CalAIM Progress Note Standards – SUD

Progress Note Functions

A focus of CalAIM is to simplify progress note documentation to decrease the time providers spend documenting so they can focus more time on working with the person in care.

- Each progress note should be understandable when read independent of other progress notes. This means, documentation should provide an accurate picture of the person's condition, treatment provided, and response to care at the time the service was provided.
- Progress notes are considered a legal record describing treatment provided for reimbursement purposes. The progress note is used for verification of billed services for reimbursement. As such, there must be sufficient documentation of the intervention, what was provided to or with the person, to justify payment.
- Progress notes are also used to communicate with other care providers. Therefore, abbreviations should be avoided, unless universally recognized, to facilitate clear and accurate communication across providers and for when notes are used for legal or other reasons. Keep in mind that the person in care has legal privilege to their medical record and may review the medical record documentation. They should be able to recognize the treatment described; therefore, it is recommended that clinical jargon be avoided.

Some Helpful Tips

Consider the following characteristics for quality documentation of progress notes:

- Concise
- Descriptive
- Reliable
- Accurate/Precise
- Timely

Drug Medi-Cal/ CalAIM Required Progress Note Service Information

- Type of Service Rendered
- Narrative describing the service, including how the service address 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 direct patient care for the service.
- 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.

- 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.
- The following 2 items do not need to be listed in the narrative of each progress note, but must be present on the claim for the service.
    - ICD-10 Code (On the "backend" of Avatar – does not need to be in the narrative of the note).
    - Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Code (On the "backend" of Avatar – does not need to be in the narrative of the note).

Group Progress Notes – All of the Above, Plus

- For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners shall be used to document the group service provided. Progress notes shall contain the information as noted above and modifications and additional information as noted below:
    - Information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity.
    - A list of group participant names shall be maintained. Please note, due to confidentiality standards, the full list of group participants must NOT be kept in any single participant's personal health records, instead the SUD program or practitioner must maintain the full participant list outside of any participant's health records.

Care Plan (formerly Treatment Plan) Requirements for Peer Support Services in Progress Notes

- Peer Support Services now require a Treatment/Care Plan to be written within the narrative of a progress note.
    - The plan of care shall be documented within a progress note in the beneficiary's clinical record.
    - Is approved by any treating provider who can render reimbursable Medi-Cal services.
        - Documentation of ongoing peer support services must only meet the "Required Progress Note Service Information" as listed in the first page of this document.

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Progress Note Timeliness

- Routine Outpatient Services:
  - Completed within three (3) business days. If a note is submitted outside of the 3 business days, document the reason the note is delayed. Late notes should not be withheld from the claiming process.
- Crisis Services:
  - Completed within 24 hours.
- Daily Service Notes:
  - Required for documentation of residential services that use a daily rate for billing. In these programs, weekly summaries are no longer required.

Additional Substance Abuse Prevention and Treatment Block Grant (SABG) Progress Note Requirement

- Progress notes shall document the client's progress toward completion of activities and achievement of goals on the treatment plan.

Compliance Monitoring by DHCS and Yolo County HHSA Behavioral Health Quality Management

- Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, or abuse within the service provision and claiming system.
- Disallowances will only occur when there is evidence of fraud, waste, or abuse.
- Documenting accurately, in a timely manner and in alignment with the guidelines listed in this manual are necessary steps to promote compliance.

Important Reminder

"COPYING AND PASTING" IS STRICTLY PROHIBITTED IN A CLIENT'S MEDICAL RECORD. Each progress note needs to be specific to the service provided. Progress notes that are submitted which appear to be worded exactly alike, or too similarly to, previous entries may be assumed to be pasted, e.g., containing inaccurate, outdated, or false information. Claiming associated with such notes could be considered fraudulent.

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Resources:

- **CalMHSA Documentation Guides: Alcohol & Drug Counselors, Clinical Staff, Medical Staff, Peer Support Specialists**
  - California Mental Health Services Authority | CalAIM (calmhsa.org)
- **CalMHSA Documentation Trainings**
  - California Mental Health Services Authority Learnings: Log in to the site (calmhsalearns.org)
- **Yolo County Policies & Procedures and Cal-AIM resources**
  - Behavioral Health Quality Management | Yolo County
- **Minimum Quality Drug Treatment Standards for SABG**
  - Document 2F(b) - Minimum Quality Drug Treatment Standards for SABG (sccgov.org)