Opioid Treatment Program Clinical/Documentation Guidelines

Topic	Documentation Standard/Timelines	Title 9 Reference/Regulation
Medical Evaluation	Prior to admission of detox or maintenance treatment the evaluation must include: • Medical history of illicit drug use • Lab tests 1. HIV testing must be offered but is optional for clients 2. Hepatitus C is a required test 3. Drug test to include Oxycodone and Fentanyl 4. Drug test to include Benzodiazepines for those treated with Buprenorphine or buprenorphine products. • Physical examination 1. Evaluation of organ system for infectious disease, pulmonary, etc. 2. Vital signs 3. Exam of head, ears, eyes, nose, throat, thyroid, chest, 4. Neurological 5. And overall impression which identifies any medical condition or health problem for which treatment is warranted In addition: • Document evidence and concur with the documentation of evidence used from the medical examination to determine physical dependence and addiction to opiates • Document the final determination concerning physical dependence and addiction to opiates • Medical director shall conduct or document review and concurrence of medical examination by physician extender	Section 10270 BHIN 20-050, Oxycodone and Fentanyl testing requirement to start July 1, 2021 DHCS NTP Regulations update 9/23/2020 Hepatitis C testing requirements
2 + 2/ 2 years of addiction and 2 failed attempts	Documentation of use and treatment failure must be in client chart or evidence of 2 + 2 form • For maintenance treatment client record must document at least 1 year of prior opioid addiction and 2 prior treatment failures or Form DHCS 5022 in client file	Section 10165 and 10270 or Form DHCS 5022 in client file

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Documentation of meeting minimum criteria	Documentation to include: • Confirmed 2-year addiction to opioids • Confirmed 2-year unsuccessful withdrawal treatment efforts with return to illicit drug use • Minimum age of 18 • Certification by physician of fitness for Narcotic replacement therapy • Observed signs for physical addiction or reason why this does not apply (Section 10270 for details) • Pregnant clients who are currently dependent on opiates and have documented history of addiction may be admitted to maintenance without meeting 2 + 2 rule • Form DHCS 5022 must be completed and filed in client record (if applicable)	Section 10270
Continuing Service Requirements	The medical director and/or physician must discontinue a client's maintenance treatment within two consecutive years after treatment began unless the medical director and/or physician complete the following: • Evaluates client progress or lack of progress in achieving treatment goals in the progress notes • Determines through clinical judgement that the client status indicates that such treatment would lead to a return to opiate addiction • Client's should be re-evaluated at least annually after 2 consecutive years of maintenance treatment and the facts justifying the decision to continue client treatment is documented in the client record. (See 2 + 2 for more details)	Section 10410
Diagnosis	A documented and substantiated diagnosis that meets the standards related to the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders or be assessed to be at risk for developing substance use disorder (for youth under 21), done by MD or LPHA, as it is within their scope to diagnose, documenting the basis for the DSM 5 diagnosis and to be done within 30 days of admission	Title 22: DMC Substance Use Disorder Services. 51341.1, h, 1, A, v, a IA: DMC-ODS, Attachment I A2, III, PP, 11, i, a

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Orientation of client to nature and purpose of treatment	Documentation must include but is not limited to: • Addicting nature of medications used in replacement therapy • Hazards and risks involved in replacement therapy • Client's responsibility to program • Program's responsibility to client • Client's participation is voluntary, and they may terminate participation without penalty • Client will be tested for opioid and illicit drug use • Client's medically determined dosage level may be adjusted without the client's knowledge, and at some point, the dose may contain no medication at all (if applicable) • Take home medication which may be dispensed to the client are for personal use • Misuse of medications will result in penalties and may also result in criminal prosecution • Client has a right to humane procedure of withdrawal and a procedure for gradual withdrawal is available • Possible adverse side effects of abrupt withdrawal • Protection under the confidentiality requirements • Acknowledgement by the client of the orientation	Section 10280
Orientation of female client of childbearing age	The following must be documented in the chart for female clients of childbearing age: • Knowledge of the effects of medication used in replacement therapy on pregnant women and the effects on unborn children • The medications are transmitted to the unborn child and may cause physical dependence • Abrupt withdrawal from these medications may adversely affect the unborn child • Use of medications or illicit drugs in addition to those used in replacement therapy may harm the client and unborn child • Client should consult with physician before nursing • Child may show irritability or other ill effects from the client's use of these medications for a brief period of time following birth • Acknowledgement by client of the orientation	Section 10285
Prior to the development of the client's maintenance treatment plan	There must be documentation of completion by the primary counselor and filed in chart of a needs assessments which includes • Summary of client's psychological and sociological background, including educational and vocational experience • Assessment of client's needs for: health care, employment, education, and psychosocial, vocational rehabilitation, economic, and legal services	Section 10305

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For Pregnant Client	**A**. Documentation within 14 days from the date of the primary counselor's **knowledge** that the client may be pregnant, as documented in the client's chart, the MD shall review, sign and date a confirmation of pregnancy and acceptance of medical responsibility for the client's prenatal care or verification that client is under the care of a licensed by the State of California and trained in obstetrics and/or gynecology. **B**. Documentation of completion of instruction by MD or licensed health personnel which shall include instructions on at least the following: • Nutrition and prenatal vitamins • Child pediatric care, immunizations, handling, health, and safety • If client refuses referrals or direct perinatal care/services; the MD shall document in the client's record the repeated refusals and have the client acknowledge in writing that she had refused these treatment services **C.** Documentation in chart no later than 60 days following termination as to whether continuation of maintenance treatment is appropriate • Physician must reevaluate no later than 60 days following the termination of pregnancy. Physician must document in client's chart if maintenance treatment is still appropriate.	Section 10360 Section 10270
Documentation of birth or termination of pregnancy	Documentation must be done within 14 calendar days of birth and/or termination of pregnancy; the primary counselor shall update the client's treatment plan in accordance with Section 10305 and MD will document: • Hospital's or attending physician's summary of the delivery and treatment outcome for the client and child • Evidence that a request for this information was made but no response was received	Section 10360
Initial dosing to new clients	Initial dose of medication was administered or supervised by program physician • New clients must have initial dose supervised by or administered by program physician	Section 10350 and Health and Safety Code section 11215 Good
New client dosing	Evidence that the initial dose was observed, and observation continued for a period prescribed by the MD or program physician. If the observation was delegated to a staff member, they will document the length of time new client was observed and outcome and the MD was notified for any adverse reactions • New clients must be observed for outcomes and adverse reactions, documentation must support that this has occurred and coordination with MD was done if task was delegated. Keep in mind that these requirements do not apply if client was receiving services from a different program the previous day	See initial dosage level in Section 10355 & Section 10350
Change in medication schedule	Each change in medication schedule and reason for the deviation must be recorded in chart, signed, and dated by MD or program physician	Section 10355

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Maintenance Dosage Levels Specific to Methadone	A daily dose of Methadone above 100 milligrams shall be justified by the MD or program physician Programs are to ensure that Methadone dose above 100 milligrams must be documented in the client chart and justification of the dose must be validated my MD with clear documentation	Section 10355
Review of Dosage levels	Review by MD or program physician of the client's dosage level at least every 3 months.	Section 10355
Missing dosages	If a client has missed 3 or more consecutive doses, a new medication order is documented from the MD or program physician before consultation of treatment • Best practice is to ensure MD is documenting missed doses and a new medication order for the client	Section 10355
Record keeping of medication administration	If program keeps separate record of types of medication administered or dispensed to a client on a day to day basis, the program is to transfer this data to the client's record at least monthly.	Section 10160.

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Take home medication	**A.** The program is to ensure compliance when granting take home medication procedures with the following: • The MD or program physician has determined the quantity of take-home medication dispensed to the client • The program has instructed the client on their obligation to safeguard the take-home medications • The program must also utilize containers for take-home medications doses that comply with the special packaging requirements as set forth in (Title 16, section 1700.14 Code of Federal Regulation) **B.** The MD or program physician documentation supports rationale for determining the client to be responsible for handling self-administered take home medications. The rationale is based on the following: • Absence of illicit drugs and abuse of other substances including alcohol • Regularity of program attendance and counseling services • Absence of serious behavioral problems while at the program • Absence of known criminal activity, including selling, distributing of illicit drugs • Stability of the client's home and social relationships • Length of time in maintenance therapy • Assurance that take-home medications can be safely stored within the client's home and • Whether the rehabilitative benefit to the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion **C.** For a client placed on take home medication schedule, must include documentation that the following criteria has been met: • Client is participating in gainful vocational, educational, or responsible homemaking (primary care giver, retiree with household responsibilities, or volunteer helping others) activity and the client's daily attendance and the client's daily attendance would be incompatible with such activity • Current monthly body specimen is both negative for illicit drugs and positive for the narcotic mediation administered or dispensed by program • No other evidence that the client has used illicit drugs, abused alcohol, or engaged in criminal activity (within the last 30 days for step levels I-V: within the last year for step level VI) D. A split dose shall be considered a one-day take-home supply, pursuant to Section 10375.	Section 10365 (see Section 10365 d for take home dosage container details) Section 10370 (6 levels as specified in (Section 10375) Section 10370
Step Level 1	Documentation supports that a client is given a 1-day supply of take-home medication. Documentation must support the following: •Day 1 –Day 90 of continuous treatment •A single dose per week • If determined responsible for State Holidays •Attend at least 6 times a week	Section 10370 Section 10375

Step Level 2 (II)	Documentation supports that a client is given up to 2-day supply of take-home medication. Documentation must support the following: •Day 91 –Day 180 of continuous treatment •Up to two doses a week • Plus one if a state holiday occurs •Attend at least 5 times a week	Section 10370 Section 10375
Step Level 3 (III)	Documentation supports that a client is given up to 3-day supply of take-home medication. Documentation must support the following: •Day 181 –Day 270 of continuous treatment •Up to three doses a week • Plus one if a state holiday occurs •Attend at least 4 times a week	Section 10370 Section 10375
Step Level 4 (IV)	• Documentation supports that a client is given up to 6-day supply of take-home medication. Documentation must support the following: • Day 271 –one year of continuous treatment • Up to six doses a week • Plus one if a state holiday occurs • Attend at least once a week	Section 10370 Section 10375
Step Level 5 (V)	Documentation supports that a client is given up to up to 2 week supply of take-home medication. Documentation must support the following: •After one year of continuous treatment •Up to a two-week supply • Plus one if a state holiday occurs •Attend at least twice a month	Section 10370 Section 10375
Step Level 6 (VI)	Documentation supports that a client is given up to a one-month supply of take-home medication. Documentation must support the following: •After two year of continuous treatment •Up to a one-month supply •Attend at least once a month	Section 10370 Section 10375

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Initial Treatment Plan	Within 28 calendar days after initiation of maintenance treatment the primary counselor shall develop the patient's initial maintenance treatment plan which shall include: • Short term goals from needs assessment based on intake and admission data • Long term goals tied to the client needs based on intake and admission data • Target dates – 90 days or less for the client to achieve • Tasks (action steps) – specific behavioral tasks the client must accomplish for each short- and long-term goal • Type and frequency of counseling services (minimum 50 minutes per month, unless waived by MD) (**see Section 10345 for details)** • An effective date based on the day the primary counselor signed the initial plan. • Supervision counselor reviewed and signed tx plan and needs assessment within 14 days of effective date • Medical Director reviewed and signed tx plan and needs assessment within 14 days of effective date • The effective date is based on the day the primary counselor signed the initial treatment plan. Documentation shall be individualized for each patient, no treatment plan should look alike **See diagram***	Section 10305
Updated Treatment Plan	Subsequent treatment plans are updated as necessary or **at least once every three (3) months** from date of admission and must include: • A summary of the client's progress or lack of progress toward each goal identified on the previous plan • The new goals and behavioral tasks for any newly identified needs or related changes in the type and frequency of counseling services to be provided to the client • Supervision counselor reviewed and signed tx plan within 14 days of effective date • Medical Director reviewed and signed tx plan within 14 days of effective date • The effective date is based on the day the primary counselor signed the updated treatment plan Documentation shall be individualized for each client; no treatment plan should look alike. **See diagram ***	Section 10305

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Progress Notes, Medical Psychotherapy Session and Client contact	Progress Notes: Counselor documented counseling session within 14 calendar days of session including: • Date of session • Type of counseling format (group, individual, med/psych) • Duration of session in 10 min intervals (excluding time required to document session) • Summary of session (description of service, client progress toward completion of treatment plan goals, response to a drug screening specimen, new issues or challenges that affect the client's treatment, goal and purpose of session and brief summary of client's participation • client's attendance at each service delivery – include date and duration of service • The following will not qualify as a counseling session: interactions conducted with a program staff in conjunction with dosage administration (see Section 10345 c 1-4, for details) • Medical Director must document in the treatment plan as specified in Section 10305 and in a progress note, the rationale for the medical order that adjusted or waived the counseling service Contact: The medical director may adjust or waive at any time after admission, by medical order, the minimum number of minutes of counseling services per calendar month. Medical Psychotherapy Sessions: Are defined as face-to-face discussions between the physician/medical director and client on issues identified in the treatment plan. Session should be conducted in private setting. Documentation should be based off of session on issues identified in the client's treatment plan and should be individualized and unique to client. Day 1 + 13 days for a total of 14 days.	Section 10345
Group Sessions	• Group sessions documentation will include number of clients in group: with a minimum of 4 clients and no more than 10, documentation must support a clear goal and it is a common issue identified in the treatment plan of all participating clients • Documentation of counseling session is in client record within 14 calendar days	Section 10345 B

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Temporary Services	Documentation will include: • A client's signed and dated consent for disclosing identifying information to the program which will provide the services on a temporary basis • The medication change order by the referring medical director permitting the client to receive services on a temporary basis from the other program for a length of time no to exceed 30 days and • will support that MD contacted other program, has accepted responsibility to treat the visiting patient, concurred with the dosage schedule and supervises the administration of the medication.	Section 10295 and 10210 D
Multiple Registration	If it is determined that a client has multiple registrations (simultaneously receiving replacement therapy from 1 or more other programs) documentation must include: • that it conferred with the other(s) program to see which program will accept sole responsibility • revoke the client take home medication privileges and • notify the Dept. of Narcotic Treatment Program Licensing by telephone within 72 hours of such determination. The program that agrees to accept sole responsibility will provide continued services. Documentation must include filing of the discharge summary provided by the discharging clinic If program does not keep client: • Must discharge client immediately • Document why client is discharge • Provide the new program with a discharge within 72 hours of discharge and provide written notification to Department of Narcotic Licensing within 72 hours of the discharge	Section 10225 Section 10205 (Prohibition Against Multiple Registration)

Continuing Services Justification	**A.** If a client is continued on maintenance beyond 2 years, documentation must support the circumstances as to why services will continue • Evidence must be seen that the MD or LPHA has re-evaluated client's medical necessity qualifications at least annually through the re-authorization process to determine that the OTP services are still clinically appropriate **B.** There is documentation to support that the client's status relative to continued maintenance treatment is re-evaluated at least annually after 2 years of continuous treatment Documentation must include from MD • Evaluating client's progress or lack of progress in achieving treatment goals • Determining that Discontinuing from treatment would lead to a return to opiate addiction Best practices would include detail to support decision. Program shall have documentation in place from MD to support continuing of services.	Section 10165 and Section 10410 COSD standard
Continuing Services Justification for CalOMS	CalOMS annual update is required no sooner than 10 months and no later than 12 months after the client is admitted. Must be entered into SanWITS	IA. DMC-ODS, Attachment I, III, FF, 3, i.e.

Discharge/ Treatment Termination Procedures	Discharge Summary is required for voluntary and involuntary discharge: If involuntary termination for cause, documentation must include: • Client was given explanation of when participation may be terminated for cause • Evidence that client was given notification • Evidence that client was given information on client's right to a hearing • Evidence that program had given information of the client's right to representation • Evidence that termination, either voluntary or involuntary, is individualized under the direction of the MD and takes place over a period not less than 15 days unless documents the reason the in the client chart: 1. Client requests shorter termination period in writing 2. Client is currently within a 21-day detoxification treatment episode It is important to have proper documentation for all discharges whether voluntary or involuntary. There should be enough detail for those treating to see progress or lack of progress especially if client returns to treatment later. It is important to document the difference between voluntary and involuntary discharge For clients that have terminated the program, a discharge summary and documentation of determination of success or failure of treatment.	Section 10165 Section 10415
Discharge /Patience Absence	Documentation in the record by MD for a client in **detoxification** treatment who misses appointments for 3 consecutive days or more • The client's episode of treatment may be terminated and noted in the record • If there is a legitimate reason for absence, documentation for the reasons for continued treatment shall be placed in the client's record. If a client in maintenance treatment misses more than 2 weeks or more, without notifying the program, client shall be terminated and discharged, and it shall be noted in the client's record. • If the client returns to treatment, the client shall be re-admitted as a new client and documentation for a new re-admission shall be noted in the client's chart.	Section 10300
CalOMS Discharge	CalOMS must be completed for discharge	IA, Exhibit A, Attachment 1: III, BB, 2, ii

Treatment Plan Diagram*

Regulations

Title 9, Section 10305(e): “Within 28 calendar days after initiation of maintenance treatment the primary counselor shall develop the patient's initial maintenance treatment plan…”

Title 9, Section 10305(f): “The primary counselor shall evaluate and update the patient's maintenance treatment plan whenever necessary or at least once every three months from the date of admission.”

Title 9, Section 10360(c): “Within fourteen (14) calendar days from the date the medical director confirmed the pregnancy, the primary counselor shall update the patient's treatment plan in accordance with Section 10305.”

Title 9, Section 10360(g): “Within fourteen (14) calendar days from the date of the birth and/or termination of the pregnancy, the primary counselor shall update the patient's treatment plan in accordance with Section 10305.”

- **Treatment Plan Scenario**