

Outpatient Service Log Form

Purpose

One purpose of the Daily Service Log form is to report all appointments missed and services that need to be submitted to the Iowa Department of Public Health. Its other purpose is to report billing information to the billing clerk and provide in-house statistics.

Procedure for Service Log

Each outpatient counselor will fill out a Daily Service Log for each day they work. For some outpatient staff this log is kept at a designated area of their facility and for other outpatient counselors they will keep their own log. All outpatient counselors will use this Log to record all of their services for that particular day. Call the Data Department if you are unsure of which log to fill out.

The designated staff person (or Counselor) will complete the new Log with counselor name, client names and Client ID number. It is important that the appointment book at the front desk of each facility be kept up-to-date at all times. When a counselor does this, use legible handwriting, spell client names out properly and completely (first and last), and if it is a crisis session indicate client status (admit, non-client etc.). If you have an appointment with someone other than a client, please indicate this in the appointment book.

Logs are due to the data office the following business day by noon and are to be sent via email to the Data email account (data@asac.us), with the exception of the logs kept at the front desk of the Main Office, these will be picked up by Data each morning. All original forms that are scanned to an electronic document and then emailed to the data office will be kept and given to the Data Department via supervisor weekly.

Once a form has been sent, **no** changes shall be made to the original Log. If there is a change, the counselor should send an email to the data department (data@asac.us). In this email state the date the service was on and what was changed about it. Please keep in mind that changes made to this log need to be made in a timely manner. The client billing is also done off of these logs and once a bill has been sent to some insurance companies there cannot be any changes made. This could affect the payment ASAC receives.

The Data Department will be responsible for making sure the billing clerk receives a copy of any necessary Service Logs.

PROCEDURE FOR COMPLETING SERVICE LOG

When client leaves after the appointment, complete #1 through #7.

When client misses the appointment, complete #2 and #3.

COLUMN #1

Primary Source of Payment can be left blank unless you know for sure the source of pay. All assessment appointments should be able to fill this in. Make sure you record both primary and other source of pay. (Ex: 19/11 or 11/10.) Pay codes can be found on the back of the Financial Form in the Office Use Only box.

COLUMN #2

Total Amount of Minutes for the session should be placed in this column unless the client no-showed cancelled or rescheduled (within a 24 hour period prior to the appointment), then you would use the appropriate code. Minutes are recorded in fifteen minute-increments. (15, 30, 75, etc.) Please use the following codes and definitions when a client does not come for their appointment:

No-Show (NS) - A person had an appointment and did not call or show up prior to the appointment time.

Canceled (CAN) - A person had an appointment and either they called or the counselor called prior to the appointment and no other appointment was rescheduled at that time.

Rescheduled (RS) - A person had an appointment but either they called or the counselor called prior to the appointment and rescheduled for another time.

COLUMN #3

Outpatient Service Codes - Listed below is the type of ASAC outpatient services and the definitions and codes of each. The code number for the service that was provided should be put in this column.

PLACEMENT SCREENING/EVALUATION (ASSESSMENT) --

90801- Assessment session

Definition: Involves the process of collecting and assessing information to determine the appropriateness of admitting an individual into a substance abuse program or referring on to other services. This must be done on a face-to-face contact. This service is done only when a client is on the intake/placement status.

Amount of minutes of service shall be recorded on the placement Screening/Admission form. This type of service would not be done on a client who has already had their evaluation with another substance abuse agency and this is the first time they're being seen at ASAC. An Encounter Note shall be placed in the client's ISmart file. See the 'Encounter Notes' procedure in the Notes section of your manual.

INDIVIDUAL COUNSELING --

90804- 15-30 minute individual session

90806- 45-60 minute individual session

90808- 75 + minute individual session

Definition: Involves the face-to-face contact with an individual on a one-to-one basis, which allows the individual to explore areas identified in the treatment plan related directly or indirectly to substance abuse or dependency. This service is done only on an admitted client status. An Encounter Note shall be placed in the client's ISmart file. See the 'Encounter Notes' procedure in the Notes section of your manual.

FAMILY COUNSELING --

90846- Family Session (Without client present.)

90847- Family Session (With client present.)

Definition: Involves the face-to-face contact with a concerned person or one or more family members of a substance abuser (who is an admitted client to ASAC), to explore areas identified in the treatment plan related directly or indirectly to an individual who is a substance abuser or chemically dependent. The substance abuser may or may not be present. An Encounter Note shall be placed in the client's ISmart file. See the 'Encounter Notes' procedure in the Notes section of your manual.

CRISIS INTERVENTION -- Can be for clients on intake OR admitted status

90801/C Crisis on intake status, can be any amount of minutes

90804/C- 15-30 minute session

90806/C- 45-60 minute session

90808/C- 75+ minute session

Column#7 if this was a phone crisis then you must record "Phone" in this column.

Definition: Includes responding to a crisis situation resulting from substance abuse or necessary for the maintenance of the recovery process. Telephone contacts are acceptable. An Encounter Note shall be placed in the client's ISmart file. See the 'Encounter Notes' procedure in the Notes section of your manual.

COLUMN #4

Client Status

The counselor would put the appropriate client status in the column using the abbreviations below:

INT -Placement Screen/Evaluation Status

INT-2 -Placement Screen/Evaluation Status
AD -Admitted Client Status

Intake/Placement Screening Status - a person may receive intake/placement screening or crisis services.

Admission Status -- the person may receive individual, family or crisis services. The client can receive group services too, but those would be recorded on a Group Roster. See the 'Group Roster Procedure' of the Notes section of your manual on how to fill those services out.

Intake/Placement Screening Status-2 – If a client has already had an assessment, but no recommendation was made due to certain circumstances, then a follow up evaluation might be necessary.

COLUMN #5

Client Facility: see the backside of the Outpatient Service Log for a list of facility codes.

COLUMN #6

Client Environment should be coded with the client's current level of care. For Assessment/Placement Screening services, these will always be recorded as 19 for type of environment.

18 = Continuing Care
20 = Intensive OP

19 =Extended Outpatient

COLUMN #7

Billing Information:

Primary Diagnosis Code-the primary diagnosis for client's who are seen for an assessment or intake needs to be recorded. This only needs to be filled out on the client one time and needs to be done the first time they are seen. The primary diagnosis code should be the same that was listed in the Diagnosis screen in the client's ISmart case. For more information on Diagnosis codes, please see Appendix A of the manual.

Alcohol Dependence	303.90	Hallucinogens Dependence	304.50
Alcohol Abuse	305.00	Hallucinogens Abuse	305.30
Amphetamine Dependence	304.40	Inhalants Dependence	304.60
Amphetamine Abuse	305.70	Inhalants Abuse	305.90
Cannabis Dependence	304.30	Opioids Dependence	304.00
Cannabis Abuse	305.20	Opioids Abuse	305.50
Cocaine Dependence	304.20	Cocaine Abuse	305.60
Sedatives Etc, Dependence	304.10	Phencyclidine Abuse	305.90
Sedatives Etc., Abuse	305.40	Phencyclidine Dependence	304.90
Other/Unknown Dependence	304.90	Polysubstance Abuse	NONE
Other/Unknown Abuse	305.90	Polysubstance Dependence	304.80

Family Codes-

CO - You have met with a client one-on-one without the family present, but have talked about family issues. Or you are a family therapist and the client has been referred by their primary counselor and met with the client one-on-one.

SO - You have met with the client's significant other(s) without the client present.

FA - You have met with the client and significant other(s).

JMRT Client's - record "JMRT" for those clients.

Crisis Codes – If you are doing a crisis session on a client and it was conducted over the telephone then you will need to write "Phone" in this column.