral Connections form (Treatment Providers) needs to be completed. The Appointment and Referral Disposition form is not required in this scenario. |

| Assessment Questions | Answer |
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| | The “no show” can be documented in a progress note if the intake was scheduled with a non-screening provider. If the client is not enrolled with your agency, attempts should be made to contact the individual for rescheduling and document in Appointment and Referral Disposition form.<br><br>Appointment and Referral Disposition form should be completed within three (3) calendar days following the appointment date.<br><br>Please refer to SAPC IN 25-11 for details. |
| Where and how are initial screenings documented and what code is used for billing? | **CENS:**<br>(1) Conduct either ASAM CO-Triage or Youth and Young Adult Screener. (2) Complete Service Connections Log. (3) If individuals need referral to SUD treatment services, please use H0049-CN for billing (FY 24-25) or H2017 (FY 25-26). If screening results indicate individuals do not need SUD treatment services, please use H2017 for billing.<br><br>**DMC-ODS Treatment Services Providers:**<br>Conduct either ASAM CO-Triage or Youth and Young Adult Screener.<br>**If clients are not admitted to your agency:**<br>Complete Referral Connection Form. Providers should use H0049-N for billing (FY 24-25), or H2017 and H0049 (FY 25-26). For more information about Screening billing and PAuth submission, please refer to the Billing for Screening Job Aid on the SAPC website.<br>**If clients are admitted to your agency:** In FY25-26, upon completion of ASAM CO-Triage or Screener of Youth and Young Adult, complete a Referral and Disposition form. Providers should use H2017 (residential and withdrawal management LOCs, and Recovery Services) or H0049 (outpatient LOCs) for screening services when admitting client directly after screening. |
| If we are admitting a screened client to our program, do we | If the client was screened by SASH, CENS, or CORE and referred to your agency, then there |

| Assessment Questions | Answer |
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| have to do a Referral Connections? | should be a Service Connections Log on file for the client and no Referral Connections form is necessary. However, as the admitting provider you will need to complete the Appointment and Referral Disposition form.<br><br>If you are screening the client (using either the ASAM CO-Triage or the Youth and Young Adult Screener), the Referral Connections form must also be completed. This is true even if you are admitting the client to your program. For additional information see SAPC IN 25-11. |
| Is the "Narrative of Patient's Risk Factors" in the Youth and Young Adult Screener a summary of the responses that the youth or young adult gives to the questions about the six ASAM dimensions? If so, how much detail does SAPC require in this section? | A paragraph is sufficient, but it should include a summary of client's responses in the screening process, which may include but not limited to client's responses to the six (6) ASAM dimension questions, substance use history, and other available referral information. The information of this section will serve as a rationale for determining medical necessity for ASAM 0.5 Early Intervention enrollment, or a rationale to support a preliminary Level of Care (LOC) for clients who need a higher LOC than ASAM 0.5 Early Intervention.<br><br>To establish medical necessity for ASAM 0.5 Early Intervention Services, providers must include justification in the "Narrative of Patient's Risk Factors" section. This section should summarize the client's risk factors and explain the rationale for determining that a youth or young adult is at-risk of developing a SUD and is appropriate for ASAM 0.5 Early Intervention LOC.<br><br>If youth or young adults require a higher LOC beyond Early Intervention Services, providers must refer them to the appropriate treatment LOC. A full ASAM assessment is required for youth and young adults needing outpatient, intensive outpatient, residential, withdrawal management, and/or Opioid Treatment Program services. |

| Assessment Questions | Answer |
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| What resources are available during intake to refer youth who may benefit from MAT services? | When youth may benefit from Medication for Addiction Treatment (MAT) services, treatment providers must ensure that clients have access to all required addiction medications either directly on-site or through coordinated referrals. Research and clinical experience have not identified any age-specific safety concerns for addiction medications, and all treatment options should be considered for clients of all ages.<br><br>According to SAPC IN 24-01, each treatment agency shall have available to its staff and keep updated a current list of which addiction medications are available directly via practitioners providing on-site services, including when these medications are prescribed through fee-for-service Medi-Cal and picked up at an offsite pharmacy. Each treatment agency who does not directly offer each required addiction medication described within Attachment B of SAPC IN 24-01.<br><br>Providers treating Youth (age 17 and under) with addiction medications must obtain parental or guardian consent when required to administered or prescribe medication services. However, a minor 16 years of age or older may consent to treatment for opioid use disorder (OUD) that uses buprenorphine outside of an OTP setting, with or without the consent of their parent or guardian. |
| Is there certain language that needs to be documented when screening, reassessing, referring a client to MAT services? | 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. |

## Care Coordination

| Care Coordination Questions | Answer |
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| Can Care Coordination be rendered without the client present? | Yes. With CalAIM Payment Reform the presence of the client is required for almost all services; the general exception is Care Coordination. When a |

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| | client is not present for care coordination services, providers should include the rationale of providing the services without the client and why it is clinically appropriate in the progress note. |
| Can Care Coordination that is not client-facing be documented/billed while the client is participating in another service (e.g., in group)? | Yes, however, provider documentation should be clear that client was not present for the Care Coordination service in order to not raise any flags during an audit. |
| Is linking clients with community resources (such as toys for their children) considered Care Coordination?<br>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 clients 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 client'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.<br><br>Please see the Provider Manual for a summary of the Core Functions of Care Coordination (pg. 61-62). |
| The Rate Matrix doesn't have an option for collateral. Would collateral calls with social workers, DCFS, or outside providers regarding client's treatment be considered a care coordination service? | The use and term of "collateral" has changed under payment reform. It is no longer a standalone service, but is incorporated into assessment, individual, and family services.<br><br>Please see DHCS' CalAIM BH Initiative FAQ for additional information.<br><br>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, they would not be billable. |

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| Would making DCFS/APS reports also be considered a billable care coordination service? | Regarding 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 a person who is taking the report could be billable, depending on how it is written and if the client was part of the conversation. |

## Consents

| Consent Question | Answer |
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| 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, clients cannot sign a single document to cover all of these components. They are individual consents for each service component. |

## Field Based Services (FBS)

| FBS Questions | Answer |
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| How do I bill for time spent at an FBS location? | Providers may only submit claims for allowable FBS services listed within the Provider Manual and FBS Standards and Practices. Time waiting for clients, documentation time, and outreach is not billable. Providers may only claim time that they are actively providing treatment services. FBS must be accurately and correctly documented within progress notes and align with documentation within claims. |
| Does FBS have additional documentation requirements beyond outpatient services at a non-residential treatment facility? | FBS does NOT have additional documentation requirements, but different information must be documented when providing services in the field. Since services are not being rendered at a treatment facility, the Place of Service Code will change to |

| FBS Questions | Answer |
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| | reflect the location. Moreover, the Place of Service for progress notes and claims must align. While these are not additional requirements, the documentation procedures will change to reflect the method of service delivery.<br>BHIN 23-068 and the SAPC Provider Manual specify that the location where services are rendered must be documented within progress notes. Providing FBS requires documenting the location, which will be different from the non-residential treatment facility. Again, this is not a new documentation requirement, but it is a change in the information added to a progress note.<br>FBS requires greater attention to the time that treatment is actively being provided and accurate documentation of services and time. As a best practice, rendering providers should document how the location and environment impacts the services and the client's recovery. For example, FBS providers have noted that in-home FBS offers the provider the opportunity to observe where the client lives and have been able to identify additional needs that impact their recovery. By providing care coordination, the provider was able to assist the client with obtaining financial, health, and mental health services necessary for their recovery. |
| How do I bill for taking a client to an appointment? | Transporting a client to an appointment is NOT billable under FBS. |
| Is there a limit to how long a FBS can last? | Rendering providers can only claim time actively providing treatment and are not permitted to simply claim time in the field. Rendering provider is responsible for accurately accounting for time providing services while in the field.<br>Maximum units that can be billed per rendering provider per beneficiary per day can be found in the Rates Matrix under the Billing Rules tab. |
| Can I take a client outside of the county? | There are no prohibitions on taking a client out of the county. However, simply transporting a client to an appointment out of the County is not a billable service. |

| FBS Questions | Answer |
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| How do I know what Place of Service Code (POS) to use for my FBS location? | Refer to the POS descriptions listed in the Field-Based Services: Standards and Practices to find the appropriate POS code for your FBS location. Email for guidance SAPC-SOC@ph.lacounty.gov to confirm the appropriate POS is being used. |
| If I am providing services to a client in an encampment or street outreach, how do I document the address? | FBS can be provided to clients where they live, including encampments. Document the location using the Place of Service Code for Home – 12 and list the location as the client's home or encampment with detailed location information (e.g., cross streets, name of area, geographic landmarks) in the Progress Note. |
| Can telehealth be billed as a field-based service? | No. FBS and telehealth are different methods of service delivery. FBS are in-person treatment services outside of DMC Certified facilities. Telehealth is synchronous audio-only and synchronous video interactions but does not include asynchronous store and forward communications or remote client monitoring. |
| Why are recovery bridge housing facilities excluded from in-home FBS if that is where the client resides? | Per SAPC's Field Based Services Standards and Practices: "FBS cannot be utilized in lieu of obtaining a California Department of Health Care Services (DHCS) DMC Site Certification for providers' directly operated sites where agency operated SUD or mental health treatment services are the primary business, and agency staff deliver services." |

## Peer Support Services (PSS)

| PSS Questions | Answer |
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| Can a Wellness coach provide PSS? | Only Certified Medi-Cal Peer Support Specialists (CMPSS) are eligible to bill for PSS. However, some CMPSS may be hired under different job titles (e.g., Wellness Coach). If the individual holds the CMPSS certification, they can bill for PSS regardless of their job title. |

| PSS Questions | Answer |
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| How should the "P" in a PIN Note be documented for group or individual PSS? | The Plan of Care, Interaction, Next Steps (PIN) format for documentation is not mandatory but only a suggested format. It was provided only as an example that other counties have found useful. Agencies may continue using PIN if they prefer, but you are free to use your existing documentation format.<br><br>*See SAPC Peer Support Services Guide (January 2024) - pg. 6.* |
| How and where does the Plan of Care need to be documented? | SAPC does not require a separate Plan of Care form for non-OTP services. Instead, it should be reflected throughout the episode of care in the plan section of clinical progress notes. To be reimbursable, services must be based on an approved, individualized Plan of Care.<br><br>Primary Sage users should document using the "Plan of Care" service type on the Progress Note form; Secondary Sage users should document in their SAPC-approved EHR Progress Note form.<br><br>CMPSS' can develop the Plan of Care, but it must be reviewed and signed by an LPHA or CMPSS Supervisor within the required timeframes outlined in the Provider Manual.<br><br>OTP providers should continue to use Treatment Plans to document plan of care for clients receiving OTP services.<br>*See SAPC Substance Use Disorder Treatment Services Provider Manual (V10.0) - pg. 71-73.* |
| What service type/procedure code should be used for a PSS Plan of Care? | Service Type: Peer Support Service – Plan of Care<br>Procedure Code (CPT/HCPCS): H0038. |
| Do all clients need a Plan of Care, or only those receiving ongoing services? | A Plan of Care should be created for all clients after intake, assuming they may continue services. This ensures treatment planning is in place, even if the client later discontinues care. |
| Is there a requirement to complete a session within three | Yes. Since the Plan of Care is documented in a progress note, documentation must be completed |

| PSS Questions | Answer |
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| (3) days of the completion of the Plan of Care for PSS? | within 3 business days, including required signatures (author and LPHA/CMPSS Supervisor).<br><br>*See SAPC IN 23-04 - pg. 6 for details and additional timeframes.* |
| When must the Plan of Care be signed? | There is no explicit State requirement to obtain a signature. Agencies may interpret based on workflow. SAPC has given similar flexibility with guidance.<br><br>*See SAPC Substance Use Disorder Treatment Services Provider Manual (V10.0) - pg. 70 and SAPC IN 23-04.* |
| If the CMPSS who creates the Plan of Care is also the agency's PSS Supervisor, can their signature alone be used? | Yes. If the CMPSS is both the provider and the Supervisor, only their signature is required. There is no need for an additional signature. |
| How do we document when two CMPSS' co-facilitate a group, but only one completes the documentation? | Only one CMPSS may bill for the service. Claims must not be duplicative. Agencies may consider assigning CMPSS' to separate groups, keeping in mind group size requirements (2-12 participants). If one CMPSS is also another type of qualified provider, they may bill under that role. Note: Sage users cannot toggle between Access Groups.<br><br>*See BHIN 25-010 - pg. 21.* |
| How do I document attending an AA meeting with a client? | Attending AA meetings is not billable as PSS because the CMPSS is not delivering the service. However, if the CMPSS provides billable support (e.g., discussing recovery goals, processing the meeting, engagement support), before or after the meeting, the Progress Note should reflect the CMPSS' role in supporting the client, and only that portion may be billed with proper documentation. |
| When a service is provided by a CMPSS and Counselor simultaneously, how should that be documented? | For Group Services, the Progress Note should reflect information about the session (e.g., who facilitated, who provided peer support, and how they worked together). Documentation should make clear the distinct roles of each provider. For Group Services, only one provider may bill for the service. |

| PSS Questions | Answer |
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| | For Individual Services, each practitioner may document the portion of the service they contributed. For example, if in total, 45 minutes were spent with the client, the CMPSS' progress note AND the Counselor's progress note should total 45 combined, as billing is reflective of the session with the practitioner. |
| Is speaking on behalf of a client (e.g., a judge) allowable for PSS? | It depends. If you are advocating on the client's behalf, it is considered an allowable therapeutic activity and can be billable. However, you must first obtain written consent from the client using the Release of Information form. You should also document in the Progress Note *what* information was shared, with *whom* it was shared, reasons for sharing information and how this relates to recovery or treatment, and that *written consent was obtained* prior to disclosure.<br>As a reminder, the time not engaging in an intervention, such as sitting in the court room, is not billable. |
| Is a separate consent form required for group services led by CMPSS'? | No. A separate consent form is not required. The standard DMC-ODS consent form is sufficient for clients receiving services from a CMPSS in a DMC-ODS setting. |

## Prescriber Documentation

| Prescriber Doc Questions | Answer |
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| Can a prescriber that has access to their own EHR system through a private practice document SAPC client information through that EHR? | At this time SAPC is not be able to connect directly to a prescriber's private practice EHR. The prescriber may document in their own system and either upload documentation to Sage themselves or have an assisting staff member upload documentation into Sage. For billing purposes, if staff use the progress note status report to track claims and bill, SAPC recommends having staff enter a "tracking" progress note with the billing information so that it populates to the progress note status report. |

| Prescriber Doc Questions | Answer |
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| | The file attach naming convention should follow these examples:<br>i. History and Physical: H&P-(MM-DD-YY)-Client Initials-PATID<br>ii. Medication Services: MAT- (MM-DD-YY)-Client Initials-PATID<br><br>If you do not use the progress note status report for tracking billing, then it is still recommended a non-billable progress note be completed which points to the MD note in the file attach for tracking purposes and visibility.<br><br>Additionally, for DMC services and documentation, we do have to ensure the progress notes meet minimum DMC/Title 22 standards. Please ensure that prescriber notes meet these minimum requirements to avoid audit issues. SAPC QI and UM may assist in that process. Please email a blank note template from the prescriber's EHR to review. SAPC.QI.UM@ph.lacounty.gov |
| 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, include an SUD diagnosis and a plan of care for that SUD. The physical exam is part of the medication visit, but notes documenting a physical exam 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 the 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 an SUD diagnosis or plan of care for the SUD diagnosis. |
| What are the documentation requirements for the 90792 | In addition to requirements of all progress notes, the key elements of a psychiatric evaluation (CC, HPI, |

| Prescriber Doc Questions | Answer |
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| (psychiatric diagnostic evaluation with medical services)? | 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) should be included in a note. |
| How should a physical exam be documented? | For services to be billable to SAPC, the Progress Note denoting a physical exam must include an SUD diagnosis and the plan of care (including any applicable medications) for the SUD. For FY<br><br>FY24/25:<br>• Residential Settings may use H0034R to bill for this service.<br>• Non-residential, H0034 is allowable, as are 99202-99205 (depending on the time of the medical visit).<br><br>FY 25/26:<br>• H0034 (without the 'R') may be billed by residential settings.<br>Non-residential, H0034 is allowable, as are 99202-99205 (depending on the time of the medical visit). |

## Recovery Services (RS)

| RS Questions | Answer |
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| Is Recovery Services excluded from the use of H2010N and H2010M and calculation of the incentive deliverable percentage of clients with AUD/OUD? | We use the H2010M and H2010N code for our incentives tracking, and this includes clients receiving recovery services. |
| Is a Problem List required for Recovery Services? | Standalone Recovery Services require a Problem List. See Table 17 of the Provider Manual for details regarding timelines. |
| What are the max number of hours for Recovery Services? | At a practical level, if a client is receiving nine (9) or more hours consistently per week, it would raise the question as to whether that client would require an IOP LOC or higher. |

## Recovery Incentives – Contingency Management (RI-CM)

| RI-CM Questions | Answer |
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| 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.<br><br>As of **October 1, 2024**, (for Auths with start date 10/1/24 and after), providers are 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.<br><br>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.<br><br>BHIN 24-031 Updated Guidance for the Recovery Incentives Program: California's Contingency Management Benefit |
| What diagnosis are accepted for RI-CM? | • Amphetamine Use Disorder, Moderate/Severe<br>• Methamphetamine Use Disorder, Moderate/Severe<br>• Stimulant Use Disorder, Moderate/Severe<br>• Stimulant Use Disorder-Cocaine, Moderate/Severe<br>• Other or unspecified stimulant use disorder, Moderate/Severe<br>An "in early remission" specifier qualifies client for RI-CM benefits.<br><br>The list of diagnoses is not exhaustive. Any form of stimulant Use Disorder moderate or severe with a qualifying specifier is acceptable. |
| For RI-CM, is a Problem List required both for when one provider is rendering CM, and | 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 |

| RI-CM Questions | Answer |
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| another is rendering Outpatient (OP)? | |
| 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.<br>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.<br>If there is an ASAM in the chart within 12 months of the CM admission, UM accepts that. |

## Residential

| Residential Questions | Answer |
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| What service code should be documented when a prescriber provides non-MAT services at an IMS certified residential facility? (e.g., Medication for Anxiety or Depression). | SAPC does not pay for psychiatric or other medication services delivered to a client that do not also include the treatment of the substance use disorder.<br><br>If a client with a SUD 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 client along with the anxiety condition and psychiatric management of anxiety being considered.<br><br>Treating anxiety (and other psychiatric and medical conditions) alongside SUD is entirely permitted as long as the SUD diagnosis and related medical decision making is documented 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 client's SUD.<br><br>For more information see SAPC IN 24-01: Addiction Medication Access in the SAPC Treatment Network. |

| Residential Questions | Answer |
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| What are the required components of a Residential Daily Summary | Residential Daily Summaries must summarize all services and activities the client engages in over the course of a day. Residential Daily Summaries must include details about the service or activity, how it supports the client's progress toward care goals, attendees, start and end times of both the service/activity and the documentation, and any relevant information about the client's response. Client response must 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. |
| Now that $0 billings are required, do we still need to do separate notes? | All services provided must be documented either by individual encounter or as daily summaries. Documenting by encounter involves recording each service or activity a client participates in as it occurs. Alternatively, daily documentation entails summarizing all services and activities the client engages in over the course of a day. |
| Is there any policy that states providers are not to "hold beds" for clients in withdrawal management (WM) if they get admitted to a hospital? | The summary on Bed Holds is as follows:<br>• No bed holds for WM (Page 83 of Provider Manual 10.0)<br>• Can have bed holds in Residential for:<br>  ○ Flash incarceration<br>  ○ Medical evaluation and admission<br>  ○ Pages 78-80 of Provider Manual10: If bed is held and client is set to return within seven (7) calendar days then providers should only bill room and board and not the day rate<br>• Page 95 of Provider Manual 10.0: Recovery Bridge Housing (RBH) providers may hold beds for up to seven (7) days for clients in interim housing facility for reasons such as hospitalization, therapeutic pass (violation of post-release-supervision), or a lapse in treatment/discharging Against Medical Advice (AMA). Beds held for this timeframe and for |

| Residential Questions | Answer |
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| | the reasons listed are billable through the provider's RBH contact. |

## Assessment Forms

| Assessment Form Questions | Answer |
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| Is a new ASAM required for a client who was discharged, but returns? | Please see the ASAM Assessment Requirements document (link below) on the SAPC website that explains when a new ASAM is required.<br><br>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? | This is considered an assessment and can be billed under 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. 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.<br><br>SAPC's provider manual sections: "ASAM XX: Service Requirements" references "Treatment services at this LOC include... completing the health |

| Assessment Form Questions | Answer |
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| | status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam at each LOC." |
| Who can complete a health questionnaire? | Programs may use DHCS Form 5103 (6/16) for the health questionnaire or may develop their own health questionnaire provided it contains, at a minimum, the information requested in DHCS Form 5103 (6/16). The health questionnaire is a client's self-assessment of their current health status. The health questionnaire shall be completed and signed within 24 hours of the client's admission to the program by an LPHA and filed in the client's file. |

## Diagnosis Form

| Diagnosis Form Questions | Answer |
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| What is the difference between an admission and updated diagnosis? | Based on the Sage configuration, clients 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 clients 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. |
| When I update a diagnosis do previous diagnoses need to be included? | Yes. Each diagnosis entry overrides the previous entry, therefor all active diagnosis should be included in each diagnosis record. As a reminder an SUD diagnosis should be the primary diagnosis for clients with established medical necessity. Standalone mental health diagnosis may result in denials. |
| How can a service authorization request be submitted if there is no official SUD diagnosis yet? | This is possible via an initial engagement authorization only. Provider can submit an initial engagement authorization for 0.5, 1.0, 2.1, OTP when medical necessity has not been established. (Provider Manual 10.0 p. 41) |

| Diagnosis Form Questions | Answer |
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| How long can I use Z55-Z65? | Z55-Z65 codes can be used as a primary diagnosis during assessment period for LOC 1.0, LOC 2.1, OTP during initial engagement/assessment period.<br><br>They can be used as primary diagnosis throughout treatment for LOC ASAM 0.5.<br><br>For clients with a covered primary SUD diagnosis, there is no time limitation for using Z55-Z66 codes. |
| What diagnosis are accepted by the State? | DHCS's DMC-ODS Billing Manual has an appendix of covered diagnosis. This manual is updated yearly and is posted to the MedCCC Library. |
| What diagnosis can be used for a youth that does not meet full criteria for an SUD diagnosis and is admitted for ASAM 0.5? | While an SUD diagnosis is not required to provide Early Intervention services, claims for Early Intervention services need to include a CMS-approved ICD-10 diagnosis code. For example, these include codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services." ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances," or ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out" may also be used.<br>If the member meets the diagnostic criteria for an SUD, a full ASAM assessment needs to be performed, and the member needs to receive a referral to the appropriate LOC indicated by the assessment.<br>Please see Provider Manual pg. 74. |
| What services can someone with a sustained remission diagnosis receive? | It will be the same for all qualifying diagnosis. |

# Discharge and Transfer Form (D&T)

| D&T Questions | Answer |
|---|---|
| Who needs to complete the Discharge and Transfer form? | All providers are required to complete the Discharge and Transfer form as well as the Recover Bridge |

| D&T Questions | Answer |
|---|---|
| | Housing form in Sage regardless or Primary or Secondary Sage User status.<br><br>Please see the Discharge Planning, Transitions in Care, Residential Treatment, and Discharge and Transfer sections of the Provider Manual for additional information. |
| Are we supposed to enter all medications that client was prescribed during the treatment episode or only the ones that are active that the client is taking at the time of discharge? | The medications which are active at the time of discharge may be entered into the Discharge and Transfer Form. |

## Problem List/Treatment Plan Form

| PL/Treatment Plan Questions | Answer |
|---|---|
| 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 clients who meet the criteria of opioid, alcohol, and/or tobacco use disorder. SAPC also recommends discussing and offering MAT as a treatment option with clients who meet the criteria for cannabis use disorder, stimulant use disorder (methamphetamine type), and cocaine use disorder. Providers should provide psychoeducation to clients who meet criteria of the above substance use disorders. The explanation field should indicate why a referral was not made, such as the client 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. |
| When documenting MAT on the Problem List, does "referred" generally mean "discussed," | 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 |

| PL/Treatment Plan Questions | Answer |
|---|---|
| "linked to an appointment," "linkage attempts made," or something else? | MAT appointment or providing MAT referral sources to client. Click "no" when no referral is made, this includes client refused MAT referral after providing MAT education, or client is already receiving MAT services. |
| When 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.<br><br>In general, these are the items that need to be completed within the practitioner's scope of practice.<br><br>1. Problem<br>2. The date of the problem added<br>3. The name, credential, and title of the practitioner adding the problem<br>4. The date that the problem was resolved<br>The name, credential, and title of the practitioner who identified the problem as resolved. |
| When can the physical be removed as a problem on the Problem List? | DMC-ODS beneficiaries are required to have a physical examination per Title 22. This include a having a physical within the last 12 months prior to admission and a physician review the documentation within 30 calendar days. If the documentation is not available, the efforts made to obtain the records will be documented in a progress note.<br><br>Alternatively, an appropriate medical practitioner may perform the physical examination within 30 days of admission. If the physical examination requirements have not been met, then this should be added to the client's Problem List until resolved. Clients with ongoing outstanding physical examinations need documentation explaining circumstances as to why the examination has not been completed. Failure to |

| PL/Treatment Plan Questions | Answer |
|---|---|
| | meet this requirement may result in a Corrective Action Plan from Contracts. |
| 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 client, 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.<br><br>There are separate "clocks" for the completion of these two types of documentation.<br><br>The progress note documenting the PL development session should be completed within 3 business days from the date of service rendered.<br><br>The Problem List, which is documented in the Problem List/Treatment Plan form, has to be finalized according to the timeline outlined in Table 17 of the Provider Manual. 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.<br><br>The finalization timeline would depend on the LOC and if the client is under 21 and/or experiencing homelessness. |
| If the Problem List took more than one day to create, how should that be documented? | Sometimes it may take more than one session to develop Problem List. For example, a counselor met with client to develop a Problem List on 8/5/24 and 8/7/24.<br><br>• The counselor would enter 8/5/24 for "Date Created" on the Problem List/Treatment Plan |

| PL/Treatment Plan Questions | Answer |
|---|---|
| | form, as 8/5/24 was the date that they start developing the Problem List with the client.<br>• 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 Development sessions. The finalization of these two progress notes would be within 3 business days. |
| Do providers need to create a new Problem List when clients are transferred between levels of care (e.g. LOC 2.1 to LOC 1.0) within the same location? | Yes, providers are required to create a new Problem List whenever there is a new admission. See Table 17 of Provider Manual 10.0 for completion timeframe. |
| Can you please confirm that ASAM 0.5 and ASAM 1.0 LOC do not need to submit a treatment plan for MAT services? | Only OTP 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.<br><br>However, care planning is still an integral part of treatment. Collaborating with clients 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 10.0 pp. 53, 197-200. |

# Progress Note Form

| Progress Note Questions | Answer |
|---|---|
| What code is used for medical necessity? | The State has not identified a specific code for "medical necessity." However, with the expansion of the payment reform, they have given diagnosing (LE) LPHAs an outlet to bill for their time more specifically. Diagnosing is a task that can only be performed by |

| Progress Note Questions | Answer |
|---|---|
| | select (LE) LPHAs and is part of establishing medical necessity. Therefore, SAPC has identified the code 90885 as a way for LPHAs to capture their time. As a reminder, supervision activities are not reimbursable by the State, nor is the actual documentation of the note. |
| Which LPHAs may approve the medical necessity note? | Practitioners whose scope of practice allows them to diagnose a substance use disorder may finalize the medical necessity note. This is limited to:<br>• Registered and Licensed: Clinical Social Workers, Marriage and Family Therapists, and Professional Clinical Counselors.<br>• Psychological Associates and Licensed Psychologists<br>• Prescribers: Physicians, Physician Assistants, Nurse Practitioners<br><br>Practitioners who may **NOT** finalize a Medical Necessity note include counselors, registered nurses, licensed vocational nurses, medical assistants, CMPSS, and licensed occupational therapists. |
| What are the aspects/categories that need to be covered in a medical necessity note? | Specify client'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 client's SUD, as applicable.<br><br>For Withdrawal Management: include current withdrawal symptoms. Be as specific as possible to justify the level of WM being requested, e.g. unstable medical or psychiatric issues, need for medication management that requires medical observation.<br><br>Ultimately documentation should support the client's enrolled LOC as necessary, appropriate, and reasonable. |
| How does one expand on symptoms that may be either chronic or acute in a way that supports medical necessity? | Providers should include detailed description of client's presentation/symptoms as well as functional impairments, and/or biopsychosocial factors |

| Progress Note Questions | Answer |
|---|---|
| | contributing to client's substance use, relapse risk, and needs in substance use treatment.<br>For example:<br>• Instead of stating "client is experiencing psychosis", provide specifics such as "client reports ongoing intermittent auditory hallucinations, command, and paranoid type. Per client, 'the voices tell me I should leave because someone here wants to hurt me'".<br>• Instead of stating "Client is experiencing legal issues" provide specifics such as "Client has ongoing legal issues, including being on summary probation and having open DCFS case. Client's next DCFS court date is 3/1/25 and Client reports that if she loses her children, she is going to "give up" because 'what is the point'".<br>• For medical issues, instead of only stating "Client has a history of seizures", provide specifics such as "Client has a recent history of ETOH withdrawal-related seizures, with last seizure 6 weeks prior to admission. Client is non-compliant with prescribed medications and states, 'I forget to take my medications when I'm drinking.'"<br><br>For behavior preventing lower LOC participation and requiring higher LOC, instead of stating "Client presents agitated", provide specifics such as "Client presented as agitated and aggressive at time of screening, evidenced by pressured and rapid speech, threats to staff, and postured stance. Client required IV sedation and requires 24-hour 1:1 nursing for safety and medical observation for medication management." |
| What does the LPHA need to include in the progress note to substantiate a diagnosis? | Functional impairments and symptoms that meet medical necessity criteria for the diagnosis and requested services. Per Provider Manual pg. 44, the basis for the diagnosis, or qualification under EPSDT, should include a statement that the client's personal, medical, and substance use history were reviewed. If the ASAM does not resolve to a DMC eligible SUD |

| Progress Note Questions | Answer |
|---|---|
| | diagnosis, provider needs to document which of the 11 DSM-5 SUD criteria the client meets. Providers may use the SAPC Paper SUD DSM Form on the SAPC website. The Medical Necessity Justification Progress Note needs to be signed and finalized by a diagnosing LPHA, dated, and then submitted in the client record in Sage. |
| 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 are used to verify whether the practitioner was working during the stated hours, as indicated on their timecards, as well as to determine the length of service provided.<br><br>Note: The Start and End fields account for the time spent with the client, but not necessarily the time spent 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.<br><br>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 to bill E&M codes for MAT assessments, which resulted in all the services being denied by the State. In this case, SAPC instructed providers to rebill using a different code. |
| If the same provider sets up a morning visit and an 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 client, 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 directly to creating claims. |

| Progress Note Questions | Answer |
|---|---|
| | Generally, if 2+ of the same service is rendered to the same client, on the same day, by the same practitioner, then when the service is billed, it has to be “rolledup” into a single billed service for the duration of both services.<br>Roll up billing exemptions:<br>• Group/Client Education groups<br>• Procedure codes (mostly CPT) with duration ranges. Example if the description says 21-30 minutes<br>• Procedure code with 1-unit maximums |
| When do we use office as a location? | Office (11) is defined by DHCS 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.<br><br>For accuracy of place of service, use the following:<br><br>• Outpatient providers should use: Non-residential Substance Abuse Treatment Facility (57)<br>• Residential providers should use: Residential Substance Abuse Treatment Facility (55)<br>• OTP providers should use: Non-residential Opioid Treatment Facility (58)<br>• Field-Based Service providers: see the FBS Standards and Practices |
| What location code should be used when a client is not present, such as a care coordination medical team conference? | Typically, the location refers to the client's physical location during the service. When the client is not present, use the code that best describes the site location:<br>• Non-residential Substance Abuse Treatment Facility<br>• Residential Substance Abuse Treatment Facility<br>• Non-residential Opioid Treatment Facility |

| Progress Note Questions | Answer |
|---|---|
| For campus providers, what site should be documented on the progress note? | For clients in residential services, select Residential Substance Abuse Treatment Facility.<br><br>For clients in non-residential LOCs, select Non-residential Substance Abuse Treatment Facility.<br><br>For billing: Use an NPI from a site in the agency that provides the same LOC.<br>http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm#<br>http://publichealth.lacounty.gov/sapc/docs/providers/sage/finance/office-hour/Billing-Office-Hours-091224.pdf |
| How is the location code determined if the location type does not match exactly? | If there is not an exact match for an FBS site, try to choose the best location code that matches the site type as closely as possible. If you need assistance, please email:<br>SAPC-SOC@ph.lacounty.gov |
| How do we document the incentives for MAT Education (H2010M) and Naloxone Handling/Distribution (H2010N) to receive the incentives? | The incentive is based on the 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 in conjunction with another service, such as counseling, group therapy, or care coordination. For the H2010N/M incentive codes, a separate progress note is NOT required by SAPC.<br>For 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.<br>**FY 24/25**<br>For primary providers who rely 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 during 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. Please see |

| Progress Note Questions | Answer |
|---|---|
| | Sage Provider Communication from 2/14/2025 for documentation examples.<br><br>**FY25/26**<br>On August 6, 2025, SAPC updated the Progress Note form in Sage to include a new field at the bottom of the page, 'Check all applicable services delivered as part of treatment.' As H2010M and H2010N are not standalone services, when the practitioner writes their note for the session, they can check off the appropriate box if either of those two incentive services was also rendered. This will populate the Progress Note Status report, allowing billers to identify whether one or more services need to be billed for the session. |
| Does H2010S require any face-to-face interaction or additional documentation outside of logging in the medication into PCNX?<br>FY 24/25 ONLY | For H2010S, the client must be present for the time billed. A medical safeguarding note can be written for the time the staff spend coordinating medications without the client, but the time spent without the client is not billable. |
| What is meant by H2010S is a "standalone?"<br>FY 24/25 ONLY | Standalone refers to a service that does not require association with or provision in combination with another service.<br><br>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 client? If so, can you provide any written documentation to support this claim?<br>FY 24/25 ONLY | Yes, it can. This was addressed in the All Provider Meeting in the Clinical Services Division update on 11/5/2024, which has the instruction in writing.<br><br>• If an eligible practitioner handles 2 medications for Client A and 10 medications for Client B during a morning pill call, there would be one H2010S service billed for each client.<br>• If that same practitioner handles an evening pill call service for these same clients, there would be an additional H2010S service billed for each client. |

| Progress Note Questions | Answer |
|---|---|
| | • No other service other than the handing of medication was rendered. |
| How should a note document a counselor providing individual counseling for 60 minutes and another 60 minutes providing MAT Education? | H2010M/N are not standalone services because these billing codes are codes for tracking incentives, and they are $0 claim codes.<br><br>The amount of direct service provided to the client should be accounted for in the reimbursable service code. In the provided example, the full 120 minutes (8 units) would be billed for the individual session, which would get billed to the State.<br><br>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. Therefore, when billing H2010 M/N, the unit can also reflect the time-specific amount spent on that service, in this case, 4 units.<br><br>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. |
| What are the available medication service codes for residential programs, as well as program type/licensure requirements for providing these services at both IMS-designated sites and non-IMS sites? | H0033 is for medical staff administering medication, which requires a medication administration note, and for the site to have IMS.<br><br>H2010S is for any DMC-ODS practitioners to handle/store medications for client self-administration (FY 24/25 ONLY). It does not require IMS.<br><br>The Rate and Standards Matrix, released per Fiscal Year, will indicate which services are reimbursable by provider discipline. |
| We are seeking clarification on which CPT code an LVN would use to provide services that | DHCS accepts both H0033 (even though it says oral in the description) and H0034 for injections; you can use either. |

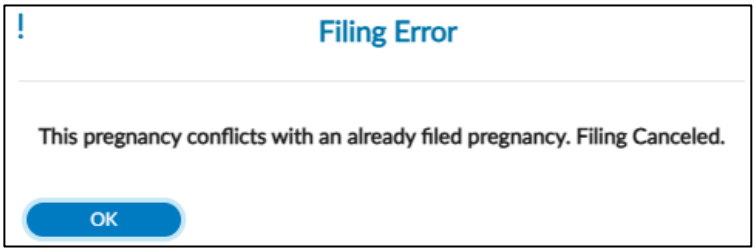
| Progress Note Questions | Answer |
|---|---|
| include injections for both MAT medications and non-MAT medications in residential and outpatient programs. | You can use H0033 to bill for the administration of any medically necessary medications, even if they aren't FDA-approved to treat substance use 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 client's recovery from the diagnosed SUD(s). |
| Med pass doesn't usually take over 8 minutes. Is there a way to still bill for distributing medications? | H0033 is subject to the midpoint rule; therefore, at least 8 minutes of direct service must be provided for it to be reimbursable. For clients with a medication administration time of less than 8 minutes, the medication pass may be documented in the medication administration record; however, it cannot be billed. |
| Does each staff member who begins telehealth with a specific client need to document verbal telehealth consent at the first telehealth session, or is it sufficient if one staff member does it, and all staff are covered? | All staff are technically covered under the telehealth consent. However, it is a good clinical practice for each staff member to evaluate if the specific services they provide are appropriate to be delivered via telehealth. |
| When should a Discharge Planning/Summary Service Type Progress Note be completed? | A progress note should be completed whenever a session is spent discussing matters related to planning a client's discharge, such as preferences and needs upon discharge from the current LOC, plan of care for discharge, and the client's goals achieved at discharge. Provider 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 whenever an encounter is had with the client, and to document the work being done for the client if they are 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 can bill. |

| Progress Note Questions | Answer |
|---|---|
| What is the difference between Group Counseling and Patient Education? | In general, Patient Education groups are informational and take more of a teaching approach by the facilitator(s) about a substance use related topic.<br>Counseling groups may cover similar topics; however, the focus is on a dynamic discussion with the participants on how it relates, impacts, and/or can be applied toward their identified problems and treatment goals.<br><br>Patient Education groups are limited to 2-12 participants except in residential levels of care where there may be up to 30 participants. These are billed under the base code H2014 with the HQ modifier.<br>Counseling groups are limited to 2-12 participants at all levels of care and are billed under the base code H0005. |

# Release of Information (ROI)

| ROI Questions | Answer |
|---|---|
| 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.<br>http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm#clinical |
| Are all providers required to use the ROI in Sage? | Effective July 1, 2025, all Primary Sage Users will be required to use the Sage Release of Information - In Network form to record client releases of information (ROI).<br><br>For Secondary Sage Users, while we are not requiring use of the form at this time, it will still be greatly beneficial to utilize the form in Sage for tracking and consents management functionality.<br>http://publichealth.lacounty.gov/sapc/Sage/Communication/SAPC-Sage-Provider-Communication-060925.pdf |

# Women's Health History Form (WHH)

| WHH Questions | Answer |
|---|---|
| Do all clients require a Women's Health History form? | The Women's Health History (WHH) form is required to be completed in Sage by all providers for clients 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 clients will result in State denials.<br><br>*Note: this is not limited to PPW providers nor PPW authorizations.* |
| What fields need to be completed on the WHH? | The following items are required to submit the form:<br>• Add, Edit or Delete a Record<br>• Client ID<br>• Episode Number<br>• Selected Record [conditionally required]<br>• Assessment Date<br>• Pregnancy Start Date [needed for billing purposes]<br>• Pregnancy End Date [should be entered for existing record to close out the pregnancy period and for clients who enter treatment within the 1-year postpartum period]<br>• Have you started prenatal care at another facility? |
| Does the WHH need 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 client 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 per agency**. If a client returns to treatment at the same agency during the course of the same pregnancy, the system will prevent a new record from being filed.<br>  |

| WHH Questions | Answer |
|---|---|
| | If the pregnancy ends during the course of treatment, providers will need to update the WHH and enter a "Pregnancy End Date."<br><br>If the client returns to treatment and is experiencing a new pregnancy, the provider must enter the end date of the client's previous pregnancy in the existing WHH form.<br><br>Once the previous pregnancy is end dated, the provider will be able to file a new WHH for the client's current pregnancy.<br><br>*Note: **Each agency is required to have a unique record for a pregnancy**. Therefore, the list of records that populates on the WHH may have multiple entries with the same pregnancy dates as they belong to a different agency. This may occur if a client receives treatment at different facilities during the course of the pregnancy or 1-year postpartum period.* |
| 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 clients 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.<br><br>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 regardless of gender, not just women who are pregnant or postpartum.<br><br>Before completing the Reproductive Health form, providers must first attend SAPC's Pregnancy/Parenthood, 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.<br><br>**Note: Sexual and Reproductive Health Specialists are required to attend the PATH training and complete the Reproductive Health form for all appropriate clients.* |

# Secondary Sage User Documentation

| Secondary Sage User Questions | Answer |
|---|---|
| What needs to be done if we are converting to a secondary provider or we are switching EHR vendors? | 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.<br><br>Email form templates to email:<br>SAPC.QI.UM@ph.lacounty.gov<br>Subject line: [Agency Name] Secondary Provider Form Approval Request<br><br>Forms requiring approval:<br>• Progress Note<br>• Treatment Plan (OTP)<br>• Problem List |
| 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 SAPC 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.<br>• Admission (Outpatient)<br>• Update Client Data<br>• All Cal-OMS related forms<br>• ASAM Assessment/Finalize ASAM Assessment (CO-Triage and Continuum)<br>• Youth and Young Adult Screener<br>• Provider Site Admission<br>• Referral Connections<br>• Service Connections Log (CENS only)<br>• Monthly Activity Report (CENS only)<br>• Appointment and Referral Disposition<br>• Financial Eligibility<br>• Service Authorization Request<br>• Diagnosis |

| Secondary Sage User Questions | Answer |
|---|---|
| | • Progress Notes<br>• Problem List/Treatment Plan<br>• Real Time Inquiry 270 Request and Posting of 271 Response<br>• Discharge and Transfer Form<br>• Recovery Bridge Housing Discharge<br>• Women's Health History (PPW sites only)<br>• Reproductive Health (PPW sites only) |