RECORDS MANAGEMENT

AND

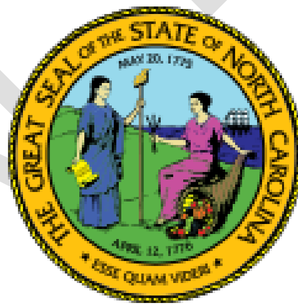
DOCUMENTATION MANUAL

For

Providers of Publicly-Funded Mental Health, Intellectual or Developmental Disabilities, and Substance Use Services

and

Local Management Entities-Managed Care Organizations



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North Carolina

Department of Health and Human Services

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

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Preface

Revisions to the Records Management and Documentation Manual [RM&DM]

This is the third major revision to the Records Management and Documentation Manual [RM&DM] since its original publication in November 2007. Since that time, there have been many changes in the Mental Health/Intellectual or Developmental Disabilities/Substance Use [MH/DD/SU] service system, some of which have had a direct impact on how records are managed and how services are documented in the service record. Along with these changes there have also been efforts toward greater uniformity in recordkeeping practices across North Carolina to assure that all relevant clinical information is captured and appropriately documented in the service record.

Recent advancement toward the use of electronic records as an integral part of a record management system has become more prevalent among service providers and more efficacious in practice. This shift from paper records to electronic records will facilitate the interoperability of systems, from the local provider's record management system to the larger service delivery system, resulting in improved care coordination across the continuum of services as the needs of the individuals we serve change.

Unimpeded by these recent changes, the guidance we provide to the service delivery system continues to stand on the sound principles of Continuous Quality Improvement [CQI]. When these principles are embraced, the results produce increased professionalism and responsibility at every level. The information contained in the RM&DM should reflect the various efforts to incorporate these principles as they relate to documentation and putting them into practice. The implementation of new initiatives and improvements to the system fit well into CQI endeavors. Consistent review and adjustment of processes through CQI can be challenging, and guidance documents need to reflect important changes. As a result, this manual has been revised to serve as an ongoing mechanism through which providers can access current and accurate information in order to ensure that the appropriate levels of documentation and accountability have been met.

A major initiative within our service delivery system has been the development and implementation of a system for Local Management Entities [LMEs] to operate a Medicaid managed care program as a Managed Care Organization [MCO] for mental health, intellectual and developmental disabilities, and substance use services within their catchment area under a Medicaid waiver. Through extensive planning and preparation for statewide expansion in the replication of an existing Medicaid 1915(b)/(c) waiver implemented in 2005, the LMEs have consolidated and become LME-MCOs under this model. Medicaid funds are now allocated to each LME-MCO, and the LME-MCO is responsible for managing the behavioral health services within their catchment area. The primary goals are for each LME-MCO to improve service access, to improve the quality of care, to ensure that services are managed and delivered within a quality management framework, to empower individuals and families to shape the system through their choices of services and providers, and to empower the LME-MCOs to build partnerships with individuals, providers, and community stakeholders to create a more responsive system of community care.

The current revisions to this manual reflect many of the recent policy changes, as well as various clarifications throughout the manual in response to questions or comments from the field. Some of the revisions to this edition of the RM&DM include the following:

- The elimination of the *Standardized Consumer STR Interview and Registration Form* and the *LME Consumer Admission and Discharge Form*;
- An expanded section of the Consumer Data Warehouse [CDW] reporting requirements;
- The elimination of the Introductory Person-Centered Plan [PCP] and the implementation of an updated PCP format;
- The basic requirements for a service plan when a Person-Centered plan is not required;
- Additional documentation guidance related to discharge planning;
- Updated information on service notes;
- Additional information about signatures;

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- Removal of requirements specific to CAP-MR/DD, now NC Innovations;
- Updates for Respite, Opioid Treatment, Psychosocial Rehabilitation [PSR], and other specific services;
- A renaming of some chapters; and
- An updated appendix.

The guidelines and requirements outlined in this manual reflect current policy unless superseded by subsequent changes in Division of Mental Health, Developmental Disabilities, and Substance Abuse Services [DMH/DD/SAS] or Division of Medical Assistance [DMA] policies, requirements in the specific service definitions, Joint Communication Bulletins, other related Department of Health and Human Services [DHHS] policies, procedures, rules, or North Carolina General Statutes. While every effort has been made to keep this manual current to reflect ongoing policy and procedural changes, providers are responsible for keeping abreast of all rules, policy changes, and other communications to the provider network and stakeholders through regular reference to the DMH/DD/SAS and DMA web sites.

Scope

The requirements and guidelines addressed in this manual have incorporated Medicaid standards, DMH/DD/SAS rules, policies, and procedures, as well as other applicable regulations, such as HIPAA, UETA, etc. in an effort to move toward greater uniformity in recordkeeping. The standards identified in this manual apply to mental health, intellectual or developmental disabilities, or substance use services provided by an individual practitioner or agency that is:

- A Local Management Entity [LME] and behavioral health Managed Care Organization [MCO], also referred to as a 1915 (b)/(c) Medicaid waiver entity, along with the providers within its network[*];
- A provider of services under the North Carolina Innovations waiver[†]; or
- A provider of state-funded services through a contract with a Local Management Entity.

In addition, some of the requirements in this manual also are applicable to certain court-ordered, private-pay services, such as:

- Driving While Impaired [DWI] services;
- Alcohol and Drug Education Traffic School [ADETS] services; and
- Drug Education School [DES] services.

The documentation and records management requirements outlined in this manual do not apply to behavioral health service providers/organizations who are licensed as:

- Inpatient hospital providers;
- State-operated facilities; or
- Intermediate care facilities.

There are additional rules and policy manuals that address certain requirements that are beyond the scope of this manual, the focus of which is primarily on records management and documentation. Providers are responsible for following the requirements in all policies that govern the services they provide. Some of these requirements can be found in DMA's Clinical Coverage Policies, DMH/DD/SAS service definitions, all applicable rules [including Core Rules: 10A NCAC 27G .0100-.7101], statutes, and other standards.

[*] For purposes of this manual, any future reference to a behavioral managed care organization, a 1915 (b)/(c) waiver entity managed by an LME, or to an LME, will simply be referred to as an LME-MCO.

[†] While the records management requirements and general documentation guidance in this manual apply to providers of the North Carolina Innovations waiver [formerly known as CAP-MR/DD services], the documentation requirements which are specific to the waiver services are now outlined in DMA Clinical Coverage Policy 8P. As a result, much of the detail addressing the CAP-MR/DD documentation requirements in this manual has been removed. Innovations waiver providers should consult Clinical Coverage Policy 8P for any documentation standards that are unique to those services.

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How to Use This Manual

The RM&DM has been designed to be a single stand-alone guidance document, embedded with electronic links throughout, to connect the user to pertinent source documents that provide more background and detail on certain topics or requirements.

This manual reflects current policy by outlining required and recommended procedures regarding service record management, maintenance, and documentation requirements. When used as an online reference, the search function can be used to facilitate successful navigation through the manual to find specific topics of interest [e.g., record retention]. This feature will be especially helpful to the new provider.

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Chapter 1: General Records Administration and Reporting Requirements

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THE VALUE OF RECORDKEEPING

Recordkeeping is a fundamental and necessary component of any business, public or private, and careful, accurate record keeping is critical to business success. An agency that has staff persons who embrace and promote good record-keeping practices will go far in documenting clinical assessment, treatment, and outcomes, ensuring accountability, and reducing legal and other risks. It is crucial that agency leaders and supervisors demonstrate a commitment to vigilance in record-keeping practices and to elicit the same commitment from all of their employees.

Record-keeping requirements have increased significantly in recent years. This is especially true in the areas of administration, reporting, and service provision as a result of the increased complexity of the MH/IDD/SU service system and the growing emphasis on accountability.

Diligent record-keeping practices for documenting service provision during the course of treatment are vital for practitioners in the human services field. Recordkeeping serves as a formal and systematic accounting of an individual’s need for services and creates a written record which demonstrates over time how the provider has responded to those needs through service delivery. The service record holds vital information that contributes to service planning and establishing goals for the individual. Careful and accurate documentation in the service record also describes the individual’s response to the planned treatment provided over time, and assists the individual and the provider in measuring progress toward goals and assessing the effectiveness of the planned course of treatment on an ongoing basis.

While the predominant focus of this manual is to address the documentation requirements of the clinical service record, there is a broader set of requirements that goes beyond the clinical service record. Providers must understand that these broader requirements are necessary because they undergird the service delivery system. These administrative and reporting requirements are mandatory and must be in place in order to ensure compliance with all the applicable rules, regulations, policies, and standards of care. Providers are responsible for implementing and maintaining a well-managed record-keeping and reporting system within their agencies in order to verify compliance and to demonstrate the organizational integrity of their agencies. In addition, records must be made available for monitoring and auditing purposes to demonstrate documentary evidence of accountability for all services rendered. The intent of this chapter is to outline the basic administrative and reporting requirements that are to be followed.

ADMINISTRATIVE REQUIREMENTS

Along with the requirements for documenting treatment and service delivery in the clinical service record, there are administrative requirements for maintaining and managing other types of mental health, intellectual or developmental disabilities, or substance use records. These requirements include personnel record, an index of individuals served, the assignment of a unique identifier (if the LME-MCO-issued service record number is not being utilized), and compliance with policies governing the retention and destruction of records. It is the responsibility of the agency to determine which number format the agency will use. The agency should create policy and procedure for the assignment of unique identifiers for their service recipients. For LME-MCOs, this includes the establishment of an administrative record for every individual who is receiving services. Providers must also maintain all the appropriate business records for their agency, such as financial, reimbursement/claims

processing, and operational records; however, a discussion of those types of records is beyond the scope of this manual.

Personnel Records

Community service providers must maintain personnel records that identify and verify the required education, licensure, credentials, and other qualifications of staff performing the service. This includes evidence of any required criminal background checks and criminal record disclosures as applicable per rule, statute, and/or Medicaid waiver, and evidence that sanctions from professional boards and/or health care registry have been reviewed when applicable. Personnel records also include transcripts, position descriptions, records of continuing education, in-service training, clinical or administrative supervision, and documentation of supervision plans and activities when supervision is required. These records must be retained according to the records retention schedule outlined in the *Records Retention and Disposition Schedule – DMH/DD/SAS Local Management Entity (LME)* division publication, APSM 10-6 and the *Records Retention and Disposition Schedule – DMH/DD/SAS Provider Agency* division publication, APSM 10-5, addressed later in this chapter and must be made available to auditors and other reviewers upon request.

Indices and Registers

The following indices and registers shall be permanently maintained manually or electronically to facilitate the identification and the retrieval of individual service records upon request:

- Master Index – This index is a file of all persons served.
- Service Record Number Control Register – Whether it is the service record number assigned by the LME-MCO, or the unique identifier generated by the provider, any individual admitted shall retain the same number on subsequent admissions.
- Staff Signature File – This is an inventory of the signatures of each person who is authorized to enter information in the service record.

Record Retention and Disposition

Each entity, including the LME-MCO and service providers, owns the records that they generate, and bears an inherent responsibility for the maintenance and retention of those records at their own expense and in accordance with all applicable federal and state requirements, including the DHHS Record Retention Policy.

LME-MCO Responsibility

The "Record Retention" section of the performance contract between DHHS and each LME-MCO outlines the dual responsibilities of the LME-MCO in terms of record retention, disposition, and protections. First, the LME-MCO has responsibility for its own records and is subject to the requirements of APSM 10-6. In order to protect documents and public records that may be involved in DHHS litigation, the Department shall notify the LME-MCO when documents may be destroyed, disposed of, or otherwise purged through the biannual Records Retention and Disposition Memorandum from the DHHS Controller's Office.

In addition, the LME-MCO shall facilitate and monitor provider compliance with all applicable requirements of record retention and disposition. This includes the implementation of the proper protections and safeguards for records [security, privacy, and storage] for the duration of the record retention period, including monitoring, to assure that when a provider goes out of business, they have arranged for their records to be stored in an environment that ensures continued preservation and safeguarding, and that the provider has submitted to the LME-MCO a copy of their record storage log with documentation that outlines where the records are stored, the designated custodian, and contact information. LME-MCOs should use the information discussed below about funding source requirements to give providers guidance regarding the retention and disposition of their records. When funding for individuals includes a combination of local, state, or federal funds, the longest applicable retention period must be applied.

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Provider Responsibility

Service provider agencies are legally and ethically responsible for fulfilling the record retention and disposition requirements for all the records generated within their agency, in accordance with the APSM 10-5. Record retention is addressed in the provider contract with the LME-MCO, and providers must manage their records in accordance with their contract and all other applicable statutes, rules and requirements, including those discussed in this manual.

When an individual changes providers, relevant clinical and person-specific information should be copied and sent to the new provider in order to avoid disruption in the continuity of care. The current provider should have the appropriate written consent of the individual when such consent is required before releasing those records. For additional details on releasing person-specific information, see Chapter 11 – "Accessing and Disclosing Information". Custody of the original record generated by the provider shall be retained by the provider agency.

In the event that a provider agency ends services in a given region, or dissolves for any reason, the provider is required to arrange to continue the safeguarding of both the clinical and fiscal records per the record retention guidelines described in this chapter. At a minimum, safeguarding includes making certain that records are stored in an environment that ensures the preservation, as well as the protection, of the privacy, security, and confidentiality, of the records. These obligations are binding and extend beyond the period that a provider agency is enrolled as a mental health, intellectual or developmental disabilities, or substance use service provider, or is under contract with the LME-MCO or the state for service delivery. In addition, provider agencies may not "transfer" or "sell" a service record to another provider agency for any reason. The original record must be appropriately retained by the agency that generated the record.

The following provider agency safeguards and record maintenance/retention/disposition responsibilities are inherent in the discipline and practice of service provision to individuals with mental health, intellectual or developmental disabilities, or substance use disorders. These responsibilities are required whenever an agency provides these services in North Carolina:

- The original record, in its entirety, always stays with the agency that created the record, provided the service, and billed for the service. The original service record is not transferable.
- All records and documents that support service provision must be properly safeguarded and maintained for the duration of the retention period. These include service records, billing and reimbursement records, and personnel records.
- All records subject to audit, state or federal review or litigation shall be made available promptly to the appropriate party upon request. These records must be retained for the specific time period as defined in the retention schedule upon the completion and resolution of the audit, review, or litigation.
- Providers shall make provisions for individuals and legally responsible persons to access and authorize the release of information contained in their records until the close of the record retention period.
- Whenever an individual transfers from one provider agency to another, the original provider who holds the original record has responsibility to send copies of pertinent information to the new provider in a timely fashion. Providers may not "transfer" an original service record to another provider.

When a provider agency decides to close their North Carolina operations, the provider must notify each LME-MCO the agency has/had contracted with and has provided/billed for services, of their decision to close. The agency must develop a record retention and disposition plan that encompasses the transfer of all their records to the respective LME-MCO. For paper records, the provider shall compile a record storage log, identifying all individuals served by the agency according to their county of eligibility. All service records, according to the agency's Master Index, must be accounted for and listed in the record storage log. The record storage log must list every individual served, the dates of service, and in which box each record is stored.

Providers shall then submit to the records officer at the appropriate LME-MCO(s) the original record storage log and all the necessary information that outlines how the records will be transferred to the respective LME-MCO. A sample record storage log form can be found in the appendix and on the DMH/DD/SAS web site on the Records Management page.

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- When a provider agency decides to close, all current and former service recipients shall be informed how to access their records before the agency closes.
- When there is a request for the release of information needed from a provider agency that is no longer in business by an individual, his or her legally responsible person, subpoena, court order, or other agency, the LME-MCO records officer should be contacted to facilitate the request, utilizing the information contained in the provider's record storage log.
- When a provider agency sells or transfers ownership of their agency to another owner, the purchase or transfer of the agency may not include the transfer of service records of the original business. In these cases, the original service records are to be transferred to the LME-MCO.

The abandonment of records, or any failure of the provider to safeguard the privacy, security, retention, and disposition of records, is a violation of state and federal laws, and is subject to legal sanctions and penalties. The LME-MCO must take appropriate action upon notification of any situation where records have been abandoned exposed, or susceptible to a privacy or security breach. After an investigation by the LME-MCO has determined that a violation of health information/privacy/security rights has occurred, a formal complaint shall be filed with the Office of Civil Rights [OCR] as mandated by 45 CFR Part 160, Part 162 and Part 164 [HIPAA Privacy and Security Rule] and by Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 [ARRA], P.L. 111-5 of the Health Information Technology for Economic and Clinical Health Act [HITECH Act]. When an LME-MCO discovers that a provider has abandoned their records, the LME-MCO shall take possession of the abandoned records and notify the relevant national accrediting organization and all DHHS state agencies involved with the associated provider, including, but not limited to, DMA, DMH/DD/SAS, and the Division of Health Services Regulation [DHSR], in addition to the federal reporting noted above.

When the LME-MCO accepts custody of abandoned records, they assume responsibility for the continued protection and accessibility of the record per HIPAA regulations and other requirements outlined in this manual. Such records shall be made available to individuals receiving services to facilitate continuity of care. In those cases where such a record is subpoenaed and/or court-ordered, the LME-MCO may provide an uncertified copy of the record. The LME-MCO cannot certify that any of the records were maintained in the normal course of business without defacement, tampering or alteration prior to receipt. Such an attestation can only be made by the provider whose responsibility and liability for the records continues after the dissolution of the business per the applicable sections of the DHHS Provider Administrative Participation Agreement.

The only exception to the guidance about the transfer of custody of records when a provider goes out of business is as follows: If a service record was classified as an historic record [i.e., the original service record was created by an Area Program when the Area Program was still a service provider, prior to the system transformation to managed care] and was "transferred" to the provider, as was the practice in some situations, upon provider agency dissolution, the provider must return the historic record to the LME-MCO that encompasses the Area Program that created the record.

<u>Records Management Requirements</u>

The original service record remains the property and responsibility of the provider and shall not be relinquished to another provider or disposed of outside the parameters of record retention requirements. This section outlines the retention and disposition requirements of the two schedules, along with the Medicaid record retention requirements, and discusses how the guidelines apply in certain situations. The references cited must be consulted directly when determining the disposition of specific records. When making such determinations, community provider agencies and LME-MCOs should remember two fundamental principles and standards that apply across the board to record retention:

- All records must be retained if there is a reason to believe that they may be subject to an audit, investigation, or litigation.
- When records are subject to two or more sets of standards, records management must follow the strictest standard.

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For the purposes of record retention, service records are viewed as having two distinct components: the clinical record and the financial record, the latter of which contains financial, billing, and reimbursement information for the services provided. [For the purposes of this manual, "reimbursement information" includes any administrative records that document that the staff providing billed services held the proper credentials.]

The records retention and disposition requirements for publicly-funded MH/IDD/SU services are specific to a specific entity or type of funding. There are three schedules which address the retention and disposition requirements for publicly-funded mental health, intellectual or developmental disabilities, or substance use services:

- *Records Retention and Disposition Schedule – DMH/DD/SAS Local Management Entity (LME)*, APSM 10-6
- *Records Retention and Disposition Schedule – DMH/DD/SAS Provider Agency*, APSM 10-5
- *DHHS Records Retention and Disposition Schedule for Grants*

LME-MCOs and community providers are subject to the applicable standards outlined in all three schedules. Entities should refer to the appropriate schedule to determine the specific retention standards for the type record of interest. There are occasions when more than one schedule pertains to a given record. When that occurs, the more stringent retention period must be applied.

Records Retention and Disposition Schedules for LME-MCOs and Provider Agencies

LME-MCOs and providers of services as specified in this manual shall comply with the *Records Retention and Disposition Schedule – LME* (APSM 10-6, revised October 26, 2011), and the *Records Retention and Disposition Schedule – Provider Agency* (APSM 10-5, revised October 26, 2011). The links to those documents are in the previous section.

These schedules determine the procedures for the management, retention, and destruction of records by the LME-MCOs, and service provider agencies. General principles and procedures related to records retention are outlined in this document. Specific guidance in the following areas is also provided:

- Electronic storage
- Electronic medical records
- Administrative and management records
- Budget and fiscal records
- Service records
- Disaster assistance
- Legal records
- Machine readable public records
- Microfilm
- Imaging systems
- Office administration records
- Personnel records
- Public relations records
- Student records

DHHS Records Retention and Disposition Schedule for Grants

The *DHHS Records Retention and Disposition Schedule for Grants* from the Office of the Controller incorporates records management requirements for federal funds disbursed by the Department. This schedule establishes the earliest date by which the records from a federally-funded program may be destroyed, including the Medicaid program and Medicaid administration. Retention timeframes are based on when a record was created or when services were provided.

This schedule applies to all records supporting the expenditure of specific federal funding. All financial and programmatic records, supporting documents, statistical records, and all other records pertinent to a federal

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award must be retained in accordance with this schedule. This schedule applies to all state and local government agencies, nongovernmental entities and their subrecipients [i.e., LME-MCOs and providers], including applicable vendors that administer programs funded by federal sources passed through DHHS.

The *DHHS Records Retention and Disposition Schedule for Grants* is published by the DHHS Office of the Controller on a semiannual basis. At a minimum, LMEs and providers shall maintain all grant records in accordance with the schedule after the grant closes and a final expenditure report has been approved, provided there are no unresolved audit findings, pending litigation, claims, investigations, or other official actions involving the records. If the final expenditure report is amended, or if any of the above actions take place during the ensuing timeframe, the retention period starts again. The DHHS Office of the Controller notifies DMH/DD/SAS when applicable records have met their retention period. DMH/DD/SAS, in turn, notifies the LME-MCO, who then notifies applicable providers and/or vendors when specific retention timeframes have been met.

The *DHHS Records Retention and Disposition Schedule for Grants* and its related documents [a memorandum and a background document] are found on the DHHS Office of the Controller's website at the previously given link. When records are subject to two or more set of standards, those records must be retained for the longest period identified.

Destruction of Records Not Listed in a Schedule

Authorization from DMH/DD/SAS and the Division of Archives and Records shall be secured for destruction of records not listed in a schedule. To obtain authorization for disposal, a "Request for Disposal of Unscheduled Records" form must be completed, which can be found in APSM 10-5. The DMH/DD/SAS records officer should be contacted for guidance.

THE LME-MCO ADMINISTRATIVE RECORD FOR INDIVIDUALS SEEKING OR RECEIVING SERVICES

Many of the documents regarding service delivery that are maintained by the LME-MCO are administrative in nature. The LME-MCO must implement an administrative record for each individual receiving services, using the individual's name and assigned record number. The format for the administrative record is not prescriptive. However, the content of the LME-MCO administrative record shall include the documents used when the LME-MCO performs functions related to a specific individual. For example, the following documents, when they are utilized, shall be kept in the administrative record: registration documents, indication of choice of service provider(s), referral information, Consumer Data Warehouse [CDW] information, registration/admission forms, Person-Centered Plans [PCPs] or service plans, authorizations, care coordination documents, System of Care [SOC] documents, hospital liaison documentation, release of information forms, etc. The LME-MCO administrative record for individuals receiving services shall be retained until notified by the Department that such records may be destroyed.

TRANSFER OF RECORDS WHEN AN LME-MCO DISSOLVES OR MERGES

When an LME-MCO dissolves, the successor organization is obligated to assume responsibility for the records of the dissolved LME-MCO for the duration of the retention schedule for those records per the APSM 10-6. This includes service records, administrative records, and other records covered by the retention schedule. The successor LME-MCO has the option of scanning the records and disposing of the paper copies, or securing storage space and retaining the records in storage environment conducive to the proper maintenance of paper records. These records may be disposed of when the retention period in the appropriate schedule has been met. Records that have met the retention schedule requirements shall be destroyed if these records are not subject to audit, investigation, or litigation.

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There is a straight line of custody for permanent records. 42 CFR 2.19 indicates that when a program dissolves or is taken over by another, and there is a legal requirement to hold records past the time of the discontinuation of the program, the new program takes over custody of the records.

The transfer of substance use records is protected by 42 CFR Part 2. In order to ensure the security and privacy of these records, any substance use records that are transferred need to be put in sealed envelopes. The envelopes shall be labeled, "Records of [insert name of program] required to be maintained under GS 121 and the *Records Retention and Disposition Schedule DMH/DD/SAS Local Management Entity (LME) [APSM 10-6]* until a date not later than [insert appropriate date]."

It is recommended that written permission be obtained from the individuals to transfer their records. When this is not possible, 45 CFR Part 164 provides for the transfer of the records without written permission or authorization by the individual because of the LME-MCO's responsibility for facilitating continuity of care and the oversight of the mental health, intellectual or developmental disabilities, or substance use services in the community.

ADMINISTRATIVE STAFF SIGNATURE FILE

It is recommended that all agencies maintain an administrative signature file for all staff who have signatory authority within the agency. Such a file provides validation of each staff person's authentic signature used in conducting business on behalf of the agency. This includes finance office staff, reimbursement staff, contract staff, and executive staff.

Establishing and maintaining a signature file for staff entering information in the clinical record is required. Specific instructions for this can be found in Chapter 8 – "General Documentation Procedures". All staff signatures may be kept in a single file rather than separating out administrative staff from the staff who are authorized to make entries in the service record.

DATA REPORTING REQUIREMENTS

As a function of the contractual relationship of the service provider with the LME-MCO, certain information is submitted by the provider to the LME-MCO. It is vital that service providers understand and fulfill their responsibility in submitting all pertinent information to the LME-MCO about each individual's entry into, progress within, and exit from the MH/DD/SU service system. Providers are responsible for ensuring the accuracy of the information they enter into NCTracks and into the LME-MCO's Management Information System [MIS]. This includes claims submissions and information about program participants as well as updates in the system when there are changes in the participant's status (e.g., diagnosis, living situation). The provider also has the responsibility to notify the LME-MCO of any changes or updates made.

In conjunction with service delivery, providers are required to submit certain statistical data and information on outcomes and perceptions of care as required by DHHS, the General Assembly, and federal block grants. These reports provide the primary method for collecting information necessary for accountability, quality improvement, and local outcomes management for individuals receiving mental health, intellectual or developmental disabilities, or substance use services in the publicly-funded system. It is required that these reports be submitted to the designated entities and include, but shall not be limited to, CDW, NC-TOPPS, reporting to the Medicaid authorization agency [LME-MCO], and Incident and Death Reporting, as detailed below.

Documentation and Coordination of Standardized Processes for Screening, Triage, and Referral, Registration, Admission, and Discharge

Consistent with the principle of "no wrong door" for service access, individuals may enter the service system by calling or visiting the LME-MCO's access unit, or they may initiate services through direct contact with a community provider agency. Although there are different access points, in keeping with the "uniform portal" requirement, all individuals shall receive a standardized interview at intake. Information regarding individuals and

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their entry into the service system shall be electronically submitted to the LME-MCO via the LME-MCO's Management Information System (MIS). Any electronic transmittal shall conform to HIPAA standards for electronic healthcare transactions, and conform to a uniform format specified by the Division, including required encryption for secure transmission of data.

Consumer Data Warehouse Reporting by LME-MCOs

The Consumer Data Warehouse [CDW] is a data repository that contains demographic, clinical, outcomes, and satisfaction data regarding individuals receiving mental health, intellectual or developmental disabilities, or substance use services. The data stored in the CDW is used for the planning and evaluation of services. The CDW is also the main source of information regarding block grant programs, and is used to fulfill legislative requests.

Information regarding service recipients is gathered from providers through methods that include, but are not limited to, the screening, registration, and admission processes described in the previous section. Data shall be reported by the LMEs to the DMH/DD/SAS as specified in the *Division of MH/DD/SA Services Consumer Data Warehouse/LME Reporting Requirements* publication. As noted in the reporting requirements document, the *Consumer Data Warehouse Data Dictionary* is a guide to the technical aspects of the data. Please refer to the Reporting Requirements publication as the correct source of requirement information. The dictionary is for reference only.

When CDW Enrollment is Required

A demographic record provides descriptive admission information about the individuals who are receiving services. CDW enrollment is required:

- For all individuals who are admitted, served, or discharged within an episode of care that is directly or indirectly purchased, procured, supported, or assisted through state funds or federal block grants in public or private facilities where such funds are allocated or administered by DMH/DD/SAS;
- For all individuals who are supported through Medicaid, Health Choice, and other federal or state funds, or funds expended under a 1915(b) and/or 1915(c) Medicaid waiver or other capitated plan, and who are receiving one or more of the following services:
    1. *Enhanced Mental Health and Substance Abuse Services [Enhanced Benefit Services]: DMA Clinical Coverage Policy 8A*, or
    2. *Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders: DMA Clinical Coverage Policy 8-O*, or
    3. *Psychiatric Residential Treatment Facilities [PRTF] Services: DMA Clinical Coverage Policy 8-D-1*, or
    4. *Residential Treatment Services: DMA Clinical Coverage Policy 8-D-2*, or
    5. *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID): DMA Clinical Coverage Policy 8E*, or
    6. *North Carolina Innovations: DMA Clinical Coverage Policy 8P*, or
    7. Current state-defined and state-funded MH/IDD/SU services as listed on the DMH/DD/SAS Service Definitions web page, found here, and
- For all services that involve LME-MCO or provider coordination of care with the Division of State Operated Healthcare Facilities [DSOHF].

The listing above includes the following categories of individuals who are served or coordinated through an LME-MCO:

- Individuals who are supported through an LME-MCO and are provided services directly or through contracted services, DMH/DD/SAS regular funding, single-stream funding, waiver entity, or other specialized funding, and for which claims are submitted through NCTracks, accounted for through Financial Status Reports [FSRs], supported through Non-UCR (Unit Cost Reimbursement) or settlement mechanisms, or other forms of reimbursement, financial assistance, purchase of service, or procurement;
- Individuals who are supported through NC Innovations funding, or those supported through community ICF-IID Program funding;

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- Individuals who are admitted to and discharged from DSOHF facilities, including State Hospitals, Alcohol and Drug Abuse Treatment Centers [ADATCs], Developmental Centers, and other state-operated facilities for which the LME-MCO has care coordination responsibilities;
- Individuals admitted to and discharged from local community hospital inpatient units (including Three-Way Contracts) and hospital emergency departments for behavioral health services, walk-in crisis services, psychiatric aftercare, mobile crisis management teams, facility-based crisis centers, detoxification facilities, START Teams, and crisis respite for which the LME-MCO has consumer care coordination responsibilities;
- Individuals who are admitted to and discharged from jails, detention centers, prisons, and other correctional facilities, and Division of Juvenile Justice [DJJ] facilities, including Detention Centers and Youth Developmental Centers, and for whom the LME-MCO has care coordination responsibilities;
- Individuals served through specialized DMH/DD/SAS resources, such as Traumatic Brain Injury [TBI] funds, Deaf and Hard of Hearing funds, and Homeless funds;
- Individuals served through the DMH/DD/SAS Treatment Accountability for Safer Communities [TASC] Program and the Juvenile Justice SA/MH Partnership Initiative [JJSAMHP, formerly MAJORS Program];
- Individuals served through approved DMH/DD/SAS Alternative Services;
- Individuals served through DMH/DD/SAS Cross Area Service Programs [CASPs]; and
- Individuals who are served in licensed Opioid Treatment Programs [OTPs] with services that are funded through Medicaid or other public funds.

LME-MCOs may also require CDW enrollment for other individuals whose services or supports are funded with other federal, state, regional, county, or local funds, or an admission for an episode of care for any individual for whom the LME-MCO has responsibility for services, authorization, care coordination, monitoring, or funding.

A demographic record is sent to the CDW when any of the following occurs:
- An individual becomes a service recipient [initial episode of care];
- New data is collected;
- The existing demographic information is modified;
- An admission is deleted.

An Episode Completion [Discharge] Record is sent to the CDW when an individual completes an episode of care [is discharged] during the reporting period. A discharge occurs after 60 consecutive uninterrupted days when there is no billable service for the individual to NCTracks or Medicaid.

When CDW Enrollment is not Required

CDW enrollment for an individual's admission through the LME-MCO is not required for the following categories:
- Individuals served only in non-DMH/DD/SAS, non-DMA, and non-DSOHF federal, state, regional entity, county or local government-funded or supported services, except for those listed above in the required categories of admission;
- Individuals receiving services supported through Medicaid, Health Choice, and other federal or state funds, or funds expended under a 1915(b) and/or 1915(c) waiver or other capitated plan and who are not receiving one or more of the services listed in the previous section under numbers 1-7;
- Individuals receiving non-enhanced services by licensed professionals who are directly enrolled as a Medicaid provider or when Health Choice, Medicare, Tricare, or another third party payer is billed for the service received;
- Individuals served only through Employee Assistance Program [EAP] services that are directed at individuals who do not require treatment for substance use. Such programs are aimed at educating and counseling individuals on substance use providing for designated non-treatment activities to reduce the risk of substance use;
- Recipients of DMH/DD/SAS Driving While Impaired [DWI], Alcohol and Drug Education Traffic School [ADETS], and Drug Education School [DES] services only, that are exclusively privately supported, covered by private insurance, or self-pay;
- Individuals or family members served only through the DMH/DD/SAS-funded Problem Gambling Program;

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- Individuals or family members served only in DMH/DD/SAS-supported HIV Early Intervention Services [EIS];
- Individuals served only in private licensed opioid treatment program services and that are privately supported, covered by private insurance, or self-pay;
- Individuals served indirectly through consultative services only to other providers or caregivers, such as DMH/DD/SAS Geriatric/Adult Specialty Teams [GAST], also known as Gero Teams;
- Individuals served only through arrangements for the delivery of services within other host agencies such as local school districts, local health departments, and primary care physician practices;
- Individuals served only through privately-supported sources, covered by private insurance, or self-pay;
- Individuals served only through substance use, mental health, or intellectual or developmental disabilities primary prevention, education, and training sources; and
- Individuals supported only through non-governmental, foundation, business, religious, charitable, fraternal, or other private groups and organization through grants, donations, and other forms of funding or resources.

North Carolina Treatment Outcomes and Program Performance System [NC-TOPPS]

NC-TOPPS is the program by which DMH/DD/SAS measures clinical outcomes and performance. It captures key information on an individual's current episode of treatment, aids the provider in the evaluation of active treatment services, provides data for meeting federal performance and outcome measures, and supports LME-MCOs in their responsibility for monitoring treatment services.

Responsibility for completing NC-TOPPS interviews lies with the individual's primary provider agency. This is the agency that provides a qualifying mental health and/or substance use service to the individual and provides case management functions [i.e., the agency usually responsible for developing and implementing the individual's Person-Centered Plan or service/treatment plan]. The NC-TOPPS service codes for qualifying services to individuals with mental health and/or substance use issues can be found in Appendix A of the *NC-TOPPS Implementation Guidelines*.

NC-TOPPS is administered in a face-to-face interview as a regular part of developing and updating an individual's PCP and providing services. The Qualified Professional [QP] in the provider agency is the person responsible for ensuring that NC-TOPPS interviews are completed. Having the consumer present for an in-person interview is expected. If the consumer declines or cannot participate in an interview, it is the responsibility of the QP to complete the interview(s) by gathering the information through direct observations, collateral contacts, clinical records, and notes. NC-TOPPS uses four different interview forms for data collection: Initial, Update, Episode Completion, and Recovery Follow-up. The forms are specific to child, adolescent, or adult, and are printable to be completed in locations without internet access for later online submission. The Initial Interview is completed when an individual begins services. The Update Interview is completed at scheduled intervals [three (3) months, six (6) months, 12 months, and every six (6) months thereafter]. The Episode Completion Interview is completed when the individual:

- Has successfully completed treatment;
- Has been discharged at program initiative;
- Has declined treatment;
- Has a lapse in services of more than sixty (60) days;
- Has changed to services that do not require the completion of NC-TOPPS;
- Has moved out of the area or to a different LME-MCO catchment area;
- Has been incarcerated or institutionalized; or
- Has died.

NOTE: It is important to note that when question #30 ("Is the individual present for an in-person or telephone interview or have you directly gathered information from the individual within the past two weeks?") is answered "no", valuable information about the individual and their treatment experience will not be gathered, such as medical check-ups, risky sexual behavior, living situation, and suicidal thoughts/attempts. Therefore, face-to-face interviews are preferred.

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For more detailed information, please see the NC-TOPPS support materials by clicking here. Access the web portal for NC-TOPPS by clicking here.

Incident and Death Reporting Documentation

Service providers shall comply with the Death Reporting Requirements specified in 10A NCAC 27G .0201(a)(7)(G), Incident Response, Reporting, and Documentation requirements specified in 10A NCAC 27G .0601, Restrictive Intervention documentation specified in 10A NCAC 27E .0104(e)(9), and Clients Rights rules as specified in *Client Rights Rules in Community Mental Health, Developmental Disabilities, and Substance Abuse Services*, APSM 95-2, and General Statute.

Reports of incidents, including the use of restrictive interventions and deaths, shall be submitted as required above through the web-based North Carolina Incident Response Improvement System [NC-IRIS]. Quarterly incident reports shall be submitted using the standardized QM11 form and procedures as required by the Secretary of DHHS and the LME-MCO monitoring the facility/agency/recipient. The incident submission site for NC-IRIS is found at https://iris.dhhs.state.nc.us/. The Incident Response and Reporting Manual, the IRIS Technical Manual, as well as required forms and other information, are available electronically in the Forms section by clicking the above link.

Each provider shall develop an administrative system for maintaining information on incidents. Please note that the occurrence of an incident shall be recorded in the service notes. However, the completed incident report shall not be referenced or filed in the service record, but filed in the administrative files.

Service End-Date Reporting to LME-MCOs

For Medicaid and state-funded mental health, intellectual or developmental disabilities, and substance use services, providers are required to notify the LME-MCO responsible for conducting the utilization review and service authorization whenever an individual changes providers or ends a service that the LME-MCO has authorized. Providers have responsibility not only in obtaining authorizations, but also in canceling them [end-date reporting] when an individual has elected to receive the same service from a new provider, or if the individual or provider terminates treatment prior to the end of the authorization period. This is especially important because of the LME-MCO oversight and care coordination responsibilities for the people receiving services in their catchment area. Providers should follow the reporting requirements and protocol specified by the LME-MCO for end-dating services. End-date reporting is service-specific and may occur at any time throughout the course of treatment. When a service is authorized, it covers a specific period of time. The end-date is the last date service is provided for which a reimbursement claim can be submitted.

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Chapter 2: The Clinical Service Record

The clinical service record, also known as the medical record, or service record, is the official document that reflects all the clinical aspects of service delivery. This chapter addresses some of the basic requirements of a service record. Subsequent chapters in this manual address more detailed requirements, such as those outlined in Chapter 4 – "Person-Centered Planning", Chapter 7 – "Service Notes", or Chapter 8 – "General Documentation Procedures".

PURPOSE OF A SERVICE RECORD

The service record is the only written evidence of the quality of care delivered by an agency to an individual. The service record is the legal business record for an agency providing mental health, intellectual or developmental disabilities, or substance use services, and it must be maintained in a manner that follows all applicable regulations, accreditation standards, professional practice standards, and legal standards. It is used to coordinate services and communicate important information to other providers. The individual's service record helps to ensure that his or her needs are being met, and that care is coordinated among providers. In the movement toward integrated care, it is vital for providers to recognize the need for real collaboration in the best interest of the individual, and the service record plays an important role in the facilitation of communication among providers in fostering continuity of care.

Each service record must demonstrate evidence of a documented account of all service provision to an individual, including pertinent facts, findings, and observations about an individual's course of treatment/habilitation and the individual's treatment/habilitation history. The service record provides chronological documentation of the care that the individual has received and is an essential element in reflecting and demonstrating a high standard of care.

A service record may be paper-based or computer-based. A computer-based service record, or an electronic record, is a digitized version of a paper record that resides in a system specifically designed to support authorized users by providing accessibility to complete and accurate data, clinical support systems, and links to medical knowledge. In addition to these resources, electronic record systems track data over time and provide alerts, reminders, and other aids. A record is not considered computer-based if it is only stored electronically in a computer as a word-processing file and not as a part of an electronic database.

THE IMPORTANCE OF CLINICAL DOCUMENTATION

Rigorous documentation standards are necessary in assuring that all pertinent information is contained in the service record and that the information entered in the service record is clear, concise, and correct. Clinical documentation includes mental health, intellectual or developmental disabilities, and substance use services in our service delivery system. Complete and accurate documentation is vital for the continuity of optimum, high quality care. Practitioners must be complete and consistent in their approach to record documentation, and include in the record everything that is significant to the individual's condition. By following these standards, the practitioner can ensure that the documentation entered in the record:

- Serves as a basis for planning services and supports and ensuring continuity in the evaluation of the individual's condition, current status, and treatment;
- Provides a record and full accounting of the provision and continuity of services;

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- Furnishes documentary evidence about the individual's evaluation, treatment and supports, change in condition during the treatment encounter, as well as during follow-up care and services that ultimately should enhance the individual's quality of life;
- Provides a mechanism for communication among all providers contributing to the individual's care;
- Provides essential information that is used in examining and reviewing the quality of services provided and in promoting recommended or evidence-based services;
- Substantiates treatment and services for the reimbursement of services provided;
- Documents involvement of the individual to whom the service plan belongs and, when appropriate, the involvement of family members in the individual's treatment/services/supports;
- Assists in protecting the legal interests of the individual, the facility or provider agency, and the individual practitioner;
- Promotes compliance with existing rules, regulations, and service delivery requirements;
- Provides data for research; and
- Provides data for use in internal training, continuing education, quality assurance, utilization review, and quality improvement.

TYPES OF CLINICAL SERVICE RECORDS

There are three distinct types of clinical service records: pending records, modified records, and full clinical service records. All service records, however, are subject to the full protections, privacy, and safeguarding practices that are outlined in the remainder of this chapter, as well as the record retention time periods indicated in the retention schedules and requirements addressed in the previous chapter. For the purposes of this manual, each term will be defined in the next three sections.

Pending Records

For some services, especially at the point of service entry, the initial documentation is typically maintained in a pending record. As the term implies, a pending record is one that has the potential to become a full service record once it is determined that the individual meets the requirements that call for the establishment of a full service record. Usually, a pending record is created when an individual presents for screening for possible services, or when there is insufficient, partial, or incomplete information available, and a full service record cannot be established. A pending record may be used when there may have been some intervention, such as an initial screening, but the individual is not subsequently enrolled in active mental health, intellectual or developmental disabilities, and substance use services.

Documentation in a pending record should reflect the service provided. Services that are typically documented in a pending record include:

- Relevant screening information, unless or until a subsequent full clinical service record is opened; and
- Court-ordered consultation and/or evaluations that do not result in a subsequent MH/IDD/SU service.

Modified Records

A modified record is a clinical service record which has requirements that are either different from those usually associated with a full clinical service record, or one which contains only certain components of a full service record. The use of modified records is limited to specific services that have been approved by DMH/DD/SAS, and only if there are no other services being provided. When an individual receives additional services, then a full service record shall be opened, using the same record number, and the modified service record documentation shall be merged into the full service record. Chapter 10 references the specific services that can utilize a modified record, as well as the documentation requirements for such.

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Full Clinical Service Records

A full clinical service record is one that is used to document the provision of the majority of the mental health, intellectual or developmental disabilities, and substance use services discussed in this manual and contains all the elements inherent in a complete clinical service record. All services, unless otherwise specified, must be documented in a full clinical service record.

Contents of a Full Clinical Service Record

All information developed or received by the provider agency about the individual during the course of treatment should be included in the service record. Information needed for reimbursement purposes may at times be filed in the clinical service record, but this is not required as long as the reimbursement records are maintained in a consistent format and safeguarded under all the appropriate protections and regulations. Providers must properly record and retain billing and reimbursement records and related information according to the specific requirements of the payers involved.

The clinical service record shall include the following information or items when applicable, as well as any other relevant information that would contribute to or address the quality of care for the individual:

- Consents
  - Written consent for the provider to provide treatment
  - Informed written consent or agreement for proposed treatment and plan development – required on the individual's PCP or service plan, or a written statement by the provider stating why such consent could not be obtained [10A NCAC 27G .0205(d)(6)]
  - Informed written consent for planned use of restrictive intervention [10A NCAC 27D .0303(b)]
  - Written consent granting permission to seek emergency care from a hospital or physician
  - Informed written consent for participation in research projects
  - Written consent to release information [10A NCAC 26B .0202 and .0203]
- Demographic Information / In Case of Emergency / Advance Directives
  - Individual's name [must be on all pages in the service record that were generated by the agency]
  - Service record number, with Medicaid Identification Number, and/or unique identifier when applicable, if a provider chooses to use its own number or coding system, which will crosswalk those they provide service to with his/her identity
  - Demographic information entered on a service record face sheet, including, but not limited to, the individual's full name [first, middle, last, maiden], contact information, service record number/unique identifier, date of birth, race, gender, marital status, admission date, and discharged date when services end
  - Emergency information, which shall include the name, address, and telephone number of the person to be contacted in case of sudden illness or accident; the name, address, and telephone number of the individual's preferred physician; and hospital preference
  - Advance directives
  - Health history, risk factors
  - Documentation of history of mental illness, intellectual or developmental disability, or substance use disorder, according to the DSM-5 or any subsequent edition, and the ICD-10-CM or any subsequent edition
  - Documentation of medication allergies, other known allergies, and adverse reactions, as well as the absence of known allergies
- Notification of Rights
  - Evidence of a written summary of the individual's rights given to the individual/legally responsible person, according to 10A NCAC 27D .0201, and as specified in G. S. § 122C, Article 3
  - Documentation that the individual's rights were explained to the individual/legally responsible person

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- Restrictive Interventions
  - Written notifications, consents, approvals, and other documentation requirements per 10A NCAC 27E .0104 (e)(9) whenever a restrictive intervention is used as a planned intervention
  - Inclusion of any planned restrictive interventions in the individual's service plan according to 10A NCAC 27E .0104(f), whenever used
  - Documentation in the service record that meets the specific requirements of 10A NCAC 27E .0104 (g)(2) and 10A NCAC 27E .0104(g)(6) when a planned restrictive intervention is used, including:
    - Documentation of rights restrictions [10A NCAC 27E .0104(e)(15), per G.S. § 122C-62(e)], and
    - Documentation of use of protective devices [10A NCAC 27E .0104(G) and 10A NCAC 27E .0105]
- Screening, Assessments, Eligibility, Admission Assessments, Clinical Evaluations
  - Clinical level of functioning measurement tools
  - Screening, which shall include documentation of an assessment of the individual's presenting problems/needs, and disposition, including recommendations and referrals
  - Documentation of strategies used to address the individual's presenting problem, if a service is provided prior to the establishment of a plan [10A NCAC 27G .0205(b)]
  - Admission/eligibility assessments and other clinical evaluations, completed according to the governing body policy and prior to the delivery of services, with the following minimum requirements:
    - Reason for admission, presenting problem
    - Description of the needs, strengths, and preferences of the individual
    - Diagnosis based on current assessment and according to the DSM-5 or any subsequent edition of this reference material published by the American Psychiatric Association; the DSM-5 diagnoses should always be recorded by name in the service record in addition to listing the code
    - Social, family, medical history
    - Evaluations or assessments, such as psychiatric, substance use, medical, vocational, etc., as appropriate to the needs of the individual
    - Mental status, as appropriate
    - Recommendations
- Medications and Lab Documents
  - Documentation of medications, dosages, medication administration, medication errors, and a Medication Administration Record [MAR], per 10A NCAC 27G .0209
  - Medication orders
  - When applicable, orders for, and copies of, lab tests
- Treatment Team / Service Coordination
  - Identification of other team members
  - Documentation of coordination with the rest of the individual's team
  - Treatment decision-making process, including thought processes and the issues considered
- Service Plan‡
  - PCP [must include Medicaid ID number for Medicaid-eligible individuals]
  - Service plan / treatment plan / individual support plan when a PCP is not required
  - Service order by one of the approved signatories, when required; [For all behavioral health services covered by Medicaid that require an order, and for all state-funded services where a service order is recommended or required, the service order is indicated by the appropriate professional's signature entered on the PCP.] If a format other than the PCP's format is used, then a separate service order is required for services that require an order unless the format used provides for service orders to be signed on the service plan.

‡ When medication management is the only service being provided, a service plan is not required.

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- Service Authorizations
    - Authorization requests
    - As applicable: reauthorization requests, denial appeals, service end-date reporting
- Discharge Information
    - Discharge plans
    - Discharge summaries
- Referral Information, sent or received
- Service Notes or Grids: signed by the person who provided the service, which include interventions, treatment, effectiveness, progress toward goals, service coordination and other case management activities, and for entering other important information
- Incidents: Documentation of incidents, including description of the event, action taken on behalf of the individual, and the individual's condition following the event [NOTE: Completed incident reports are to be filed separately from the service record.]
- Release/Disclosure of Information
    - Documentation of written notice given to the individual/legally responsible person upon admission that disclosure may be made of pertinent confidential information without his or her expressed consent, in accordance with G. S. § 122C-52 through 122C-56;
    - Log of releases and disclosures of confidential information.
- Legal Information: Copies of any relevant legal papers, such as guardianship/legally responsible person designation
- Other Correspondence: Incoming and outgoing correspondence, including copies of all letters relating to services provided that do not fit into the other mentioned categories

ELECTRONIC MEDICAL RECORDS

An electronic medical record, or EMR, is a digital version of a person's paper record. The EMR is an electronic system that contains the medical and treatment information on individuals seen by the provider. For the most part, electronic medical records lack interoperability [i.e., they do not interface with other information systems]. EMRs have limited functionality outside of the agency or practice setting. For example, when the information in the EMR needs to be sent to the LME-MCO for utilization review, pertinent information may need to be printed and then faxed or mailed to the requesting party, using HIPAA-compliant methods of transmission.

ELECTRONIC HEALTH RECORDS

Some providers have moved from the use of paper records or electronic medical records to a bona fide electronic health record. An EHR is distinguished from a paper or EMR in that the EHR focuses on the total care of an individual's treatment across all the providers involved in the person's care, e.g., pharmacists, laboratories, and specialists. The EHR improves care coordination and efficiency while at the same time maintaining privacy and security across all providers. The individual in treatment also has access to his or her EHR.

EHRs facilitate the sharing of information across authorized providers in real time. The Centers for Medicaid and Medicare Services [CMS], and the Office of the National Coordinator for Health Information Technology [ONC] have established standards for certifying bona fide EHR systems. ONC maintains a list of EHR technology products that have been tested and met their standards, which can be accessed by clicking here.

MH/IDD/SU SERVICE ARRAY AND DOCUMENTATION REQUIREMENTS

Many service definitions contain documentation requirements that are specific to those services. For this reason, each service definition should always be consulted to ensure compliance with the documentation requirements that may be specific to that definition. If no specific documentation requirements are provided in the definition, follow the documentation requirements in Chapter 7 of this manual.

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A complete listing of the service array for mental health, intellectual or developmental disabilities, or substance use services is posted on the DMH/DD/SAS web site on the NCTracks page, found here. Detailed information regarding the requirements for the array of state-funded and Medicaid-funded mental health, intellectual or developmental disabilities, or substance use services are contained in the service definitions. The service definitions for state-funded services are located here. Medicaid-billable service definitions can be found in the clinical coverage policies published by DMA.

Forms and Formats

In general, the elements for documenting a particular service are defined by the type of service being provided [i.e., periodic, day/night, twenty-four hour], or within the service definition itself. While in most cases, there are no specific formats for documentation, there are some standard forms for certain activities [e.g., the *Person-Centered Plan* forms, and the *Comprehensive Crisis Prevention & Intervention Plan*]. In addition to the standardized forms, Appendix B includes an assortment of sample forms that may be used as a guide or prototype for meeting the service documentation requirements.

There are other forms that are administrative in nature that are required in certain situations, such as the *Incident and Death Reporting* forms. When these are addressed throughout this manual, a link is provided to facilitate access to such forms. Other required forms, such as programmatic and fiscal reporting forms, etc., are beyond the scope of this manual.

CLOSURE OF CLINICAL RECORDS

An open clinical service record is any record where there is some degree of expectation that the individual is currently receiving, or may be returning to, active treatment. The clinical service record should be considered closed in the case of death of an individual. Closure should also be considered for individuals who have permanently moved out of state.

There is no state requirement that stipulates when or under what conditions a clinical service record must be closed or terminated. Closure of the service record is not the same as discharge reporting to the Consumer Data Warehouse. An individual's service record may remain open even though an individual may have stopped receiving services; however, discharge reporting must be sent to the LME-MCO for updates in the CDW whenever the individual completes an episode of care.

The Division of MH/DD/SA Services recognizes the need to separate clinical service record requirements from statistical reporting requirements. For individuals who will likely return for services at some point, providers and LME-MCOs may prefer to leave the service record open. DMH/DD/SAS, on the other hand, needs detailed information about service completion to be able to respond to the federal requirements for the National Outcome Measurement System [NOMS], which tracks an individual's outcomes from the beginning to the end of each service provided.

For the last few years, CDW has not required that the service record be closed; CDW only requires that the LME-MCO terminate or discharge the individual from CDW after 60 consecutive days of no billable services and report this to the data system. Therefore, an individual discharged from CDW may still have an open clinical service record.

When an individual returns for services after being discharged from CDW, a new admission must be sent to the LME-MCO for CDW reporting. Although the individual's service record may have been kept "open", because this is considered a "new admission", there are certain procedures that must accompany the process, which includes updating demographic and contact information, any expired consents, notices, etc. There are other requirements associated with new admissions that may not apply if the individual's service record has not been closed. A new admission assessment is not required; however, a note in the service record that summarizes the presenting problems and reason(s) for re-admission, clearly indicating the circumstances surrounding the return for services, is required in lieu of an admission assessment. Additionally, new consent forms and release of information forms,

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client rights, and privacy notices are not required unless they have expired in the current service record. If the individual's PCP [or other service plan, as applicable] has not expired, a new plan is not required, but the current plan must be updated and revised according to the individual's current needs.

Decisions related to the circumstances under which the closure of an individual's clinical service record is required are determined locally by the service provider agency or by the LME-MCO. When a clinical service record is terminated or closed, all the treatment documents contained in the closed record, including Person-Centered [or other] Plans, are also considered closed. If an individual returns to resume services and his or her service record has been closed, he or she should be re-admitted, and a new Person-Centered Plan / service plan should be developed. Along with this process, the re-admission information, as a new episode of care, would also be reported to the LME-MCO to meet the statistical reporting requirements of CDW.

Administrative Closure of Clinical Service Records

Administrative closure of a service record is completed when an assigned clinician has left the employ of an agency without completing discharge documentation when closure of the service record is warranted. In these situations, the supervisor of the former clinician has the responsibility for processing the discharge, including discharge reporting to CDW [Episode Completion (Discharge) Record]. A discharge summary or a discharge note shall be completed by the clinician's supervisor, stating that the service record is being administratively closed because the individual is no longer in need of services or has declined continuing services, and the assigned clinician is no longer with the agency to complete the discharge process. The supervisor authenticates the closure of the record with a dated signature denoting that he or she was the supervisor for the former assigned clinician, John Doe, MA/QP, who is no longer with the agency. Each record being administratively closed should also be audited internally to ensure that all services that were billed were properly documented. If the audit reveals that the documentation requirements were not met, then all services billed without the proper documentation are to be adjusted back to the payer.

PRIVACY AND SECURITY OF SERVICE RECORDS

Providers must adhere to all federal and state laws, rules, regulations, and policies that protect and ensure the confidentiality, privacy, and security of service records. Where there are multiple sources of requirements, it is the provider's responsibility to follow the most stringent requirements, including the code of ethics of professional licensure. It is the provider's responsibility to stay abreast of all such laws, rules, regulations, policies, and procedures in order to fully protect the privacy and confidentiality rights of the individual. For further guidance regarding the release of confidential information, please see Chapter 11 – "Accessing and Disclosing Information".

Providers shall develop policies and procedures to ensure the privacy and security of service records. Such policies and procedures should address various aspects of health information management, including, but not limited to, how information will be recorded, stored, retrieved, and disseminated, as well as how such information will be protected against loss, theft, destruction, unauthorized access [breach], and natural disasters. Prior to the development of these policies and procedures, it is recommended that a risk assessment be done to judge the vulnerability of the environment in which the records are stored. The ensuing policies and procedures shall identify the safeguards that have been implemented to mitigate any potential loss or compromise of the integrity of pertinent clinical, service and non-clinical information [e.g., financial data and personnel records] necessary to document and support service delivery.

All agencies subject to the Health Insurance Portability and Accountability Act [HIPAA] regulations are responsible for developing policies and procedures to comply with the Omnibus HIPAA final rule. These regulations are designed to improve the efficiency and effectiveness of the healthcare system by standardizing the interchange of electronic data for specified administrative and financial transactions and implementing provisions from the HITECH and ARRA Acts. For additional information about HIPAA, please see the North Carolina Department of Health and Human Services [DHHS] HIPAA web site.

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Safeguards

Provider agencies must assure that each record is logged and accounted for according to the agency's Master Index each time a record is opened. Policies and procedures regarding the following assurances shall be developed:

- Provider agencies shall ensure the safeguarding of service records against loss, tampering, defacement, use or disclosure by unauthorized persons, and shall ensure that service records are readily accessible to authorized users at all times.
- If confidential information is stored in portable computers, the provider agency shall develop a policy that assures the protection of such information. Recommended areas that the policy should address are as follows:
    - Loaning and using portable computers;
    - Purging confidential data from returned computer prior to assigning the same computer to the next user;
    - Avoiding the maintenance of confidential information on portable computers by storing such on the facility network so that the information can be backed up and maintained more securely [If network storage is not possible, maintaining the information on encrypted storage devices such as flash drives and transporting separately from the computer case is required.];
    - Encrypting the information that is stored on a portable device, as well as password protecting the device.
- If the faxing of confidential information is allowed, the provider agency's policies and procedures must reflect how the information being faxed will be protected. At a minimum, the policy shall include procedures that are required if confidential information is to be faxed, including annually verifying the fax number with the receiving party and checking to ensure that the fax was received.
- If email is used to communicate confidential information, a policy regarding how the information will be secured and protected shall be developed by the agency. Unless the provider agency has the capability to encrypt email, the emailing of confidential information shall be the least preferred method of transmitting information and be used only when the information is password protected as outlined below. In this situation, the USPS or courier is the preferred method for sending confidential information. If the confidential information needs to be sent immediately, facsimile is the second preferred method. If facsimile is unavailable or the document is too large to be faxed, email may be used to transmit the confidential information. If the information is stored in a file that is password protected, such as a Word or Excel document with a password attached, and no Protected Health Information [PHI] or personally identifying information is included in the body or subject line of the email, nor the password. The individual should contact the recipient via telephone to give them the password for the document. Again, the practice of communicating PHI in a password-protected file via unencrypted email is only to be followed as a last resort.

If an electronic medical record is utilized, the following policies, at a minimum, shall be developed:

- A policy which defines the classifications of information [data sets] to which different users may have access; and
- A policy that specifies, based on the minimum necessary principles defined in the HIPAA regulations, that only authorized users whose defined role/responsibility allows access to service recipient information may access the record. The policy shall identify measures such as passwords, audit trails [a detailed record of who viewed, modified, entered, or deleted data, and when, etc.], to help ensure that only identified users have access to the minimum amount of service recipient information necessary to complete their job function.

Confidentiality

In addition to the HIPAA regulations, confidential information shall also be protected as follows:

- Information in service records for individuals who receive mental health and/or intellectual and developmental disabilities services shall be disseminated in accordance with G.S. § 122C-51 through

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122C-56 and the Confidentiality Rules, codified in 10A NCAC 26B [Division publication APSM 45-1, updated 1/1/05].

- Information in service records for those individuals who receive substance use services shall be disseminated in accordance with 42 CFR, Part 2 – "Confidentiality of Alcohol and Drug Abuse Patient Records" and must not be disclosed except as permitted by that regulation.
- Information relative to individuals with AIDS or related conditions shall only be disclosed in accordance with the communicable disease laws as specified in G.S. § 130A-143.
- Secondary records, which contain information wherein a specific individual or individuals can be personally identified, shall be protected with the same diligence as the original service record.

Transporting Records

Service records shall only be transported by individuals designated by the agency. When original service records are removed from the facility premises, efforts shall be made to ensure that the records are packaged safely and securely. When service records are transported by motor vehicle, they shall be secured in a locked compartment [e.g., locked car, locked trunk, or locked briefcase]. Policies and procedures relative to transporting records shall be developed by the provider agency. Procedures should include detailed instructions as to what the individual must do in the event that confidential information is lost or stolen. In situations where the facility determines it is not feasible or practical to copy the service record or portions thereof, a service record may be securely transported to a local health care provider, provided the record remains in the custody of a delegated employee.

Storage and Maintenance of Service Records

Service records shall be stored and maintained in a manner consistent with the principles and rules of privacy and security outlined above. Providers must implement systematic processes in order to fulfill the previously stated guidelines. Electronic records pose challenges unique to the medium. The *North Carolina Guidelines for Managing Public Records Produced by Information Technology Systems*, developed by the Government Records Section [part of the Division of Archives and Records, NC Department of Natural and Cultural Resources], contains guidelines regarding the development and monitoring of electronic records. All entities that maintain electronic records should conduct a self-warranty process and develop an electronic records policy. The link to Government Records Section information about electronic record maintenance can be accessed here.

The United States Department of Health and Human Services has a wealth of information about the HIPAA Privacy and Security rules. This site provides an introduction to organizational security issues and guidance regarding standards for administrative safeguards, physical safeguards, technical safeguards, and organizational policies. There is also information regarding risk analysis and risk management.

In general terms, the proper handling of medical records, as well as other protected health information, is facilitated by a process including the following activities on the part of the provider:

- Assessing current security, risks, and gaps;
- Developing an implementation plan;
- Implementing solutions;
- Documenting solutions; and
- Reassessing periodically.

Providers must be prepared for the policies and procedures they have developed to be reviewed by various oversight agencies (DMH/DD/SAS, LME-MCOs).

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DOCUMENTING CLINICAL EVALUATIONS AND ASSESSMENTS

All clinical evaluations and assessments, including re-assessments, require a written report, completed and signed by the person who conducted the assessment. When more than one clinician participates in completing an assessment or evaluation, then the signature of each clinician is required on the report, unless stated otherwise in the particular service definition. Each report should be easily identifiable as such and readily accessible in the service record, and not embedded in service notes. When available, relevant information from previous assessments may be used by the licensed clinician when conducting an assessment or re-assessment; the final written report must also document the individual's presenting mental status, current clinical and service needs, conclusions, and recommendations for service/treatment.

SERVICE ACCESS FOR INDIVIDUALS ENTERING THE SERVICE SYSTEM

The Screening/Triage/Referral [STR] process, which operates continuously on a 24/7/365 basis by an LME-MCO, is the starting point for individuals with mental health, intellectual or developmental disabilities, or substance use issues to access needed services. The STR process is completed by a Licensed Professional [LP], or a Qualified Professional [QP] who is supervised by an LP. Using the limited information obtained during the STR process and based on the best professional estimation of the most appropriate service for the individual at that time, the next step is to provide or arrange for a comprehensive clinical assessment. A comprehensive clinical assessment is a term used to represent an umbrella of assessments and evaluations to administer based on the presenting needs of the individual. The required elements of a CCA are described in greater detail further along in this chapter.

Prior to the completion of the CCA or the development of the Person-Centered Plan (or service plan), providers typically spend a certain amount of time collecting and sorting through important information about the individual. All events, observations, and pre-treatment activities [including STR, information gathering, and informal assessments occurring prior to the completion of the CCA], contribute to the development of an early clinical picture of the individual's presenting problems and possible service needs. The information gathered during these initial contacts is used to assist in determining an individual's approximate level of care and in formulating early clinical impressions, which are important in the beginning stages of service planning. All of these initial activities and assessments require documentation in the individual's service record, and relevant information should be used in conjunction with the Comprehensive Clinical Assessment and in the development of the PCP or service plan. From the outset, documentation in the service record of important information obtained from the contacts, events, and activities that occur when an individual initiates services is required, regardless of whether or not they may be billable to a third party payer.

Based on information gathered when completing the STR process, individuals may be referred to a provider of outpatient behavioral health services for a comprehensive clinical assessment, to outpatient treatment services, or a combination of the two.

THE COMPREHENSIVE CLINICAL ASSESSMENT

A comprehensive clinical assessment is a clinical evaluation performed by a Licensed Professional, or Associate Level Licensed Professional, who has the appropriate credentials and meets the requirements identified in the

specific assessment used. The purpose of a CCA is to provide the necessary and relevant clinical data and recommendations that are analyzed, synthesized, and carefully deliberated when developing the PCP or service plan with the individual. The Comprehensive Clinical Assessment is essential to the person-centered planning process. Upon completion of the CCA, when services other than outpatient treatment / medication management only are recommended, the clinician should work directly with the QP responsible for the development and implementation of the PCP / service plan for identifying goals and needed services, utilizing natural supports, and planning crisis prevention activities.

The CCA is the foundation upon which the service plan is developed. A CCA is required prior to service delivery except when there is a current CCA on file and there has not been a substantive change in the person's condition since the last CCA was completed or in situations when this prerequisite would impede access to crisis or other emergency services. In the event of an additional CCA being billed within a short time period (less than a year), the provider shall clearly identify the reason for the re-evaluation. For adolescent mental health residential services, a full or updated CCA is required to be completed less than 30 calendar days from the requested authorization start date.

A CCA is not a service definition, and therefore does not have a billing code specifically for comprehensive clinical assessments. A service order, additionally, is not needed in order to conduct a CCA. The following is a partial listing of some of the more frequently used procedure codes that are employed for billing a CCA:

- Diagnostic Assessment – T1023 [must meet the specific requirements of the service definition]
- Clinical Evaluation/Intake – 90791, 90791GT
- Interactive Evaluation – 90792, 90792GT
- Interactive Evaluation with Complexity – 90785, 90785GT
- Evaluation & Management [E/M codes]

Basic Required Elements of a Comprehensive Clinical Assessment

The CCA is a face-to-face evaluation and must include the following elements:

- A description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;
- A chronological general health and behavioral history (including both mental health and substance abuse) of the individual's symptoms, treatment, and treatment response;
- Current medications (for both physical and psychiatric treatment);
- A review of biological, psychological, familial, social, developmental, and environmental dimensions to identify strengths, needs, and risks in each area;
- Evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;
- Analysis and interpretation of the assessment information with an appropriate case formulation;
- Diagnoses from the DSM-5 [or any subsequent editions], including mental health, substance use disorders, and/or intellectual/developmental disabilities, as well as physical health conditions and functional impairment; and
- Recommendations for additional assessments, services, support, or treatment based on the results of the CCA.

The CCA must be signed and dated by the Licensed Professional completing the assessment. For state-funded services for individuals with substance-related issues, the ASAM criteria is to be included. For all state-funded services, a recommendation regarding benefit plan eligibility is to be included as well.

A person's status at intake may suggest that the individual has previously been in treatment. Service providers should work together to facilitate the individual's access to service. Relevant clinical information provided by other service providers is important and should be copied and sent to the new provider in a timely manner [with the appropriate consent] to ensure optimum continuity of care. HIPAA regulations do not require a written release to disclose information if the purpose of the disclosure is to facilitate the individual's access to treatment or to avert a serious health/safety threat. According to the federal substance use confidentiality law [42 CFR], obtaining written consent for disclosure of information is not required for individuals with substance use issues in

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cases of medical emergencies; otherwise, written consent must be obtained and kept in the individual's service record.

In cases of emergency (Psychotherapy for Crisis), during the first six (6) outpatient therapy sessions delivered by providers of integrated medical and behavioral health services, or when medical providers are billing E/M codes for medication management, the following domains must be included in the health record until a CCA is completed:

- Presenting problem(s);
- Needs and strengths;
- A provisional or admitting diagnosis, with an established diagnosis within 30 days;
- A pertinent social, familial, and medical history; and
- Other evaluations or assessments as appropriate.

Age- and Disability-Specific Guidelines for the Comprehensive Clinical Assessment

Services for Children and Youth

For children and youth and their families, the comprehensive clinical assessment should:

- Address the prior existence and work of the Child and Family Team, when applicable.
- Recommend to members of the Child and Family Team that the family and Qualified Professional will convene if the family is new to services, or if the child is being referred to an enhanced service.
- Assess the strengths of the child or youth and family members, preferably utilizing a strengths-based assessment tool.
- Utilize information such as reports from previous psychological testing and/or Individual Education Plans [IEPs], if available.

Adult Mental Health Services

For all adults with a diagnosis of a mental illness, the assessment should identify the clinical services appropriate to treat the diagnosed condition. The assessment should address life domains including: mental health symptoms, onset and history; mental health treatment history; substance use history and treatment history (if applicable); physical health history and current diagnoses; employment/education history and current pursuits; trauma history; cultural/religious/spiritual considerations; family/social system involvement; and hobbies and other special interests. Strengths and needs in these domains should be clearly identified and support the referral to appropriate clinical services, and the development of a Person-Centered Plan. The assessment should incorporate principles of psychoeducation, wellness and recovery, and empowerment in developing a collaborative partnership with the individual during the diagnostic process. The assessment should also identify whether there is a need for additional evaluations, such as psychological testing, psychiatric evaluation, medication evaluation, or additional assessments to identify potential co-occurring diagnoses.

Intellectual or Developmental Disabilities Services

In many cases, persons with intellectual or developmental disabilities have multiple disabilities and present with complex profiles that necessitate a more comprehensive approach in addressing their needs. Since intellectual or developmental disabilities are life-long conditions, the focus of the comprehensive clinical assessment is on identifying the person's current functioning status and identifying the supports needed to help the person achieve and maintain maximum independence. Such an approach often requires a variety of clinical assessments [e.g., intellectual assessment, psychiatric assessment, assessment of the individual's current level of adaptive functioning, physical examination, educational/vocational assessment, PT/OT evaluations]. The North Carolina Support Needs Assessment Profile [NC-SNAP] and the Supports Intensity Scale® [SIS] are two tools used to assess the level of services and supports needed by an individual based on their level of functioning. A person with an intellectual or developmental disability may require periodic re-assessments to determine ongoing needs.

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Substance Use Services

The information gathered in the CCA should be utilized to determine the appropriate level of care using the American Society of Addiction Medicine [ASAM] criteria as a clinical guide. The CCA should be consistent with the requirements of the Diagnostic Assessment service for Medicaid-funded substance use services. The ASAM criteria must be included in the disposition of the comprehensive clinical assessment for state-funded services, as substance use-related service authorizations are determined in part by the ASAM level criteria.

Other Instruments Used to Complete the Comprehensive Clinical Assessment, per Service

Detoxification Services

Detoxification rating scale tables, e.g., Clinical Institute Withdrawal Assessment – Alcohol, Revised [CIWA-AR], and flow sheets, which include tabulation of vital signs, are to be used as needed. See Chapter 9 – "Special Service-Specific Documentation Requirements and Provisions" for other requirements related to detoxification services.

Driving While Impaired [DWI] Services

The selection of instruments used in assessing DWI offenders is limited to the approved list maintained by DHHS. The assessment documentation includes a standardized test, a clinical face-to-face interview, a review of the individual's complete driving history from the Division of Motor Vehicles, Blood Alcohol Content [BAC] verification, diagnosis according to the DSM-5 or any subsequent edition, American Society for Addiction Medicine Criteria review, consent for release of information, notification of provider choice, recommendations and requirements for driver's license reinstatement, and assessment data completed on DMH Form 508-R. For additional guidance, please see Chapter 9 for other requirements related to DWI assessments and protocol.

Juvenile Justice Substance Abuse Mental Health Partnerships [JJSAMHP]

Various standardized assessments are available for persons working with juvenile offenders that can be used to determine the presence of a substance use or dependence diagnosis. All youth who are referred to the program are screened using the Global Assessment for Individualized Needs-Short Screener [GAIN-SS]; the results are used to determine if a full assessment is warranted. Examples of standardized assessment tools utilized by qualified assessors are listed on the Division of Public Safety's website. Documentation of any completed assessments shall be placed in the recipient's service record. Providers should confirm with the recipient's home LME-MCO that the assessment administered by DPS will suffice as a Comprehensive Clinical Assessment.

NC-SNAP for Individuals with Intellectual or Developmental Disabilities

The North Carolina Support Needs Assessment Profile [NC-SNAP] is a protocol used to assess the level of intensity of services and supports needed by a person with intellectual or developmental disabilities. Either the NC-SNAP or the SIS (described later in this section) is required for all individuals with intellectual or developmental disabilities, regardless of whether the services they are receiving are Medicaid- or state-funded. The NC-SNAP is not a diagnostic tool, and it is not intended to replace any formal professional or diagnostic assessment instrument. The three domains addressed by the NC-SNAP are:

- Behavioral Supports;
- Daily Living Supports; and
- Health Care Supports.

For more information and resources related to the NC-SNAP, please click here.

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North Carolina Treatment Outcomes and Program Performance System [NC-TOPPS]

As previously discussed in Chapter 1, NC-TOPPS is the program by which DMH/DD/SAS measures outcomes and performance. It must be completed in a face-to-face interview by the Qualified Professional responsible for the development and implementation of the Person-Centered Plan / service plan with individuals who receive qualifying mental health or substance use services. NC-TOPPS is administered as a regular part of developing and updating an individual's PCP to capture key information on an individual's current episode of treatment. It aids the provider in the evaluation of active treatment services, provides data for meeting federal performance and outcome measures, and supports LME-MCOs in their responsibility for monitoring treatment services. Please refer back to Chapter 1 for more detail on the use and completion of NC-TOPPS. Support materials and data entry can be found on the NC-TOPPS web page.

Supports Intensity Scale® [SIS] for Individuals with Intellectual or Developmental Disabilities

The Supports Intensity Scale® [SIS] is a tool designed to measure the relative intensity of support each person with developmental disabilities needs to fully participate in community life. In the NC public system, individuals with I/DD choosing to self-direct their services, and individuals with high medical and/or behavioral needs will be prioritized to have a SIS completed.

Either the SIS or the NC-SNAP is required for approval of the recipient's Individual Support Plan [ISP] and to show medical necessity for either Medicaid- or state-funded services. It can be used in combination with other assessment tools, such as psychological assessments, risk assessments, etc. to assist individuals receiving services and their support teams in developing person-centered plans that focus on strengths and abilities, not deficits. The SIS includes three sections, each of which measures a particular area of support needed:

- Supports Needs Scale;
- Supplemental Protection and Advocacy Scale; and
- Exceptional Medical and Behavioral Supports Needs Scale.

For more detailed information and resources related to the SIS, please use this link.

Treatment Accountability for Safer Communities [TASC]

The assessment process for TASC includes a structured interview and a standardized instrument. The MCO cannot be billed for court-ordered assessments that require the consumer to pay. The information collected and documented includes demographics, employment, education, legal issues, drug/alcohol use, family/social relationships, family history, medical status, psychiatric status, mental health screening, diagnostic impression according to the DSM-5 or any subsequent edition, ASAM Criteria, assessment outcome, and staff signature and credentials. See Chapter 9 for other requirements related to TASC.

Work First / Substance Use Initiative

Substance use disorder screening is an integral part of the Work First application process. The AUDIT (Alcohol Use Disorders Identification Test) and DAST-10 (Drug Abuse Screening Test) shall be used for screening alcohol and drug use disorders for all adult Work First applicants/recipients by the Qualified (Substance Abuse) Professional or DSS worker. An assessment for substance use disorders is required for all Work First applicants/recipients who are found to be high risk on the screening and is administered by a QSAP. The SUDDS-5, or other standardized assessment tool approved by DMH/DD/SAS, is used as part of the comprehensive clinical assessment for this population. An applicant/recipient may also be referred to a QSAP based on the documented results of the Substance Abuse Behavioral Indicator Checklist II. Screening for mental health issues is voluntary. The Emotional Health Inventory is used when screening mental health issues for adult Work First applicants/recipients. Additional documentation shall include any barriers to services.

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Medical Review of the Comprehensive Clinical Assessment

In 2008, the North Carolina General Assembly enacted new legislation [House Bill 2436, Section 10.15.(w)] requiring that a comprehensive clinical assessment be completed by a licensed clinician prior to service delivery except where this would impede access to crisis or other emergency services.

This legislation strengthened the clinical connection between the CCA and the service order for enhanced behavioral health services, which now requires written authentication by the licensed professional who signs the service order verifying medical necessity, indicating whether or not he or she:

- Has reviewed the individual's assessment; and/or
- Has had direct contact with the individual.

This is achieved when the LP signing the service order checks yes or no in the appropriate boxes in the Service Order section of the PCP signature page. The service order is not valid if these elements are not addressed. Requests for authorization with check boxes left blank will be denied/not processed by the authorizing agency, as the PCP is considered incomplete due to lack of information. The LME-MCO shall notify DHHS when this occurs, who will in turn report the failure of the licensed professional to comply with the above requirements to the appropriate occupational licensing board.

PSYCHOLOGICAL TESTING

Psychological testing involves the culturally and linguistically appropriate administration of standardized tests to assess a beneficiary's psychological or cognitive functioning. Testing results shall be utilized to guide treatment selection and treatment planning. For more detailed information on the policy governing psychological testing, please read either Clinical Coverage Policy 8C, Medicaid or the State-Funded Service Definitions for Enhanced MH/SA Services. A written report of the psychological testing must be completed and placed in the service record. At a minimum this report shall include the following:

- Reason for the referral
- Psychological tests/procedures utilized
- Review of records as appropriate
- Results of the psychological tests
- Summary
- Diagnoses or Diagnostic Impression
- Recommendations
- Signature, degree, and license of the Licensed Psychologist (LP), Licensed Psychological Associate (LPA), or qualified physician.

Often psychological testing reports include the information found in a CCA. The final psychological testing report is to be placed in the service record so that the summary and recommendations can be available to assist in diagnosis and treatment planning.

RE-ASSESSMENTS

Re-assessment is an ongoing process. Re-assessments should occur whenever the need for an update is clinically indicated. Typically, another assessment should be performed when the individual appears to have or is reported to have new behavioral health concerns, changed or unmet service or treatment needs, etc. The current assessment is valid as long as there has not been a substantive change in the person's clinical profile. Unless otherwise indicated in the service definition, re-assessments typically occur in conjunction with the re-writing of the service plan. The purpose of the re-assessment is to document the individual's current behavioral health status, clinical and service needs, and to provide conclusions and recommendations concerning the same.

If the re-assessment results in a refinement in the diagnostic formulation based on additional information or observations made which do not result in a change in diagnosis, a clinical note is sufficient. For example, a person is determined to be suffering from depression due to the loss of their spouse; however, after a few weeks in treatment, it is determined that the loss of the person's spouse triggered unresolved feelings of abandonment from the person's childhood. In this case, it was discovered that the root cause or rudiments of the person's

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emotional difficulty was exacerbated by feelings of abandonment during their childhood, which had not been fully resolved.

If, however, the re-assessment results in a change in diagnosis (either a different or additional diagnosis) and if an assessment or evaluation code is billed, a written report is required. For example, a person is determined to be suffering from a bipolar disorder; it is later determined that the person also has serious substance use issues. In that case, due to the additional diagnostic formulation and the fact that an assessment or evaluation code is billed, a written report is required.

When clinical assessments and evaluations, including re-assessments, are billed as such, they require a written report, completed and signed by the person who conducted the assessment. The report should be filed in the evaluation/assessment section of the service record.

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PERSON-CENTERED THINKING AND INDIVIDUALIZED SERVICE PLANNING

Person-centered thinking is a guiding principle that must be embraced by all who are involved in the MH/IDD/SU service delivery system. This is especially true when developing service plans. Person-centered thinking provides a way of connecting to the individual who is requesting services in order to lay a person-driven foundation for individualized care. While some services utilize a Person-Centered Plan [PCP] format, others may utilize another service plan format. Irrespective of the format used, person-centered thinking and individualized service planning are the hallmarks of the provision of high quality services in meeting the unique needs of each person served. Each plan is driven by the individual, utilizing the results and recommendations of a comprehensive clinical assessment, and is individually tailored to the preferences, strengths, and needs of the person seeking services.

A Person-Centered Plan is required for most Medicaid-funded mental health, intellectual or developmental disabilities, and substance use services. A PCP is required for all services delineated in Clinical Coverage Policies 8A (except for assessments and crisis services such as Diagnostic Assessment, Mobile Crisis Management, detoxification services), 8-D-2, 8-O, and those same services when they are state funded. A PCP is also required for all other services when they are provided *in conjunction* with a service found in the previously mentioned policies, as well as the state-funded enhanced MH/SA services.

A PCP is not required for individuals receiving only outpatient treatment and/or medication management, nor is it required for persons receiving services under the North Carolina Innovations waiver. When a PCP is not required, a plan of care, service plan, or treatment plan, consistent with and supportive of the service provided and within professional standards of practice, is required on or before the day the service is delivered. When services are provided prior to the establishment and implementation of the plan, strategies to address the individual's presenting problem shall be documented. Exception to timeframe: Providers of outpatient behavioral health services covered under Medicaid Clinical Coverage Policy 8C are required to have an individualized service plan in place within fifteen business days of the first face-to-face contact with the individual. For North Carolina Innovations, an Individual Support Plan [ISP] is used, with specific requirements and guidelines outlined in CCP 8P. NOTE: For individuals receiving only medication management, the treatment plan does not have to be a separate document and could be integrated into service notes.

The Person-Centered Plan must be developed and written by a Qualified Professional or a Licensed Professional according to the requirements of the specific service definition and in collaboration with the individual (to ensure they are involved in the planning process and the plan is not just written about them but for/with them), family members [when applicable], and other service providers in order to maximize unified planning. The person responsible for developing the PCP should present the results and recommendations of the comprehensive clinical assessment as an integral part of the person-centered planning discussions and incorporate them into the plan as appropriate and as agreed upon by the individual and/or his or her legally responsible person. The individual is always at the center of his or her plan. Family members, significant others, and professionals are invited to participate and provide input into the planning process for the services and supports included in the PCP at the discretion of the individual to whom the plan belongs.

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For children and adolescents, the Child and Family Team develops the PCP. The QP or LP facilitating the development of the PCP should work to create a balance between the needs, preferences, and supports of the individual and medical necessity. The QP or LP responsible for writing the PCP should present the results and recommendations of the CCA as an integral part of the planning discussions and incorporate them into the PCP as agreed upon by the individual, family members, Child and Family Team, and others, as appropriate. Please reference the *NC System of Care Handbook for Children, Youth, and Families* for more information about Child and Family Teams.

The contents of this chapter only speak to some of the components of the PCP, primarily those related to authorization, content, and documentation. A *Person-Centered Planning Instructions Manual* has been developed to guide providers in developing the PCP. This document outlines the over-arching values and principles of person-centered thinking that directs the planning process. It also provides a detailed and comprehensive framework for developing the PCP and delineates the required content and documentation requirements.

THE PERSON-CENTERED PLAN

The Person-Centered Plan Format

DMH/DD/SAS and DMA have developed and approved a standardized format for the Person-Centered Plan, which includes signature pages and the forms to be used for PCP revisions. This PCP format is used as a standardized form by providers across North Carolina, and may not be altered. Rule 10A NCAC 26C .0402, which went into effect on May 1, 2008, recognizes the PCP as a standardized form and specifically states in item (d) that a "standardized form or process shall not altered by an LME or provider." Providers of individuals for whom a Person-Centered plan is required shall use the standard PCP format, including the supplemental pages when making revisions to the PCP within the current PCP year. The PCP templates consist of the PCP format, plus the two supplemental pages that must be used for any revisions to the PCP that occur within the current plan year. They are available on the DMH/DD/SAS web site and can be found on the same page as the PCP Instruction Manual previously mentioned.

Required Components of the Person-Centered Plan

The Person-Centered Plan, developed and written by the QP or LP, consists of four main parts, each of which is required, and when combined together, comprises the whole Person-Centered Plan. The four required components of the Person-Centered Plan format are the:

- One-Page Profile;
- Action Plan (goals);
- Comprehensive Crisis Prevention and Intervention Plan (an Excel document that replaces the one-page Crisis Plan currently part of the document); and
- Signature Page.

Each component of the plan is briefly discussed in the next four sub-sections in this chapter.

The One-Page Profile

The PCP format begins with the One-Page Profile, which focuses upon the intent and objectives of the person-centered thinking and planning process. When developed, the One-Page Profile must include a full description of the individual and his or her supports in a particular situation or time, pulling together all the most important person-centered information into one place, including important considerations related to health and safety factors that need to be addressed. Building the One-Page Profile facilitates collaboration in deciding how to best support the individual, based on what is working and not working. To this end, the One-Page Profile contains the following sections, and each section must be addressed:

- What People Like and Admire About . . .
- What's Important To . . .

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- How Best to Support . . .
- What's Working / What's Not Working . . .

The Action Plan

The Action Plan, which includes the identification and discussion of recommended services, supports, interventions, and/or treatment options that will help meet the individual's needs, is developed with the individual/family/legally responsible person and, for children and adolescents, the Child and Family Team. The Action Plan specifically integrates the information indicated on the One-Page Profile, the results and recommendations of the CCA [and subsequent re-assessments], and any other documentation that supports medical necessity. The goals and strategies that are planned and written in the Action Plan are based on the information and recommendations from the CCA and other evaluations, input from the individual/family/LRP [Legally Responsible Person], and the One-Page Profile. The Action Plan is the section of the PCP where long-term outcomes, along with the characteristics, observations, and justifications for short-range goal planning, are documented. The Action Plan must outline specific, measurable goals, the interventions or treatments that will be used, and the specific services being utilized. It is the place where the goals and strategies work to strike a balance between what is important to and for the person. The Action Plan also requires a narrative statement summarizing the individual's progress toward achieving each goal, and justification for the continuation, discontinuation, or revision of the goal at the time of each periodic review. See the *Person-Centered Planning Instruction Manual* for further information and guidance for developing Action Plans.

All goals should address the treatment, service, and support needs of the individual, and the individual should always be the subject of each goal or outcome. It is important to remember that the PCP is written on behalf of the individual, and not the staff. There shall never be staff goals or outcomes contained in the PCP. Making a referral for an individual to a service is not a goal. That might be a strategy toward a goal. For example, the PCP goal might be for the individual to establish a medical home and to see his or her primary care physician at least once a year, more often if needed. That would be the goal, and one of the strategies would be for the staff to contact the physician's office and make an appointment. Providers should be mindful of this difference in writing goals for the people they serve.

The Comprehensive Crisis Prevention and Intervention Plan [CPIP]

The Comprehensive Crisis Prevention and Intervention Plan is a required component of the PCP and must include the interventions and supports aimed at preventing a crisis, as well as the interventions and supports to employ if a crisis occurs. It must be an individualized plan that reflects the specific needs, preferences, strengths, and challenges of the person and his or her situation. The CPIP shall be updated on the same schedule as the PCP, and/or shortly after any crisis episode occurs, and/or anytime there is a significant change in the course of treatment – including medication changes.

The QP or LP responsible for the PCP shall complete the CPIP, which includes sections for the following components:

- Basic essential information about the individual: Although this may be repetitive of other sections of the PCP, it is important to document this information in the CPIP itself, because the CPIP section is designed to be a free-standing and portable reference as needed in order to assist the individual and providers in preventing and responding effectively to crisis events.
- Persons and resources which will act as supports to the individual during a crisis event
- A description of situations and events that may trigger a crisis event for the individual
- A description of the individual's observable behavioral changes associated with the escalation of a crisis event
- A description of crisis prevention and early intervention strategies that have been effective
- A description of crisis response and stabilization strategies that have been effective
- Specific recommendations for interacting with the person receiving a crisis service

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Complete guidance, instructions, and prompts are included within the form template itself, which can be found on the Person-Centered Planning web page.

The Signature Page

The Signature Page consists of four parts with various attestations as applicable in each section:

- Part I: PERSON RECEIVING SERVICES – for the individual and/or the Legally Responsible Person to sign and attest to involvement in the planning process and denote that provider choice was allowed,
- Part II: PERSON RESPONSIBLE FOR THE PCP – for the QP or LP to sign and attest to involvement with the development of the plan content,
- Part III: SERVICE ORDERS – required for Medicaid-funded services; recommended for state-funded services, and
- Part IV: SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN – optional.

Dating the Person-Centered Plan

The date of the plan [PCP Completion Date] is the date that the Qualified Professional or the Licensed Professional [per the service definition] completes the PCP and signs and dates the signature page. For more detailed information related to the date of the plan, please refer to the table in the next section.

The Completion Date of the Person-Centered Plan

Below is a table designed to assist providers in meeting the completion date requirements of the Person-Centered Plan, followed by a section that addresses some of the details within these requirements:

Person-Centered Plan Completion Dates and Timelines	
PCP COMPLETION DATE	The *PCP Completion Date* is the date that the QP/LP [per the Service Definition] *completes and signs* the PCP.
TIME PERIOD THAT PCP IS VALID	The PCP is valid for 12 months from the *PCP Completion Date.*
TARGET DATES	Target dates may not exceed 12 months from the *PCP Completion Date.*
MEDICAL NECESSITY & SERVICE ORDERS	Must be in place for the PCP to be valid for billing Medicaid. If new services requiring an order are added during an Update/Revision to the PCP, a new service order must be obtained and is valid only for the remainder of that 12 months period.
SIGNATURES – PCP COMPLETION DATE	No signatures, including the Licensed Professional, the LRP, and the QP/LP responsible for the PCP may precede the *PCP Completion Date*. If any of the three required signatures above were entered after the *PCP Completion Date*, the latest signature is the date on which the PCP is effective and the date that billing **for the service** may begin. However, the *PCP Completion Date* is still in effect for target dates, and the date on which the annual rewrite date is based.
ANNUAL REWRITE	The *PCP Completion Date* on the PCP is the date on which the annual rewrite of the PCP is based. For Medicaid, new service order / verification of medical necessity must be obtained with each annual rewrite of the PCP, even if the last verification / service order is less than 12 months old.

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Signing the Person-Centered Plan

The Person-Centered Plan Instruction Manual specifies who is required to sign the PCP. Guidance regarding signature requirements on the PCP is as follows:

- All signatures must contain the appropriate credentials/degree/licensure or position when signatures are entered on the signature pages of the PCP. It is recommended that all signatures are legible and contain at least the first and last name of the person signing.
- Dated signatures are required for most signatories of the PCP. The signature is authenticated when the appropriate professional [constituting the service order], the individual and/or legally responsible person, and the person responsible for the plan [QP or LP], each enter the date next to their signature.
- The person receiving the services, if the individual is his or her own LRP, is required to sign and date the PCP in Part I, and to check the appropriate boxes in that section to indicate confirmation and agreement with the services/supports outlined in the PCP, as well as confirming choice of service providers. All individuals should be encouraged to sign his or her own PCP, even when the individual is not his or her own LRP, including minors.
- The legally responsible person signs and dates the PCP in Part I, confirming involvement and agreement, and checks the boxes as appropriate in this section.
  - If the QP/LP who developed the PCP is unable to obtain the signature of the legally responsible person, there shall be documentation on the signature page and/or in a service note reflecting due diligence in the efforts to obtain the signature and documentation stating why the signature could not be obtained. If this occurs, there shall be ongoing attempts to obtain the signature as soon as possible.
- The QP or LP responsible for developing the PCP must sign and date the plan, and, if the individual is a minor, answer the questions in Part II as appropriate.
- When children or youth who are receiving or are in need of an enhanced service are court-involved [probation, post-release, parole, community service or other diversion program], documentation that the provider has convened/scheduled the Child and Family Team meeting or assigned TASC Care Management as deemed appropriate, is required. The provider is also to confer with the clinical staff at the LME-MCO for care coordination, as required by that entity.
  - Check boxes that confirm that these requirements have been met by the provider are in Part II of the signature page of the PCP.
  - The appropriate boxes must be checked when requesting services in order to ensure that the child or youth receives the appropriate services.
- As previously outlined in this manual, there are some additional signatory requirements that go beyond the signature, credentials, and date on the PCP signature page. This is especially true for entering service orders [Part III of the signature page] and when providing services to children and youth who are involved with the court system [Part II of the signature page].
- For medical necessity of Medicaid-covered services, one of the following professionals must sign and date the PCP in Part III, Section A of the PCP signature page and comply with the additional signatory requirements as outlined above and in previous sections of this manual, indicating that the requested services are medically necessary and constituting the service order:
  - Licensed physician [MD] or Doctor of Osteopathy [DO],
  - Licensed psychologist [LP],
  - Licensed physician assistant [PA], or
  - Licensed nurse practitioner [NP].
- For medical necessity of state-funded services, unless specifically stated in the service definition[§], it is recommended that one of the same four signatories noted above sign the PCP in Part III, Section A of the Service Order section. If not any of the four listed above, it is recommended that a QP or LP sign the

[§] *Supervised Living – Moderate* requires a physician's or licensed psychologist's signature on a service order. *Community Rehabilitation* requires the signature of a QP or AP to certify eligibility for this service.
A Certificate of Need is required for *Inpatient Hospital* service provision for individuals under 21 years of age.

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order in Part III, Section B when service orders are indicated. When issuing an order for state-funded services, the check boxes shall also be completed as previously discussed in this section.

- Other team members involved in the development of the PCP may also sign the PCP in Part IV to confirm participation and agreement with the services/supports listed, but these signatures are not required.
- When the local department of social services, or any other agency, has legal custody of an individual, the provider agency must obtain a copy of the custody papers and file them in the service record in order to verify that agency's authority to act on behalf of the individual and sign the PCP, as well as to ensure proper consent and maintain confidentiality.
- There are special conditions upon which the signature of a minor is required. The following section in this chapter outlines these conditions.

NOTE: A PCP is valid for billing when the last of the three required signatures is in place:

1. Dated signature of the person to whom the PCP belongs [and/or legally responsible person], with the appropriate check boxes completed;
2. Dated signature of the Qualified Professional or Licensed Professional who wrote the PCP, with the appropriate check boxes completed when required; and
3. Dated signature of the person ordering the service(s), with appropriate check boxes completed.

For additional information on signatures, please see Chapter 8 – "General Documentation Procedures".

<u>Signatures of Minors</u>

One of the signatures referenced in the above section is the signature of a minor. Two laws serve as the policy documents for the issue of the signature of a minor:

- G.S. § 90-21.5 – allows for some situations where a minor's signature on a plan will be sufficient (without the signature of the legally responsible person). A minor may consent for treatment of controlled substance or alcohol abuse, or emotional disturbance. This treatment has to be provided by a licensed physician in North Carolina. An emancipated minor may give consent for any medical or dental treatment.
- G.S. § 122C-223 – allows a minor to consent for emergency admission to a 24-hour facility for substance use or mental health treatment when the legally responsible person is not available to give consent. Within 24 hours the facility shall notify the LRP of the minor's admission. If the LRP is not able to be contacted within 72 hours of admission, the responsible professional shall contact Child Protective Services.

Under the above circumstances, the minor's signature on the plan is sufficient. However, once the legally responsible person becomes involved, he or she shall also sign the plan/consent. For minors receiving services for a substance use disorder in a non-emergency admission to a twenty-four hour facility, both the legally responsible person and the minor are required to sign the plan.

REVIEW, REVISION, AND ANNUAL REWRITE OF THE PERSON-CENTERED PLAN

Reviews and Revisions

A PCP review and subsequent revisions must occur whenever changes to the plan are needed within the current plan year or as required by the service definition. When a review occurs, the "Progress toward goal…" section on the Action Plan pages of the current PCP and the supplemental pages are to be used to document the review as required during the course of the plan year. Completion of the signature page by the QP or LP and the individual/LRP is required each time the PCP is reviewed, even if there are no changes or revisions to the plan. In addition, if a new service that requires an order is added, then new service orders are also required on the signature page by the appropriate signatory. The PCP Update/Revision page and Update/Revision Signature Page are utilized for this purpose.

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Specifically, the PCP must be reviewed and/or revised whenever the following situations occur within the plan year:

- The target dates assigned to each goal are due to expire, the goals are in need of review and revision, or new goals are needed;
- The individual's needs change and a new service is being planned/requested;
- The individual's needs change and an existing service is being reduced or terminated;
- The individual's needs change and goals need to be revised, added, or terminated;
- There is a change in designated service providers; or
- The specific service being provided requires a review at a designated interval that is more frequent than an annual review, such as PSR or Residential Treatment Services.

<u>Documenting the Review</u>

For each goal, a narrative statement must be provided, summarizing the individual's progress toward the goal and justifying the continuation, discontinuation, or revision of the goal, in the space allocated for such, found under the "How" box in the Action Plan section. Whenever the review results in planning a new goal or adding a new service, or when an individual is changing service providers, the PCP Update/Revision form must be used.

<u>Signatures</u>

All PCP reviews must be properly signed by the appropriate parties, including the appropriate signatory for any new service which requires an order. The PCP Update/Revision Signature Page shall be used for all reviews.

Whenever the PCP is reviewed or revised, the LP or QP who is responsible for the plan, the individual, and/or his or her LRP must also sign the plan, even if there are no changes as a result of the review. The individual's/LRP's signature verifies his or her involvement in the review process and agreement that no changes are needed or the revisions made are agreed upon. If the plan is not signed by the individual and/or LRP, then the agency must document the attempts made to obtain the signature.

For Medicaid-funded services, whenever a new service is requested at the time of the review, a licensed physician [MD] or Doctor of Osteopathy [DO], licensed psychologist, licensed physician assistant, or a licensed nurse practitioner must sign and date the review and revision of the PCP in Part III of the signature page to fulfill the service order requirements.

For state-funded services for which a service order is recommended, a Licensed Professional or a Qualified Professional shall sign and date the review and revision to the plan in the service order section of the signature page.

Annual Rewrite

At a minimum, the PCP shall be rewritten annually. The minimum time requirement for the annual rewrite is based on the PCP Completion Date, which is found at the top of the first page of the Person-Centered Profile page. A revision may not be written in lieu of a required annual rewrite. When a new PCP is written, all required signatures are entered on the new PCP Signature Page. A new plan constitutes a new service order, even if the services remain the same, so a new signature is required from one of the above-named licensed professionals.

INDIVIDUAL SUPPORT PLAN

For individuals receiving Medicaid-covered services under the NC Innovations waiver, an Individual Support Plan, or ISP, is required. The ISP is developed through a person-centered planning process, not unlike when developing a PCP. The standardized format covers Life Situation, School/Vocational, Social Network, and Medical/Behavioral domains. ISPs are valid no longer than one calendar year from the start date of the [annual] plan. Unlike a PCP, an ISP typically has a future start date, which is not dependent upon the dates next to the

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signatures required for the plan to be valid. The plan is effective on the first day of the following calendar month of the individual's birth month.

Care Coordinators for the various LME-MCOs are responsible for creating the ISP, specifically naming the provider agency or agencies from which the beneficiary is receiving services. Care Coordinators facilitate the planning process, which is led by the individual and/or legally responsible person, and involves other persons at the individual's request, such as the residential staff/provider, a family member, or other natural/community support. The plan contains information necessary to assist individuals with recognizing their own strengths and capabilities, as well identifying what is needed to help them reach goals based on what they want and desire. Long-range outcomes are formulated and included in the Action Plan section of the ISP, along with (an) identified service(s)/support(s) needed to reach that outcome, service providers, frequency of service(s), and a target date for achieving that goal.

A Back-Up Staffing Plan is included in the ISP. It is designed to ensure that if the assigned staff person is unable to provide the service, another qualified person is available. This is especially important when the assigned staff person's absence presents a health and welfare risk to the participant. Each Care Coordinator, in conjunction with the provider agency, is to design an effective back-up staffing plan that is designed to meet the unique needs of the individual.

ISPs are revised when there is a change in services, a service provider, when a significant change occurs in the individual's life that affects his/her current status, or at the request of the individual based on their individual circumstances. Any identified risks or areas where support is needed are to be included and addressed in the plan. Other reports or any assessments utilized in developing this plan are identified as well.

The signature pages included in the ISP address the recipient's/LRP's choice of services and confirms the individual's participation in plan development. Signature requirements are explained in Chapter 8 of this manual. In this section, individuals/LRPs are able to express any concern or disagreement with issues related to that person's ISP. The completed ISP shall be placed in the recipient's clinical service record.

SERVICE PLAN REQUIREMENTS WHEN A PERSON-CENTERED PLAN FORMAT IS NOT REQUIRED

When a PCP format is not required, a plan of care, service plan, or treatment plan, consistent with and supportive of the service provided and within professional standards of practice, is required on or before the first day the service is delivered. Exception to timeframe: Providers of outpatient behavioral health services covered under *Medicaid Clinical Coverage Policy 8C* are required to have an individualized service plan in place within fifteen business days of the first face-to-face contact with the individual. When services are provided prior to the establishment and implementation of the service plan, strategies to address the individual's presenting problem shall be documented.

According to 10A NCAC 27G .0205, the service plan shall be developed based on the assessment, and in partnership with the individual or legally responsible person or both, within 30 days of admission for individuals who are expected to receive services beyond 30 days. The service plan shall include at least the following elements, also according to 10A NCAC 27G .0205:

- Client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;
- Strategies;
- Staff responsible;
- A schedule for review of the plan at least annually in consultation with the individual or legally responsible person, or both, to review goals and strategies to promote effective treatment;
- Basis for evaluation or assessment of outcome achievement; and
- Written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

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If an agency's format for a service plan includes a space for entering service orders, then the service orders may be entered on the service plan by the appropriate signatory instead of on a separate document. See Chapter 5 for additional information on service orders. For North Carolina Innovations waiver services, an Individual Support Plan [ISP] is used, with specific requirements and guidelines outlined in *CCP 8-P: North Carolina Innovations* and in the *NC Innovations Technical Guide*.

NOTE: While the rule cited above allows 30 days for a service plan to be developed, reimbursement sources may have more stringent requirements. Whenever there is a disparity between the requirements established by DMH/DD/SAS and the LME-MCO, providers are to follow the more stringent expectation.

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Chapter 5: Medical Necessity, Service Orders, and Service Authorization

MEDICAL NECESSITY

Most MH/IDD/SU services are based upon a finding a medical necessity. Medical necessity is established by an assessment of the individual's needs by a professional who is licensed or certified to diagnose mental health, intellectual and developmental disabilities, and/or substance use issues, and it is determined by generally accepted community practice standards. All covered MH/IDD/SU services must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the individual.

For the provision of mental health, intellectual or developmental disabilities, and substance use services, specific criteria for the justification of medical necessity are identified within each service definition. In order for a service to be eligible for reimbursement by Medicaid or the state, the individual has to have met the medical necessity criteria (often listed in the Entrance Criteria section) identified in the service definition. That judgment is made by a person who is licensed or certified to diagnose mental health, intellectual and developmental disabilities, and/or substance use conditions, and who is operating within his or her professional scope of practice, knowledge base, and experience. All applicable Medicaid-funded policies can be found on DMA's Behavioral Health Clinical Coverage Policies page. State-funded service definitions are located on the NCDHHS Service Definitions web page.

SERVICE ORDERS

All mental health, intellectual or developmental disabilities, and substance use services reimbursed by Medicaid, except for assessments or evaluations, must be ordered prior to, or on the day of the service and re-ordered, at a minimum, on an annual basis.

- Medicaid-funded services ordered via signature on a PCP must be re-ordered at the time of the annual re-write.
- The dated signature of the appropriate professional in the designated service order section of the PCP for the services outlined in the PCP becomes the service order. Therefore, there is no requirement for a separate form to be used to order the service.
- Any time the PCP is revised to request a new service, there must be a new signature constituting the service order to establish medical necessity for that service. This signature is entered on the revision/update page of the PCP.
- New service orders added after the PCP was originally written are valid only for the duration of the plan; when the PCP is due for annual rewrite, all existing orders will need to be renewed as appropriate via new orders on the rewritten PCP.

Please see the section entitled "Medical Review of the Comprehensive Clinical Assessment" in Chapter 3 and/or the *Person-Centered Planning Instruction Manual* for requirements of professionals signing service orders.

Although service orders are not required for most state-funded services, in recognition that the Medicaid eligibility status for many individuals changes over the course of a year, it is highly recommended that the PCP be signed by one of the approved Medicaid signatories in Part III, Section A of the PCP signature page as described in Chapter 3. Alternatively, services may be ordered in Part III, Section B on the signature page of the PCP.

While the appropriate signature on the PCP constitutes the service order for most mental health, intellectual or developmental disabilities, and substance use services, there are some situations when a treatment plan is use in

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lieu of a PCP, e.g., an individual who receives outpatient treatment services only. When a treatment plan [or service plan] is used instead of a PCP, a separate service order is required for the services listed in the plan, unless the format provides for orders to be signed on the service plan, or unless the service itself does not stipulate the need for an order. The service order must be signed and dated by the appropriate professional as described in Chapter 3 for Medicaid-covered services prior to or on the date of service, and filed in the individual's record. For outpatient behavioral health services, the following Licensed Professionals, who are able to provide and bill for the services, may serve as the professional ordering the service:

- Licensed Psychologist (LP) or Psychological Associate (LPA)
- Licensed Professional Counselor (LPC) or Associate (LPCA)
- Licensed Clinical Social Worker (LCSW) or Associate (LCSWA)
- Licensed Marriage and Family Therapist (LMFT) or Associate (LMFTA)
- Licensed Clinical Addiction Specialist (LCAS) or Associate (LCAS-A)

All service orders must be renewed annually. There is no standardized form issued by the state for this purpose. Provider agencies should have a written policy indicating what constitutes a service order and validation of medical necessity when ordering services under a plan outside the auspices of the PCP. Providers of Medicaid-covered outpatient treatment services must also follow the specific requirements outlined in Clinical Coverage Policy 8C for service orders.

Verbal Service Orders

Sometimes a verbal service order is necessary in order to expedite the establishment or verification of medical necessity for a service. The need for a verbal order might occur in an emergency when the individual's need for a new service [e.g., Mobile Crisis Management] has been identified, and the need to expedite the service is crucial.

Whenever the situation presents the need for a verbal order, a few basic procedures must be followed in order for the verbal order to be valid. Treatment may proceed based on a verbal order by the appropriate professional as long as the verbal order is documented in the individual's service record [typically the PCP signature page] on the date that the verbal order was given. The documentation must specify the date of the order, who gave the order, who received the order, and identify each distinct service that was ordered. The documentation should reflect why a verbal order was obtained in lieu of a written order. The appropriate professional must countersign the order with a dated signature within 72 hours of the date of the verbal order.

SERVICE AUTHORIZATION

Most mental health, intellectual or developmental disabilities, and substance use services require prior authorization, or prior approval, in order to assure that the service requested meets medical necessity and other service-specific criteria. Each LME-MCO in North Carolina is responsible for conducting utilization review for Medicaid- and state-funded behavioral health services for their network providers. This means that providers must obtain prior authorization from the LME-MCO for all services requiring prior approval, statewide.

The service authorization process establishes the provision of a service related to the scope, amount, and duration of a service, based on documented medical necessity. Requests for authorization for more services are required prior to initiation of the service and for continuation of the service beyond the initial or any subsequent authorization period. See the specific service definition for more information.

Service Authorization and Early and Periodic Screening, Diagnostics and Treatment [EPSDT]

Some limitations regarding service provision are built into the service definitions. However, Early and Periodic Screening, Diagnostics, and Treatment [EPSDT] provides additional allowances for Medicaid-funded services for recipients under the age of 21 to receive services in excess of the limitations or restrictions found in Medicaid's clinical coverage policies, when such services are medically necessary. When submitting requests for prior

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authorization to the LME-MCO, the diagnostic information needed should reflect medical necessity to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the individual's physician, therapist, or other licensed practitioner to be reviewed under EPSDT criteria. Providers may access the request for prior approval under EPSDT through NCTracks, or by using the link found here.

Service Authorization for MH/IDD/SU Services

It is preferred and strongly recommended that all completed authorization forms and service authorization response letters [approvals and denials] received be filed in the individual's service record. If not, these authorization forms and related correspondence must be securely filed and retained in the financial records of the provider agency for immediate access and verification for monitoring and auditing purposes.

The LME-MCO requires providers to submit authorization requests for services electronically through the LME-MCO's MIS. Written requests are only accepted if the LME-MCO's Management Information System is inaccessible or for emergent/urgent requests. Each provider should work closely with the LME-MCO with whom they contract and follow their utilization management protocol, including submissions and timelines, in order to expeditiously request and obtain authorization for services requiring prior approval, as well as with ValueOptions for services not authorized by the LME-MCO but still fall under the purview of DMH/DD/SAS (Medicaid recipients 0-3, NC HealthChoice). It is strongly recommended that providers retain copies of authorization requests submitted to ValueOptions or their LME-MCO, as the requests are only available in their systems for a specified period of time.

Reauthorization of Services

All requests for reauthorization within the current service plan year require an updated or revised PCP to be submitted to the LME-MCO, along with justification for continuing with service provision. The PCP revision is to be accompanied by a new signature page dated no earlier that the date the PCP update/revision occurred. Providers should follow the utilization management protocol regarding reauthorization of services to avoid a disruption in billing and service provision. Any revisions, updates, and all reauthorization requests should be kept in the clinical service record with the original authorization request.

Appeals

Both Medicaid and non-Medicaid service recipients have appeal rights when a service has been denied, reduced, suspended, or terminated. Documentation pertaining to any partial or full denial for re/authorization of services should be kept in the client service record, along with any documentation of appeals made on behalf of the service recipient. The individual's LME-MCO will contact the individual and the provider when a request has been partially or fully denied for any reason. The provider shall work with the individual on responding to any denial, based on the individual's preference.

SERVICE END-DATE REPORTING TO LME-MCOs

Service providers are required to notify the LME-MCO when an individual changes providers or ends a service that the LME-MCO has previously authorized. Any time there is an open authorization and the individual is no longer participating in treatment, the provider needs to notify that individual's LME-MCO that the service has been terminated. End-dating is service-specific and may occur at different times throughout the course of treatment, especially when multiple services are provided and therefore, may have different authorization time frames. Providers are expected to follow the specific reporting procedures outlined by the LME-MCO for end-dating services. This is not only important for reporting purposes and utilization management, but it is also crucial for care coordination. It is suggested that the reporting of the individual's last date of service and the consequential end-date reporting to the LME-MCO is recorded in the individual's service record, either in the discharge summary or as a separate document.

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Chapter 6: Special Admission and Discharge Planning Requirements

MEDICAL EXAMINATIONS AS A SPECIAL ADMISSION REQUIREMENT

There are some services for which a medical examination is required for admission. The purpose of such examinations is to assure that the individual is able to participate in the program and must include the physician's directions regarding management of the individual's medical condition(s), if the individual has specific medical issues. The medical examination shall also note the presence of any communicable diseases or a condition that presents a significant risk for transmission within the program, except as provided in G.S. § 130A-144 [Public Health Statutes: "Investigation and Control Measures"]. For children and adolescents, the examination shall also assure compliance with the immunization requirements in G.S. § 130A-152 [Public Health Statutes: "Immunization Required"]. Documentation of such examinations shall become part of the client service record, as well as the physician's direction regarding management of any identified condition.

DISCHARGE PLANNING

Discharge planning begins at the point of admission for all mental health and substance use services. Service providers must think about how an individual's service needs can be fully and effectively met in the least restrictive capacity. Movement from a facility-based service, for example, to one in the community should be a seamless transition for the individual as a result of appropriate discharge planning. The step down process should afford the individual the lesser-restrictive level of service needed without losing the focus of treatment or interventions required to facilitate continued progress.

DISCHARGE SUMMARY

When it is determined that treatment is no longer necessary or no longer meets the conditions of most appropriate and least restrictive, a discharge summary shall be completed which contains the following elements:

- the reason for admission,
- course and progress of the individual in relation to the goals and strategies in the individual PCP or service plan,
- condition of the individual at discharge,
- recommendations and arrangements for further services or treatment,
- final diagnoses, and
- dated signature.

The discharge summary shall be completed within 30 days following discharge of the individual. The discharge summary is to be filed in the client service record. Once the discharge is complete, the record may be closed in accordance with directives given in Chapter 2 – *The Clinical Service Record*.

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SERVICE-SPECIFIC ADMISSION, DISCHARGE, OR TRANSITION PLANNING REQUIREMENTS

The remainder of this chapter addresses a number of service-specific admission, discharge, or transition planning requirements and guidelines. Services not listed below must have a documented discharge plan that demonstrates discussion with the individual and is included in his/her service plan.

Assertive Community Treatment [ACT] Team Services

For ACT services, discharge documentation shall include:

- The reasons for discharge or transition, as stated by both the individual and the ACT Team;
- The individual's biopsychosocial status at discharge or transition;
- A written final evaluation summary of the individual's progress toward the goals set forth in his or her PCP;
- A plan, developed in conjunction with the individual, for follow-up treatment after discharge; and
- The signature of the individual, the team leader, and the psychiatrist.

Child and Adolescent Day Treatment

For Child and Adolescent Day Treatment, planning for transition and discharge begins at admission and must be documented in the Person-Centered Plan. Child and Adolescent Day Treatment services are titrated based on the transition plan outlined in the PCP. The service record shall reflect outcomes sustained and progress made toward implementing the transition plan. At a minimum, this information shall be noted at utilization review intervals and/or service team meetings. Transition planning must be coordinated through the Child and Family Team and with members of the local system of care as necessary, including the local education agency [LEA], other involved individuals, and community providers, such as social services, juvenile justice, and vocational rehabilitation. A documented discharge plan shall be included in the PCP along with the transition plan previously mentioned.

Child and Adolescent Residential Treatment – Level III & Level IV

There are detailed requirements specifically related to discharge and transition planning for this level of residential treatment, and these requirements begin prior to the youth's admission and continue throughout his or her stay.

Prior to admission to this service, there must be a discharge/transition plan, developed by the Child and Family Team, using the *Child/Adolescent Discharge Plan* form, also known as Attachment A, originally published in Implementation Update #60, but found here (in Implementation Update #85). This discharge/transition plan must be updated and submitted to the LME-MCO with each request for service authorization. Child and Adolescent Residential Treatment providers are required to document collaboration with the LME-MCO and the System of Care Coordinator (per LME-MCO requirement) throughout the youth's stay in the residential treatment facility. SOC Coordinators may be required to sign off on the discharge plan. Reauthorization is required every 30 days. A copy of this form may be attached to the individual's PCP or kept in the individual's file as a separate document.

Medically Supervised or ADATC Detoxification/Crisis Stabilization

A documented discharge plan, which has been discussed with the individual, must be included in the individual's service record. The plan is required unless the person leaves against medical advice, or leaves due to the need for emergency medical care. Outpatient Opioid Treatment services require a documented discharge plan that shall be discussed with the individual and included in the service record.

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Psychiatric Residential Treatment Facilities [PRTF]

Admission

Federal regulations require the completion of a Certificate of Need [CON] statement prior to or upon admission to a PRTF facility when the individual is Medicaid-eligible or when Medicaid eligibility is pending. The last dated signature on the CON determines the effective date of the CON and authorization for payment. A copy of the CON must be maintained in the individual's service record. The specific requirements for the CON can be found in the *DMA Clinical Coverage Policy 8-D-1*.

Discharge

For this service, there must be documented evidence of active discharge planning from the beginning of treatment. The discharge plan must be individualized, appropriate, and realistic, and efforts for discharge to a less restrictive community residential setting shall be documented in the service record from the date of admission. Upon discharge, the provider must ensure that timely follow up care is in place.

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Chapter 7: Service Notes and Service Grids

Service notes are the heart of the clinical record. While the evaluation, diagnosis, and service planning activities chart the course for intervention, treatment, and supports, the service notes document the individual's ongoing progress and response to those interventions, treatments, and supports over time. Service notes also reflect significant events that occur in the individual's life that may impact progress during the course of services.

The required contents of a service note are listed below. However, there is more to writing a service note than just meeting the minimum requirements. Service notes must be written in such a way that there is substance, efficacy, and value. The descriptions of the interventions, treatment, and supports provided must all address the goal(s) listed in the service plan [the Person-Centered Plan, in most cases]. Service notes should be written in a clear and meaningful way so that they individually and collectively outline the individual's response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service.

"Canned" service notes are not acceptable. Examples of canned notes are notes that are cut and pasted from a computer or photocopied, with new dates and/or signatures attached, or notes that are copied verbatim, or almost verbatim by hand or typing from previously-written notes. Each service note should have its own inherent value as documentation of a separate and unique event and shall reflect:

- The actual and relevant activities that occurred during the service event;
- Important issues discussed;
- The interventions and treatment provided;
- The effectiveness of the interventions and treatment provided and the individual's response; and
- Relevant observations and updates that occurred and were specific to the service delivery provided that day.

Documentation must be specific and individualized and must accurately reflect the service provided per session. Each service note requires its own newly-composed evidence of the service provided.

DOCUMENTING SERVICE PROVISION

In most cases, when an individual receives a service, the person who provided that service shall write and sign a service note on, or within twenty-four hours of, the day that the service is provided. This is the predominant expectation for service documentation and is applicable for all periodic and most twenty-four hour services.

Service Periods and General Time Frames for Entering Notes

Most services are documented per date of service, immediately following the provision of that service. For some services, the frequency requirement for documentation of progress in a service note spans a specified range of time, e.g., weekly, monthly, or quarterly, allowing for a single note to address the individual's progress that occurred within that specified time period. For these services, the service note must be written or dictated on the closing date of the designated service period, or within twenty-four hours of the close of the service period. For the purposes of determining a start and end point, this range of time is referred to in this manual as the "service period". For any service where the documentation of service provision is permitted to cover a period of time that is less frequent than per date of service by means of a weekly, monthly, or quarterly note, provider agencies must designate the beginning and close of each service period in their written policies in order to determine if the documentation has been completed in a timely manner. An example of a designated service period would be that

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the agency's policy has defined the service period permitted for weekly notes to start on Monday and end on Friday of each week.

When a service that is provided over such a span of time and/or where one or more service providers within the same team/agency have carried out the same discrete service for an individual on different days, then the Qualified Professional or other designated staff who directly provided the service during the service period is responsible for gathering all the relevant information from the other staff on the team and writing and signing a composite service note that outlines the individual's progress during that service period. Such documentation of progress must be based on the specific individualized goals that were the focus of interventions for the service period being addressed in the service note.

CONTENTS OF A SERVICE NOTE

While there are no specific formats required for the documentation of service delivery, all service notes must contain required elements. *Appendix B* comprises an assortment of sample formats that may be used. Service notes shall include, but are not limited to, the following:

1. Name of the individual receiving the service [on every service note page]
2. Either the service record number of the individual issued by the LME-MCO along with the Medicaid Identification Number (as applicable), or unique identifier issued by the agency [on every service note page]
3. Full date the service was provided [month/day/year]
4. Name of the service provided [e.g., Intensive In-Home services]
5. Type of contact [face-to-face, phone call, collateral]
6. Place of service [when required by the service definition]
7. Purpose of the contact [tied to specific goal(s) in the service plan]
8. Description of the interventions, treatment, and support provided. Interventions must include active engagement of the individual and relate to the goals and strategies outlined in the individual's PCP or service plan. NOTE: The interventions described in the service note, whether for periodic, day/night, or twenty-four hour services, must accurately reflect treatment for the duration of time indicated.
9. Total amount of time spent performing the service [required for periodic services unless the periodic service is billed on a per event basis, and any other service as required by the relevant Medicaid Clinical Coverage Policy, Medicaid State Plan, State-Funded Enhanced Mental Health and Substance Abuse Services, or State-Funded MH/DD/SAS Service Definitions]. NOTE: Although the duration for each separate activity or intervention occurring within a given shift is not required when writing shift notes in a twenty-four hour facility, the shift hours must be specifically indicated in the note to ensure coverage for the entire period, e.g., "Third Shift: 11:30pm – 7:30am".
10. Effectiveness of the interventions, treatment, or support provided, and the individual's response/progress toward goal(s).
11. *For professionals*: Signature, with credentials, degree, or licensure of clinician who provided the service. For Licensed Professionals, the full signature denotes the clinician's licensure and/or certification; for non-licensed professionals, the full signature denotes the degree [e.g., BA, MSW] and shall also include the individual's professional status (QP or AP), and any other certifications the person may hold [e.g., CSAC].
12. *For paraprofessionals*: Signature and position of the individual who provided the service.

NOTE: For electronic signature requirements, see the *Electronic Signatures of Staff* section, found in Chapter 8 – "General Documentation Procedures".

Shift Notes

For twenty-four hour facilities requiring shift notes, there must be a note for each shift, and the coverage hours for each shift must be clearly identified in each note.

- All interventions, treatment, service coordination, and other significant information must be documented in the shift notes as described in the section above.

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- Due to the nature of twenty-four hour services, it is understood that there may be a shift when no interventions occur [e.g., when the resident is asleep at night for the duration of the entire shift]. While there might be no interventions, treatment, or service coordination activities provided for an individual during a particular shift, there must still be a service note for that shift in order to capture all the other events and supports for the individual that occurred during that shift, and to indicate the status, situation, or location of the individual, e.g., asleep or in school. In those situations, the shift note should reflect the care, oversight, support, and non-treatment events that took place during that shift, but there is no requirement for those shift notes to include the purpose of contact/intervention/effectiveness elements. However, using the same example, should the individual awaken during the night and receive any type of care, treatment, or intervention, a full note as described in the section above, including the purpose of contact/interventions/effectiveness is required.
- Shift notes should also include partial coverage when indicated. If, for example, a child is in school for most of a shift, but not the entire shift, the service note must include interventions provided before and/or after school, as applicable for the duration of the shift.
- When someone other than shift staff provides an intervention or treatment service during the shift, the occurrence of the treatment event should be noted by the shift staff in the shift note. For example, the shift note might say, "The LCSW conducted group therapy for one hour after dinner," but the interventions and the individual's response during the therapy session shall be documented by the person providing the intervention or treatment service [in this case, the LCSW] in a separate note.
- When more than one staff person is providing services for an entire shift, [as is required in most Child and Adolescent Residential Treatment settings], only one staff person need write and sign the shift note.

Service Notes When Providing Group Therapy

When a service is provided to a group of individuals at the same time (group therapy), a full service note is required for every person in the group receiving the service, and each note must contain all the required elements as outlined in this manual. Although a description of the interventions utilized during the provision of a service to a group might well be the same for each note entered in each group participant's service record, the effectiveness of, and each individual's response to, the interventions will vary from person to person and must be addressed individually in the note. Additionally, while many of the interventions for members of the group may be similar [and indicated as such in the note], the staff person writing the note must also indicate any individual interventions provided as well. The purpose of the contact is based on the specific goals in the individual's service plan, with an individualized description of his or her response to the treatment [effectiveness of the interventions, progress or problems noted, group dynamics, and other information relevant to the individual's participation, comments, or reactions during the treatment session].

Service Notes When Provided by a Team

When the same discrete service or intervention is provided to an individual by more than one staff member at the same time, such as PSR or Day Treatment, or in the case of certain teams, such as ACT or CST, one of the members of the team who provided the service may write and sign the service note. The service note must include the full names of the other participating staff members involved and describe their role in providing the service. While it may be the practice of some providers to require all participating to sign the note, there is no state requirement to do so.

While the above paragraph is valid, it is important for providers to differentiate between the concept of team members providing the same discrete service and individual team members providing distinctly different interventions or activities within a given service. When different members of a team provide such distinctly different interventions or activities, then a separate note written and signed by the person who provided that intervention or activity is required. Example: Direct interventions provided to an individual receiving CST services are documented in one service note, but a case management activity performed on the same day by a different CST staff member must be documented by that person in a separate service note.

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Service Note Requirements for Case Management Activities

Service notes for case management activities provided as a component within another service definition [e.g., Intensive In-Home services], have a slightly different focus, since case management is not a direct treatment/intervention type of service as described above. For this reason, items 2 and 3 below reflect this difference and replace items 8 and 10 in the *Contents of a Service Note* section above. A full service note is required for documentation of all case management services provided per service definition stipulations.

Service notes for case management activities shall include the following:
1. All the elements in *Contents of a Service Note* section above, except items number 8 and 10
2. A description of the case management activities provided [i.e., assessing, arranging, informing, assisting, monitoring], which relate to a goal/activity in the Person-Centered Plan (replacing item number 8)
3. A description of the results or outcome of the case management activities, any progress noted, and next steps, when applicable (replacing item number 10)

When documenting multiple case management events that are provided for the same individual within a single day, a composite note may be written, as long as all the case management activities that occurred within the day are addressed collectively in the service note.

PERIODIC SERVICES

Most MH/IDD/SU services are classified into three distinct categories: Periodic, Day/Night, and Twenty-Four Hour services.

A periodic service is defined as a service provided on an episodic basis, either regularly or intermittently, through short, recurring visits for persons with a mental illness, intellectual or developmental disability, or substance-related issue, as defined in APSM 30-1, *Rules for MD/DD/SA Facilities and Services.* For all periodic services, the frequency requirements for entering service notes is per event, or at least per date of service, when the service is provided. When a periodic service is provided, it shall be documented per date of service by the individual who provided the service on a full service note that contains the elements noted above in the *Contents of a Service Note* section, unless a modified service note or grid is specifically permitted. If a modified service note or service grid is permitted, the documentation must meet the requirements outlined in the *Services for Which a Modified Service Note may be Used* section, or the *Service Grid Documentation* section in this chapter.

DAY/NIGHT SERVICES

A day/night service is defined as a service provided on a regular basis, in a structured environment that is offered to the same individual for a period of three or more hours within a twenty-four hour period (APSM 30-1). The minimum frequency requirements for entering service notes vary among the different services within the day/night category.

Documentation of day/night services shall be entered in the service record on a full service note unless otherwise specified, following the required elements noted above in the *Contents of a Service Note* section. The date(s) of attendance shall also be documented in the service record for day/night services. In addition, the following minimum requirements must be met when documenting day/night services:

- The following day/night services shall be documented per date of service:
  - Child and Adolescent Day Treatment;
  - Partial Hospitalization; and
  - Substance Abuse Intensive Outpatient Program.
- Psychosocial Rehabilitation shall be documented on a weekly basis.
- The following day/night services shall be documented on a quarterly basis:
  - Adult Developmental Vocational Program [ADVP];
  - Community Rehabilitation Program;
  - Day/Evening Activity;

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- Before/After School and Summer Developmental Day;
- Long-Term Vocational Support Services [Extended Services]; and
- I/DD Supported Employment.

For day/night services requiring a DOS/weekly/quarterly note, but billed in 15-minute increments, the total amount of time spent performing the service per day must be documented in the service record. For each date of service note the total time is to be in the note. For weekly and quarterly notes, this information may be indicated with the attendance information or included in the notes. Be aware, however, that the timeframe in which to submit billing is no more than 90 days from the date of service, and each calendar quarter spans at least 90 days.

If the duration of services is less than the above noted frequency, a service note shall be documented for the period of time that the individual received the service. If Medicare is billed for Partial Hospitalization or for any other service covered by Medicare, then the Medicare documentation requirements shall be followed.

TWENTY-FOUR HOUR SERVICES

A twenty-four hour service is defined as a service provided to an individual on a twenty-four hour continuous basis, as defined in APSM 30-1, *Rules for MH/DD/SA Facilities and Services*. The following twenty-four hour services shall be documented according to the minimum frequency requirements as specified below in a full service note, unless otherwise specified:

- Child and Adolescent Residential Treatment – Level I/Family Type: Daily;
- Child and Adolescent Residential Treatment – Level II, Family Type [also known as Therapeutic Foster Care]: Per date of service; *(may use service note or grid)*;
- Child and Adolescent Residential Treatment – Level II, Program Type: Daily;
- Child and Adolescent Residential Treatment – Level III: Per shift;
- Child and Adolescent Residential Treatment – Level IV: Per shift;
- Family Living: Monthly, or duration of stay if less than a month;
- Group Living: Monthly, or duration of stay if less than a month;
- Medically Supervised or ADATC Detoxification/Crisis Stabilization: Per date of service;
- Non-Hospital Medical Detoxification: Per date of service;
- Professional Treatment Services in a Facility-Based Crisis Program: Per shift;
- Psychiatric Residential Treatment Facility [PRTF]: Per shift;
- Residential Treatment/Rehabilitation for Individuals with Substance Use Disorders: Per shift;
- Respite: Per date of service; may be documented on a modified service note, a service grid, or a combination of the two. SPECIAL NOTE: For Community Respite [YP730], if using a service gird, documentation is required per date of service. If using a modified service note, or a combination of a modified note and a service grid, documentation frequency is per date of service, if the duration of the service was no longer than a day. If longer than a day documentation shall be for the duration of the event, but not less than weekly. Institutional Respite is documented per State Developmental Center documentation requirements;
- Social Setting Detoxification: Shift note for every 8 hours of service provided;
- Substance Abuse Halfway House: Per date of service; and
- Supervised Living: Monthly, or duration of stay if less than a month.

Regardless of the service type, significant events in an individual's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements.

TIMELY DOCUMENTATION AND LATE ENTRIES

Timely documentation is essential to the integrity of the service record and for meeting reimbursement requirements of funding sources. Late entries and missing documentation can cause numerous problems for agencies and should be avoided. Late entries are defined as those which are entered after the required time frame for documentation has expired.

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For most mental health, intellectual or developmental disabilities, and substance use services, the requirement is that service notes [and grids when permitted] are written or dictated on or within twenty-four hours of the day that the service is provided. Timely documentation is evidenced by service notes or grids that are written or dictated within these parameters. For these purposes, weekends and holidays are not counted in terms of writing a note within 24 hours of the date of service unless the agency is operating on weekends and holidays.

There are a few day/night and twenty-four hour services, where the requirement is that certain categories of service notes, i.e., weekly, monthly, or quarterly notes, are to be written or dictated at the close of a designated service period, or within twenty-four hours of the close of the service period. In these situations, timely documentation is evidenced by service notes that are written or dictated within these parameters.

Late Entries

If a service note or grid is written or dictated any time after twenty-four hours of the date of service or close of the service period, it is classified as a late entry. All late entries must be marked as such and must include a dated signature. The following pages in this chapter detail the procedures for documenting late entries and are categorized by service type.

Some late entries are billable, i.e., eligible for seeking reimbursement, while others are not. The next two sections provide an explanation of the difference between late entries that are billable and those that are not.

<u>Late Entries – Billable</u>

In order for any service note [or grid when permitted] to meet reimbursement requirements, the documentation to support the service provider must be written or dictated within seven calendar days from the date of service [or from the closing date of the service period for some day/night and twenty-four hour services]. When a service note or grid is entered after twenty-four hours of the date of service, or after twenty-four hours of the close of the service period, but within seven calendar days that the staff member was on duty as previously described, then it is considered a late entry, but it is still billable for reimbursement. The note or grid shall be identified as a late entry and must include a dated signature.

<u>Late Entries – Not Billable</u>

Service notes are expected to be written or dictated within the seven-day time frame, not only to meet reimbursement requirements, but also to ensure that the description of the service provided is accurate. There should be very few occasions for a service note to be written or dictated after the seven-day time frame, as the possibility for the accuracy and detail depicted in the note to be compromised increases with time. When a service note or grid is written or dictated after the seven-day time frame has lapsed, it is classified as a late entry, must be indicated as such, and a dated signature is required, <u>but it may not be billed</u>.

Following is a table that may help in understanding the time frames for entering service notes:

Service Note Timeline Requirements for Billing, from Date of Service [DOS], or From Closing Date of Service Period [Day 1]							
Day 1 *[DOS, or Close of Service Period]*	Day 2 *[Within 24 hours of DOS, or Close of Service Period]*	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
Service Note Due	Service Note Due	Late Entry; Dated Signature	Late Entry; Dated Signature	Late Entry; Dated Signature	Late Entry; Dated Signature	Late Entry; Dated Signature	Late Entry; Dated Signature – **MAY NOT BILL**

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Dictation

When a service note is dictated for transcription, the date that the note was dictated must be indicated in the dictation by the service provider and included in the transcribed service note in order to verify that the note was dictated within the allowable time frame. When a service note is dictated more than twenty-four hours from the date of service / closing date of the service period, then the procedures for late entries above should be followed in the dictation and transcription.

Late Entry Procedures for Periodic Services

For periodic services, the completion of a service note or grid to reflect the services provided shall be documented on the day that the service was provided, or within 24 hours of the day of service, in order for the note to be considered timely documentation. Any service note or grid written or dictated after 24 hours from the date of service is classified as a late entry and must include the applicable documentation requirements below:

- The note shall be labeled as a late entry and shall include the date the documentation was made and the date that the documentation should have been entered, i.e., the date of service. For example, "Late Entry made on 11/20/14 for service provided on 11/17/14."
- The late entry service note requires a dated signature.

If an electronic health record is used, late entries are tracked/date-stamped in the system; therefore, the procedures for labeling late entries as outlined above are not required. For more information about entering service notes for specific periodic services, see the *Frequency and Other Requirements for Entering Service Notes* section in this chapter.

Late Entry Procedures for Day/Night Services

For day/night services, late entries are defined in different ways, depending on the specific frequency requirements for documenting certain types of day/night service provided. For more information about entering service notes for specific day/night services, see the *Frequency and Other Requirements for Entering Service Notes* section later in this chapter.

Day/Night Services Requiring Service Notes per Date of Service

When the frequency requirement for a day/night service is per date of service, the completion of a service note to reflect services provided shall be documented on the day that the service was provided, or within twenty-four hours of the date of service in order for the note to be considered timely documentation. Any service note written or dictated after 24 hours from the date of service is classified as a late entry and must include the applicable documentation requirements below:

- The note shall be identified as a late entry and shall include the date the documentation was made and the date that the documentation should have been entered, i.e., the date of service. For example, "Late Entry made on 3/20/15 for service provided on 3/17/15."
- The late entry service note requires a dated signature.

If an electronic health record is used, late entries are tracked/date-stamped in the system; therefore, the procedures for labeling late entries as outlined above are not required.

Day/Night Services Requiring Weekly or Quarterly Service Notes

When the frequency requirement for a day/night service is a weekly or quarterly note, the completion of a service note to reflect the services provided within the week or quarter shall be documented at the close of the service period, i.e., on the last day of the service period, or within 24 hours of the close of the service period, in order for the note to be considered timely documentation. Any service note written or dictated after 24 hours from the

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close of the service period is classified as a late entry and must include the applicable documentation requirements below:

- Each note shall be identified as a late entry and shall include the date the documentation was made and the date that the documentation should have been entered, i.e., closing date of service period. For example, “Late Entry made on 4/3/15 for service provided on 3/31/15.”
- The late entry service note requires a dated signature.

If an electronic health record is used, late entries are tracked/date-stamped in the system; therefore, the procedures for labeling late entries as outlined above are not required.

Late Entry Procedures for Twenty-Four Hour Services

For twenty-four hour services, late entries are defined in different ways, depending on the specific frequency requirements for certain types of 24-hour services provided. For more information on entering service notes for specific twenty-four hour services, see the *Frequency and Other Requirements for Entering Service Notes* section later in this chapter.

Twenty-Four Hour Services Requiring a Service Note per Shift or per Date of Service

When the frequency requirement for a twenty-four hour service is a service note per shift, or a service note per date of service, the completion of the note to reflect services provided shall be documented on the day that the service was provided, or within 24 hours of the date of service in order for the note to be considered timely documentation. Any service note or grid written or dictated after 24 hours from the date of service is classified as a late entry and must include the applicable documentation requirements below:

- The note shall be identified as a late entry and shall include the date the documentation was made and the date that the documentation should have been entered, i.e., the date of service. For example, “Late Entry made on 8/5/15 for service provided on 8/8/15 for third shift: 11:30pm – 7:30am.”
- The late entry service note requires a dated signature.

If an electronic health record is used, late entries are tracked/date-stamped in the system; therefore, the procedures for labeling late entries as outlined above are not required.

Twenty-Four Hour Services Requiring Monthly Service Notes

When the frequency requirement for twenty-four hour services is a monthly note, the completion of a service note to reflect the services provided during the month shall be documented on the last day of the service period [close of the service period], or within 24 hours of the close of the service period, in order for the note to be considered timely documentation. Any service note written or dictated after 24 hours from the close of the service period is classified as a late entry and must include the applicable documentation requirements below:

- The note shall be identified as a late entry and shall include the date the documentation was made and the date that the documentation should have been entered, i.e., closing date of service period. For example, “Late Entry made on 4/3/15 for service provided on 3/30/15.”
- The late entry service note requires a dated signature.

If an electronic health record is used, late entries are tracked/date-stamped in the system; therefore, the procedures for labeling late entries as outlined above are not required.

SERVICES FOR WHICH A MODIFIED SERVICE NOTE MAY BE USED

When the services listed in this section are provided, a modified service note may be used in lieu of a full service note. However, allowing the use of a modified service note for documenting certain services does not release the provider from the responsibility of documenting any unusual or significant responses on the part of the individual, changes in his or her situation, or including other pertinent or updated information.

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At a minimum, a modified service note is documented per event, containing the following components:

1. Name of the individual on each service note page;
2. Service record number along with Medicaid ID number (as applicable) or unique identifier on each service note page;
3. Service provided;
4. Date of service;
5. Duration of service;
6. Tasks performed; and
7. Full signature and credentials [or initials, if the full signature is included on the page when the use of a grid, attendance log, or checklist is allowed for documenting the service].

A modified service note may be used to document the provision of the following services:

- Opioid Treatment: A modified service note for Opioid Treatment shall be written at least weekly, or per date of service, in addition to documenting the administration and dispensing of methadone or other medication ordered for the treatment of addiction, which is documented on a Medication Administration Record (MAR);
- Personal Assistance;
- Personal Care Services: This service may be documented using a modified service note, a service grid, or a combination of a grid/checklist and a modified service note, unless provided by a home care agency that is following the home care licensure rules;
- Respite: This service may be documented using a modified service note, a service grid, or a combination of a grid/checklist and modified service note; or
- Community Respite.

For additional documentation requirements for these services, see Chapter 9 – "Special Service-Specific Documentation Requirements and Provisions".

SERVICE GRID DOCUMENTATION

A service grid is a format that is designed to efficiently document the service provided which includes the identified goal(s) being addressed. If a grid is not used to document the provision of any of the services listed below, then a full service note, or modified service note [when allowed] is required. A grid must contain an accompanying key that specifies the intervention/activity provided, as well as a key that reflects the assessment of the individual's progress toward the goal(s) during that episode of care. See *Sample Grid Form* and *Instructions for Using a Grid, Including the Sample Grid* in Appendix B.

When a grid is used to document the provision of a service, it shall be completed per event, or at least per date of service, to reflect the service provided and may only be used for the following services:

- Behavioral Health Prevention Education Services in Selective and Indicated Populations
- Child and Adolescent Residential Treatment – Level I and Level II, Family Type
- Community Networking [NC Innovations]
- Day Supports [NC Innovations]
- In-Home Intensive Supports [NC Innovations]
- In-Home Skill Building [NC Innovations]
- Personal Care Services [NC Innovations & I/DD] (This service may be documented using a combination of a grid/checklist and a modified service note, unless provided by a home care agency that is following their home care licensure rules.)
- Residential Supports [NC Innovations]
- Respite – all categories, except for Institutional Respite, which shall follow the state Developmental Centers' documentation requirements. Respite may be documented using a modified service note, a service grid, or a combination of a grid/checklist and a modified service note. See section entitled *Twenty-Four Hour Services* in this chapter for stipulations on Community Respite documentation.
- Supported Employment services [NC Innovations]

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Required Elements of a Service Grid

A service grid shall include all the following required elements:

1. Name of the individual on each service grid page;
2. The service record number along with Medicaid ID number, or unique identifier on each service grid page;
3. Date [month/year] that the service was provided;
4. Name of the service being provided [e.g., Personal Care Services];
5. Goals addressed;
6. A number or letter as specified in the appropriate key that reflects the intervention, activities, and/or tasks performed;
7. A number/letter/symbol as specified in the appropriate key that reflects the assessment of the individual's progress toward goals;
8. Duration;
9. Initials of the individual providing the service – the initials shall correspond to a full signature and initials on the signature log section of the grid; and
10. A comment section for entering additional or clarifying information, e.g., to further explain the interventions/activities provided, or to further describe the individual's response to the interventions provided and progress toward goals. Each entry in the comment section must be dated.

FAXED SERVICE NOTES

In situations when a service note or grid is completed and properly signed by the person who provided the service, and the note needs to be submitted to the office for timely review, coordination of care or filing, it is permissible to fax the service note to the office, provided that the reasonable administrative, technical and physical privacy precautions and safeguards are securely in place to protect the information from inappropriate use or disclosure. Such safeguards include but are not limited to the following:

- Documentation that is faxed must follow confidentiality guidelines and authorization requirements as is the case with any other protected health information.
- The fax cover sheet shall include a confidentiality statement.
- Care should be taken to ensure that the documentation is received by the intended recipient and that the fax machine is located in a secure area.
- The fax number should be double-checked before transmitting the fax.
- Fax confirmation sheets should be checked immediately to verify that the fax went to the correct number.
- A fax confirmation sheet should be attached to and maintained with each set of faxed documents.

Such safeguards should be followed including notifying the privacy and security officer at the agency when there is a question about the correct procedures to follow to ensure compliance with 45 CFR § 164.530(c) or when a breach occurs.

In all cases and throughout this process, the agency must safeguard, protect, and account for all original service notes, which contain confidential and protected health information. Staff who are writing service notes away from the office must take all the necessary steps to ensure that the original note is protected while in their possession, following all the appropriate safeguards outlined in this manual until the service note safely reaches the office, even if the note had previously been faxed to the office for review.

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DOCUMENTING IN SERVICE RECORDS

- All service record entries, including assessments/evaluations, shall include the date [month/day/year] the service was rendered.
- All service record entries shall be legible and made in permanent black ink, typewritten, or computer generated.
- Each page in a service record that originated within the provider agency shall include the individual's name and the service record number / unique identifier (for provider agencies).
- Each page of service notes shall include the Medicaid Identification Number for all Medicaid beneficiaries of behavioral health services.
- Goals and service notes must be specific and individualized and reflective of the needs of the person served. NOTE: Documentation that has been photocopied from an earlier service date or from another person's service record with a new date put in its place, or handwritten exactly or almost exactly as an earlier service note or from another person's service record <u>is not acceptable</u> as an individualized service note.
- Providers must exercise good judgment regarding relevance or sensitivity when determining what should be documented, realizing that any documented information has the potential to be reviewed and released.
- For those services where multiple practitioners provide different types of treatment to an individual, each practitioner shall document a separate note in the service record for each discrete service, treatment, or intervention provided.
- When a single, discrete service, treatment, or intervention is provided by a team in a single episode, there is no requirement for each team member to write a separate note; nor is it required that the service note be co-signed by each member of the team. Each staff member involved, however, and his or her role in the delivery of the service, must be specified in the service note. [See section entitled *Service Notes When Provided by a Team* in Chapter 7 – "Service Notes and Service Grids".]

GENERAL DOCUMENTATION DOs AND DON'Ts

<u>DO</u> enter information that is:

- Accurate – Document the facts as observed or reported.
- Timely – Record significant information at the time of the event, since delays may result in inaccurate or incomplete information.
- Objective – Avoid drawing conclusions. When a professional opinion is expressed, it must be phrased to clearly indicate that it is the view of the recorder.
- Specific, Concise, and Descriptive – Record in detail rather than in general terms; be brief and meaningful without sacrificing essential facts. Thoroughly describe observations and other pertinent information.
- Consistent – Explain any contradictions and give the reason for the contradiction.
- Comprehensive, Logical, and Reflective of Thought Processes – Record significant information relative to an individual's condition and course of treatment or habilitation.
- Clear – Record meaningful information and write in non-technical terms when possible.
- Inclusive of follow-up care, calls, or contacts, ensuring that unresolved problems from previous contacts are subsequently addressed, and recording plans for next contact [date/time], etc.

- Person-Centered – Use person first language when describing individuals, behavioral characteristics, treatment, events, and all other information that produces a picture of this person.

Document pertinent findings, service/supports rendered, changes in the individual's condition, and response to treatment/interventions/habilitation.

DON'T enter information that:

- Is unprofessional, critical of treatment carried out by others, or biased against an individual unless accompanied by a statement reflecting the need for documentation of the information. Such remarks, if made, cannot be obliterated.
- Personally identifies other individuals receiving services [with the exception of family/marital records]. If a provider must reference another individual in the record, the other person may be referenced by using his or her initials, record number, or letters/numbers, etc.
- Clearly identifies non-service recipient(s), significant other [spouse, sibling, girlfriend] by name. The use of the names of non-service recipients should be limited to those situations when the responsible professional determines that the use of the individual's name is clinically pertinent. Individuals who have a significant influence on the person receiving services may be identified by name as long as the extent and type of relationship and specific influence are also included. However, when non-service recipient names are included in the service record, such information should be reviewed prior to any release to determine whether the information should be disclosed or redacted.
- Is not based on fact, report, or observation.

ABBREVIATIONS

Agencies shall develop policy and procedures regarding the development, use, and maintenance of an abbreviation list. Only symbols and abbreviations contained in the agency's abbreviation list, or abbreviations listed in a standard dictionary and referenced in the provider agency's policy, may be used when entering information in the service record.

CONSENT

Informed written consent is required for a variety of situations, including, but not limited to, consent for treatment, release of information, and other situations. When consent is obtained, it shall be filed in the individual's service record. See Chapter 11 – "Accessing and Disclosing Information" for specific guidance related to the release of information.

Consent for Treatment

- Informed written consent or agreement for proposed treatment and plan development is required on the individual's PCP or service plan, or a written statement by the provider stating why such consent could not be obtained [10A NCAC 27G .0205(d)(6)].
- Written consent for the provider to provide [authorized] treatment is obtained prior to treatment services and shall be signed by the individual and/or legally responsible person.
- A written consent that grants permission to seek emergency medical care from a hospital or physician shall be obtained from the individual or LRP.
- A minor may seek and receive periodic services from a physician without parental consent in accordance with G.S. § 90-21.5 [See *Appendix C*].
- Per 10A NCAC 27D .0303(b), there must be informed written consent for planned use of a restrictive intervention.
- Additional written consent is obtained to cover other areas not specified on a service plan, such as advanced directives.

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Please see *In Loco Parentis* and *Consent for Minors* in this chapter for additional information related to obtaining consent for treatment.

Consent for Research

For research purposes, written consent, signed by the individual or legally responsible person, shall be obtained to authorize the person's participation as a subject in a research project. The consent shall reflect that the individual or LRP has been informed of any potential dangers that may exist, that the conditions of participation are understood, and that the individual has been informed of the right to terminate participation without prejudicing the treatment that is being received.

SPECIAL PRECAUTIONS

1. Known allergies and adverse reactions shall be clearly documented in the service record.
2. A lack of known allergies and sensitivities to pharmaceutical and other substances shall also be prominently noted in the individual's service record.

TIMELY DOCUMENTATION AND LATE ENTRIES

All documentation in the individual's service record should be entered in a timely manner in order to ensure that the information is current and up-to-date. Timely documentation is important to ensure the accuracy of documentation and to facilitate continuity of care should the individual require follow up services in the interim.

From an ethical, professional, and business standpoint, and in the best interest of the individual, timely documentation is essential. In addition, documentation related to billing and reimbursement [writing clinical assessments, entering diagnoses, writing service notes, updating the service plan or PCP, etc.] must be diligently recorded in the service record in order to verify service provision. Entering documentation beyond the allowable time frames causes unnecessary risk to an agency, and enables staff to write service notes with less detail or enter incomplete information, and can disrupt the billing and reimbursement process. For more information on late entries related to service notes, see Chapter 7 – "Service Notes".

CORRECTIONS IN THE SERVICE RECORD

It is important that the information contained in the service record is accurate. Provider agencies should have sufficient protocols and internal controls in place to ensure that all documentation in the record is correct and complete. All staff should make an ongoing effort to ensure that the information in the service record is correct. As changes occur in people's lives, updates are expected, e.g., updating the individual's new phone number.

The integrity of the original documentation that was entered into the service record to substantiate service provision and reimbursement of that event must be maintained, even when the original documentation contains an error. Subsequent revisions, changes, or corrections in the record must adhere to the procedural guidelines outlined in this manual. Changes or modifications to the original documentation for the purpose of making a correction can be made at any time when appropriate and shall be carried out in the manner described below.

Electronic Records

Agencies which utilize an electronic service record shall develop procedures that staff is required to follow whenever corrections are necessary in the service record. These procedures shall include the following requirements:

- Corrections must be made by the individual who recorded the entry;
- Corrections shall be electronically signed and shall include a date stamp;
- The original text shall not be deleted; and

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- An explanation as to the type of documentation error shall be included whenever the reason for the correction is unclear [e.g., “wrong service record”].

Paper Records

Whenever corrections are necessary in an individual’s paper record, the following procedures shall be followed:
- Corrections shall be made by the individual who recorded the entry;
- One single thin line shall be drawn through the error or inaccurate entry, making certain that the original entry is still legible;
- The corrected entry shall be recorded legibly above or near the original entry;
- The date of the correction and initials of the recorder shall be recorded next to or near the corrected entry;
- An explanation as to the type of documentation error shall be included whenever the reason for the correction is unclear [e.g., “wrong service record”];
- Whenever omitted words cannot be inserted in the appropriate place above the record entry, the information should be made after the last entry in the record. Never “squeeze’ additional information into the area where the entry should have been recorded; and
- Correction fluid or tape shall not be used for correction of errors.

SIGNATURES

All entries in the service record shall be signed, and all signatures must contain the appropriate credentials, degree, licensure, and/or title of the person entering information in the service record, constituting a “full signature”. The use of initials in lieu of a person’s signature is only allowed when correcting an error in a paper record, or when a service is documented on a service grid, and only if the provider’s full signature is included on the page [or the back of the page]. In this manual, a person’s signature is defined as the way an individual usually signs his or her name. Initials may be used only if it is the way the person usually signs his or her name. Every provider must have a staff signature file indicating the typical signature or each staff person. All of the following examples represent an acceptable signature:
- *Mary Jane Edwards*
- *M. Jane Edwards*
- *Mary J. Edwards*
- *Jane Edwards*
- *Mary Edwards*
- *M. J. Edwards*

Full signatures must contain the following elements:
- For professionals: Signature, with credentials, degree, or licensure of clinician who provided the service. For Licensed Professionals, the full signature denotes the clinician’s licensure and/or certification [e.g., LCSW, CCS]; for non-licensed professionals, the full signature denotes the degree [e.g., BA, MSW] and shall also include the individual’s professional status [e.g., QP or AP], and any other certifications the person may hold [e.g., CSAC].
    - For paper records, the signature must be handwritten; however, the credentials, degree, or licensure may be typed, printed, or stamped.
    - When using electronic signatures as permitted in the *Electronic Signatures of Staff* section of this chapter, a handwritten signature is not required.
    - When the service provider has an approved and documented reason per the Americans with Disabilities Act [ADA] for not being able to sign, then a stamp or other means for providing the signature is acceptable.
- For paraprofessionals: Signature and position of the individual who provided the service.
    - For paper records, the signature must be handwritten; the position may be typed, printed or stamped.

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    - When using electronic signatures as permitted in the *Electronic Signatures of Staff* section of this chapter, a handwritten signature is not required.
    - When the service provider has an approved and documented reason per the Americans with Disabilities Act [ADA] for not being able to sign, then a stamp or other means for providing the signature is acceptable.
- For individuals, parents, LRPs, and representatives from other agencies: Handwritten signature of the individual; for others, handwritten signature and relationship to the individual [or position].
    - Any handwritten signature given by the individual receiving services and his or her parents or LRP is acceptable.
    - Electronic signatures are permitted through the use of a pen/tablet combination, PIN-enabled attestation ("click-to-sign"), or other approved methods of affixing the signature or notation on the document. See *Signatures of Individuals, Parents, and Legally Responsible Persons* for more information.
    - When an individual receiving the service, a parent, LRP, or an individual from another agency has a reason per the Americans with Disabilities Act [ADA] for not being able to sign, then the service provider shall provide reasonable accommodations for the person, such as a stamp or other means for providing the signature.

Whenever a staff member is no longer available [extended leave, death, termination from position] to sign a record entry, a notation reflecting this shall be documented in the service record and signed by the staff member's supervisor on behalf of the previous staff member. See also the section *Administrative Closure of Clinical Service Records* in Chapter 2 for related guidance for conducting administrative closure of service records.

Authenticated/Dated Signatures

There are some instances where a person's signature is critical to the authenticity of a document, whether it is the signature of the service provider, the individual, the legally responsible person, or other individual. In situations when a dated signature is required, as in the case of service orders, Person-Centered Plans, service plans, etc., the signature is not acceptable without the date appearing next to it.

When a dated signature is required, an electronic signature shall include a date stamp. A handwritten signature requires a handwritten date by the signatory. Entering the date at the time that the signature is written confirms that the signature was made on that date. The date entered next to any signature must always be entered on the date that the person signs the document. The practice of pre- or post-dating signatures in any form or circumstance is prohibited. If the individual or his or her legally responsible person is unable to enter the date next to his or her signature on a paper document that he or she is signing, the legally responsible person or the service provider representative should enter the date next to the individual's signature on his/her behalf, along with his or her initials and an explanation of why the person could not enter the date (e.g. illiteracy, learning disorder), near the date entry at the time the signature is obtained.

As previously discussed in this chapter, for late entries, a dated signature is indicated. When entering corrections in the service record, the staff's initials and date that the correction was made are required for paper records; the staff's electronic signature and date stamp are required for electronic records. Providers should confirm with their electronic record vendors that audit trails will be able to validate when staff members revise/update records.

Use of Rubber Stamps

A rubber stamp may only be used by staff for medical/physical reasons and Americans with Disabilities Act [ADA] accommodations. If the individual is unable to use the stamp for medical/physical reasons, the individual shall authorize someone of his or her choosing to use the stamp. This designation shall be in writing and kept on file in the agency. When an individual receiving the service, a parent, LRP, or an individual from another agency requires reasonable accommodations per the ADA, then a stamp or other means for providing the signature is acceptable.

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Electronic Signatures[**]

According to HIPAA standards, an electronic signature is the attribute affixed to an electronic document to bind it to a particular party. An electronic signature:

- Secures the user authentication [proof of claimed identity] at the time the signature is generated;
- Creates the logical manifestation of signature [including the possibility for multiple parties to sign a document and have the order of application recognized and proven];
- Supplies additional information such as date stamp and signature purpose specific to that user; and
- Ensures the integrity of the signed document to enable transportability of data, interoperability, independent verifiability, and continuity of signature capability.

Verifying a signature on a document also verifies the integrity of the document and associated attributes and verifies the identity of the signer. When an entity uses electronic signatures, the signature method must assure all of the following features:

- Message integrity [evidence that the document has not been altered];
- Nonrepudiation [strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid]; and
- User authentication [evidence of the identity of the person signing]. No specific technology is mandated by HIPAA.

The NC Department of Health and Human Services follows the guidelines set by federal and state law that pertain to electronic signatures. These regulations govern what constitutes an electronic signature and who may use them. The Secretary of State's office has determined that, of the different forms of recognized electronic signatures, digital electronic signatures alone provide the security features required. For more information on the Secretary of State's decision, please review the page that addresses electronic signatures.

In keeping with the requirements for handwritten – or "wet" – signatures, the date signed must appear next to the electronic signature just as it would appear next to a handwritten one. Provider agencies' systems will need to be set up to allow the date to appear next to the signature, whether it is a digitized representation of the person's handwritten signature (like from a store's signature pad) or the computer-generated notation of an electronic signature.

When a handwritten signature is required because someone was not able to sign electronically, the signed page may be printed out to allow the additional signatures to be added to the signatures already obtained. Persons joining a meeting via phone or teleconference would sign a copy of the signature page with the other signatures already affixed.

For purposes of internal or external audits/reviews, it is recommended that the 'incomplete' signature pages are kept in the individual's file along with the completed, fully executed document containing all signatures required. The file will then contain two signature pages: one having been fully executed with a combination of electronic and traditional wet signatures, and the other having just the electronically signed signatures. The partially completed signature page will allow providers to verify which participants signed electronically.

Later in this chapter, specific guidelines are given for circumstances when electronic signatures can be used for staff, for individuals, parents, and legally responsible persons, and for individuals from other agencies.

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[**] The Uniform Electronic Transactions Act [UETA] of 2000 allows for the use of electronic records and signatures between parties. The MISs utilized by the LME-MCOs are required to be used by provider agencies for claims submission as well as requesting service authorization. When documentation is uploaded into the LME-MCO's system, it becomes an electronic document in compliance with the provisions of UETA.

Countersignatures

Countersignatures of entries in the service record are not required by DMH/DD/SAS. Provider agencies who elect to utilize countersignatures should have a policy reflecting who would be responsible for signing and monitoring the countersignatures.

SIGNATURES OF STAFF

Staff Signature File

Regardless of the type of records an agency utilizes, provider agencies shall establish and maintain an official staff signature file. This file must contain the printed name, the appropriate credential(s)/title(s), the written signature, and how the individual initials his or her name, for each person who is authorized to enter information in the service record. Such a file may be used to confirm or verify staff signatures in audit situations or clinical review activities, and should provide the greatest assurance of the authenticity and validity of staff signatures.

When provider agencies utilize electronic records, the governing body shall authorize the use of electronic signatures, and a list of all current staff who are authorized to use electronic signatures shall be maintained and kept on file. Compliance to this requirement shall be documented in the governing body minutes, and the governing body chairperson shall sign and date the authorized list, which should be maintained by the executive director or designee of the organization and the designated medical records staff person. If the agency does not have a governing body, then the executive director or designee, along with the medical records staff person or office manager, shall document compliance to this requirement and the authorization of staff to use electronic signatures, in an administrative meeting or supervision. A dated letter of authorization for using electronic signatures shall be placed in each staff member's personnel file.

Electronic Signatures of Staff

When an electronic signature is entered into the electronic record by agency staff, the following standards shall be followed:

1. The provider shall be given an opportunity to review the entry for completeness and accuracy prior to electronically signing the entry.
2. Once an entry has been signed electronically, the computer system shall prevent the entry from being deleted or altered. The entry shall include a date stamp.
3. If errors are later found in the entry, or if information must be added, this shall be done by means of an addendum to the original entry. The addendum shall be signed electronically and shall include a date stamp that will automatically be generated by the system.
4. Passwords or other personal identifiers shall be controlled to ensure that only the authorized individual can apply a specific electronic signature. Passwords should be changed at specified intervals.
5. Any staff authorized to use electronic signatures shall be required to sign a statement that acknowledges their responsibility and accountability for the use of their electronic signature. The statement should explicitly state that the provider is the only one who has access to and use of this specific signature code/password.
6. The provider shall maintain a log for staff who are authorized to use electronic signatures. The log should be updated regularly to reflect staffing changes.
7. An electronic signature shall be under the sole control of the person using it. A provider shall not delegate their electronic signature authorization to another person.
8. Policies and procedures shall be developed to:
    a. Safeguard against unauthorized use of electronic signatures. The policy shall also address sanctions for improper or unauthorized use of electronic signatures.
    b. Address procedures that staff should follow if the application is unavailable.
    c. Address procedures for the agency to follow when a staff member is not available to electronically sign documents.

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NOTE: The above electronic signature standards are subject to revision based upon state law and/or HIPAA requirements. Providers are responsible for staying current with all such standards and requirements.

SIGNATURES OF INDIVIDUALS, PARENTS AND LEGALLY RESPONSIBLE PERSONS

There are times when the signature of an individual's legal guardian, or legal representative, is required. The designation of a legal representative, or Legally Responsible Person [LRP], can occur in different ways. When the LRP is a relative of an individual, a copy of the appropriate legal papers must be filed in the individual's service record as verification of the legal relationship [e.g., legal guardian or power of attorney]. When the local department of social services, or any other public or private agency, has legal custody of an individual, the provider agency must obtain a copy of the court order and file it in the service record in order to verify that agency's authority to act on behalf of the individual and sign the PCP or service plan, and other documents as required, as well as to ensure proper consent and maintain confidentiality.

Handwritten signatures shall be accompanied by a handwritten date as applicable. When a signature from an LRP is required, the relationship is noted in addition to the name and date. If the individual or LRP is unable to enter the date next to his or her signature on the paper document that he or she is signing, the LRP or service provider representative should enter the date next to the individual's signature on his or her behalf, along with his or her initials and an explanation of why the individual or LRP did not enter the date, near the date entry at the time the signature is obtained.

Electronic signatures of individuals and/or LRPs are permitted, provided they meet the same requirements as previously described. Providers may allow limited access to individuals and/or legal guardians specifically for the purpose of signing documents electronically; the date shall be entered beside the signature just as for staff signatures. Another option for individuals to sign electronically is through the use of a pen and tablet. When someone has a reason per the Americans with Disabilities Act for not being able to sign, the service provider shall provide reasonable accommodations for the person to provide his/her signature.

In Loco Parentis and Consent for Minors

When the signature of a legally responsible person is required for a minor, and the parent is not involved in a child's life, but there has been no legal action to appoint a legally responsible person or guardian, an individual who has been acting in a parental role may still be able to make decisions for the minor child.

"In loco parentis" is a legal doctrine describing a relationship similar to that of a parent to a child. It refers to an individual who assumes long-term parental status and responsibilities for a minor child without formally obtaining legal recognition of that relationship [e.g., guardianship or adoption]. Chapter 122C-3(20) of the General Statutes defines a legally responsible person to include a person standing "in loco parentis", meaning someone who is acting on behalf of, or in the role of, a parent.

Service providers should carefully explain in the child's service record the details of how and why the person has assumed responsibility for the child. Providers should encourage the caregiver to seek a more official designation as a legally responsible person through for example a guardianship order, adoption, or power of attorney. Individuals acting in loco parentis may sign required documents as the legally responsible person on behalf of the child, indicating their identity and their relationship to the child near their signature.

SIGNATURES OF INDIVIDUALS FROM OTHER AGENCIES

When individuals from other agencies sign certain documents that are filed in the service record, their identity, job title/credentials, and/or their relationship to the individual should be indicated near their signature.

The following protocol is specific to the electronic signatures obtained from representatives from other agencies and others who are not agency staff. This guidance applies when an agency is seeking any non-agency

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signatures on documents such as Person-Centered Plans, service plans, release of information forms, consent forms, etc. The same stipulations listed in the *Signatures* section of this chapter apply for agency representatives of any sort.

ELECTRONIC DOCUMENTS

An electronic document is the document that is completed and scanned/uploaded or otherwise saved to an entity's computer or database system. LME-MCOs require provider agencies to submit requests for service authorization through their Management Information System [MIS], which includes uploading various required documents.

SPECIAL SITUATIONS

Documentation of Suspected/Observed Abuse/Neglect/Exploitation

1. Whenever abuse/neglect/exploitation of an individual is observed, suspected, or reported, relevant facts shall be documented in the service record, including reports made by the individual and actions taken by staff.
2. Documentation of observations and other information gathered during an episode or course of an interview or investigation shall be objectively formulated without judgment statements.
3. Per G.S. § 7B-301, any person or institution has the duty to report abuse, neglect, dependency, or death due to maltreatment of any juvenile to the Child Protective Services division of the Department of Social Services in the county where the juvenile resides or is found.
4. Per G.S. § 108A-102, any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the Adult Protective Services division of the Department of Social Services in the county in which the person resides or is present.
5. Per 10A NCAC 27G .0604, Category A and B providers shall submit an incident report to the LME-MCO responsible for the catchment area where services are provided, and DMH/DD/SAS [as appropriate for the level of incident] whenever there is an allegation of abuse, neglect, or exploitation of an individual, in accordance with the timeframes for submitting the incident report.
6. Per 10A NCAC 27G .0504(c), the LME-MCO Client Rights Committee shall oversee the implementation of client rights protections through a review procedure of cases of alleged abuse, neglect, or exploitation.

Incident Reports

Documentation of incidents must be kept in a separate file from the clinical service record. The occurrence of an incident shall be recorded in the service notes; however, the completed incident report shall not be referenced or filed in the service record, but filed in administrative files. Please see Chapter 1 – "General Records Administration and Reporting Requirements" for more information regarding incident reporting requirements. All incident reports shall be kept on file by the provider agency according to the *Records Retention and Disposition Schedule – DMH/DD/SAS Provider Agency*, Division Publication APSM 10-5.

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Chapter 9: Special Service-Specific Documentation Requirements & Provisions

The services described in this chapter have certain documentation requirements or provisions that are specific to the service and extend beyond, or differ from, some of the requirements noted elsewhere in this manual. Unless otherwise specified, the requirements or provisions listed in this chapter are in addition to the documentation requirements outlined elsewhere in this manual.

AMBULATORY DETOXIFICATION SERVICES

Detoxification rating scale tables, e.g., Clinical Institute Withdrawal Assessment – Alcohol, Revised [CIWA-AR], and flow sheets, which include tabulation of vital signs, are to be used as needed. A PCP is not required for this service.

ASSERTIVE COMMUNITY TREATMENT [ACT] TEAM SERVICES

ACT requires a full service note for each contact or intervention [for example, counseling, case management, crisis response, etc.] for each date of service, written and signed by the person(s) who provided the service. Each service note shall also include the place of service – the location where the service occurred. Please see the ACT Team section in Chapter 6 for discharge documentation requirements.

BASIC BENEFIT SERVICES

Outpatient behavioral health services provided to Medicaid or NC HealthChoice beneficiaries may be self-referred or referred by some other source. If the individual is not self-referred, documentation of the referral must be maintained in the service record.

For basic benefit services, also referred to as outpatient treatment and medication management services, written consent for treatment is required at the time of the initial service. This consent does not exempt the provider from also obtaining written consent on the service plan, once it has been developed with the individual.

A PCP is required when basic benefit services are provided in combination with any other mental health, intellectual or developmental disabilities, or substance use service that requires a PCP.

Basic benefit services require a written service order after the 16th visit for Medicaid beneficiaries under age 21, and NCHC beneficiaries age 6 through 18, if the services are being provided by an Associate Licensed Professional. For Medicaid beneficiaries 21 and older require a written service order after the 8th visit for services to be provided by an Associate Professional.

Providers of basic benefit services shall document coordination of care activities in the service record, including progress reports and summaries, communications by phone, treatment planning processes, coordination of care activities with CCNC/CA care manager, primary care physician, the “incident to” oversight physician, the LME-MCO, and others jointly determined by the referring provider and the behavioral health provider as necessary for assuring continuity of care.

Pursuant to 10A NCAC 27G .0205(a), a comprehensive clinical assessment that demonstrates medical necessity must be completed by a licensed professional prior to the provision of basic benefit services, including individual,

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family and group therapy. For further detail regarding requirements pertaining to the comprehensive clinical assessment, refer to CCP-8C. Chapter 3 – "Clinical Assessments and Evaluations", in this manual, also provides further guidance in this area.

For clinicians using Psychotherapy for Crisis codes, if the disposition is not an immediate transfer to a more intensive emergency setting, the disposition must include a written copy of an individualized crisis plan for the purposes of handling future crises. The crisis plan must include a scheduled outpatient follow up session.

Each treatment encounter requires a full service note. See CCP-8C and Chapter 7 – "Service Notes" in this manual for more information about writing service notes. The only exception to this requirement is when a medical provider is providing medication management and billing Evaluation and Management [E&M] codes. In this case, the medical provider must document the chosen E&M code with all of the necessary elements as outlined in the current edition of the American Medical Association's Current Procedural Terminology [CPT] manual.

BEHAVIORAL HEALTH PREVENTION EDUCATION SERVICES FOR CHILDREN AND ADOLESCENTS IN SELECTIVE AND INDICATED POPULATIONS

Modified records are required for all children and adolescents who meet eligibility for selective and indicated population criteria for receiving Behavioral Health Prevention Education Services. See Chapter 10 – "Documentation Requirements for Modified Records" for modified record requirements, and *Appendix D* in the companion manual for additional information about Behavioral Health Prevention Education Services. A Person-Centered Plan is not required if this is the only service being provided; however, a service plan, based on the requirements outlined in Chapter 10, is required.

CHILD AND ADOLESCENT DAY TREATMENT

Child and Adolescent Day Treatment providers are required to select and follow at least one clinical model or evidence-based treatment consistent with best practice. For each child in the program, the selected model or evidence-based treatment must address the clinical needs identified in the comprehensive clinical assessment and be documented in the Person-Centered Plan.

The Child and Adolescent Day Treatment Qualified Professional is responsible for convening the Child and Family Team and developing, implementing, and monitoring the PCP, which shall include the Crisis Prevention and Intervention Plan. While Child and Adolescent Day Treatment providers are not required to carry out 24/7/365 first responder functions, they are responsible for developing, implementing, and monitoring the crisis plan as part of the PCP, and the Day Treatment provider shall coordinate with the LME-MCO and the individual/family/legally responsible person in order to assign and ensure first responder coverage and crisis response as indicated in the child's Person-Centered Plan.

A discharge plan shall be developed with the child, the family/caregiver, and the Child and Family Team and included in the service record. The discharge plan may be separate from, or incorporated into, the transition plan that is included in the PCP.

The provision of Child and Adolescent Day Treatment is documented on a full service note for each date of service, written and signed by at least one of the persons who provided the service. Service notes must include the status of the child's progress and the effectiveness of the strategies and interventions outlined in the Person-Centered Plan.

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CHILD AND ADOLESCENT RESIDENTIAL TREATMENT – LEVEL I & II, FAMILY TYPE

Providers of Child and Adolescent Residential Treatment – Level I & II, Family Type are responsible for the development and implementation of the Person-Centered Plan in situations where a child does not have a current community-based behavioral health service provider. When this situation occurs, only a Qualified Professional monitoring the residential service may develop the PCP.

Documentation is entered per date of service on a service note or service grid and describes the staff's interventions and activities that are used to assist in restoring, improving, or maintaining the individual's level of functioning and are directly related to his or her identified needs, preferences, choices, specific goals, services, and interventions outlined in the PCP. In addition, documentation of critical events, significant events, or changes in status over the course of treatment shall be included in the service record as appropriate. When applicable, documentation must include the specific goals of sex offender treatment, as carried out in the therapeutic milieu and the interventions outlined in the individual's Person-Centered Plan.

CHILD AND ADOLESCENT RESIDENTIAL TREATMENT – LEVEL II, PROGRAM TYPE

Prior to and upon admission, and throughout a youth's stay in a residential treatment facility, the Child and Adolescent Residential Treatment provider should be collaborating with the Child and Family Team, the LME-MCO and the System of Care Coordinator, and other service providers. Evidence of these collaborative activities must be documented in the service record.

Providers of Child and Adolescent Residential Treatment – Level II, Program Type are responsible for the development and implementation of the Person-Centered Plan in situations where a child does not have a community-based behavioral health service provider. When these situations occur, only a QP delivering the residential service may develop the PCP.

Documentation requires a full service note or daily contact log that records the interventions and activities that are used to assist in restoring, improving, or maintaining the individual's level of functioning and are directly related to his or her identified needs, preferences, choices, specific goals, services, and interventions outlined in the Person-Centered Plan. In addition, critical events, significant events, or changes in status over the course of treatment shall be included in the service record as appropriate. When applicable, documentation must include the specific goals of sex offender treatment, as carried out in the therapeutic milieu and the interventions outlined in the individual's plan.

CHILD AND ADOLESCENT RESIDENTIAL TREATMENT – LEVEL III & LEVEL IV

Prior to and upon admission, and throughout a youth's stay in a residential treatment facility, the Child and Adolescent Residential Treatment provider should be collaborating with the Child and Family Team, the LME-MCO and the System of Care Coordinator, and other service providers. Evidence of these collaborative activities must be documented in the service record.

Providers of Child and Adolescent Residential Treatment – Level III or Level IV are responsible for the development and implementation of the Person-Centered Plan in situations where a child does not have a community-based behavioral health service provider. When these situations occur, only a QP delivering the residential service may develop the PCP.

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Initial Authorization Requirements

To obtain prior authorization for admission to a Child and Adolescent Residential Treatment – Level III or Level IV facility, a Comprehensive Clinical Assessment [CCA], which also includes a discussion of all life domains (emotional, social, safety, housing, medical, educational, legal, and vocational), shall be completed and signed by the licensed mental health professional completing the assessment within 30 days of the requested admission date to assure the appropriateness of placement. There must also be documentation that the Child and Family Team [CFT] has:

- Reviewed the current CCA;
- Reviewed all other alternatives and recommendations, and currently recommends Child and Adolescent Residential Treatment – Level III placement to maintain the health and safety of the child;
- Fully informed the youth and family/legally responsible person of all service options; and
- Developed a discharge/transition plan on the approved DMH/DD/SAS and DMA *Child/Adolescent Discharge/Transition Plan* form, found here.

In addition, there must be written evidence that one or more of the following have been met:

1. Placement shall be a step down from a higher level of placement, such as a Child and Adolescent Residential Treatment Level IV facility, a Psychiatric Residential Treatment Facility [PRTF], or an inpatient setting.
2. Multisystemic Therapy [MST], Intensive In-Home [IIH], or Residential Treatment Level II (or Level III as applicable) services have been unsuccessful, and severe functional impairment persists.

Once the above requirements have been met, the initial authorization request can be submitted electronically; the CCA, PCP, and discharge/transition plan shall be uploaded and attached to the service request. Provider agencies should consult with the LME-MCO for signature requirements on the discharge/transition plan, namely if the System of Care Coordinator's signature is required for authorization. All signatures on the discharge/transition plan are to be dated.

Consecutive Authorization Requirements

Because the length of stay at this level of care is limited to 180 days, any exception that may be granted will require all of the following:

- A psychiatric assessment [performed by a psychiatrist (MD/DO), a psychiatric physician assistant who is working under a psychiatrist's protocol, or an advance practice psychiatric clinical nurse specialist or advanced practice psychiatric nurse practitioner] or a psychological assessment [performed by a psychologist (PhD)] is required to provide clinical justification for continued stay at this level of care. For non-CABHAs, the assessment must be completed by an independent practitioner who is not associated with the residential service provider. For CABHAs, the assessment may be completed by a practitioner within the CABHA.
- There must be documentation of the following:
    - The Child and Family Team has reviewed the individual's goals and treatment progress;
    - The child/adolescent's family or discharge setting is involved in treatment planning and engaged in treatment interventions;
    - The review reflects active participation of the prior authorization vendor [LME-MCO]; and
    - The discharge/transition plan, using the required form found as an attachment to Implementation Update #85, has been updated with the most current information related to the discharge setting and/or service needs.

The authorization request must include a completed authorization request form, a copy of the psychiatric or psychological assessment, the revised PCP documenting the Child and Family Team review and family or discharge setting involvement in treatment, and the updated discharge/transition plan.

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Other Requirements

This service requires a full service note per shift that documents the interventions and activities that are used to assist in restoring, improving, or maintaining the individual's level of functioning and are directly related to his or her identified needs, preferences, choices, specific goals, services, and interventions outlined in the PCP. In addition, documentation of critical events, significant events, or changes in status over the course of treatment shall be included in the individual's service record as appropriate. When applicable, documentation must include the specific goals of sex offender treatment, as carried out in the therapeutic milieu and the interventions outlined in the individual's plan.

During Child and Adolescent Residential Treatment – Level III or Level IV stays, there must be documentation of the child's inclusion in community activities and the parent and/or legally responsible person's participation in treatment.

COMMUNITY REHABILITATION PROGRAMS

The documentation requirements specified in this manual do not apply to individuals supported by the Division of Vocational Rehabilitation Services. For these individuals, the documentation requirements specified by the Division of Vocational Rehabilitation Services shall be followed, which can be found here.

COMMUNITY SUPPORT TEAM SERVICES

Provision of Community Support Team services requires a full service note for each contact or intervention [such as individual counseling, case management, crisis response], for each date of service, written and signed by the person(s) who provided the service. In addition, a documented discharge plan shall be discussed with the individual and included in the service record.

COURT-ORDERED CONSULTATION OR ASSESSMENT-ONLY DOCUMENTATION REQUIREMENTS

Alcohol and Drug Education Traffic School [ADETS]

Documentation for Alcohol and Drug Education Traffic School records shall include:

- Information regarding the initial assessment to determine eligibility to attend school, including driving record, documentation of Blood/Breath Alcohol Concentration [BAC], and review of diagnostic criteria according to the DSM-5 or any subsequent edition of this reference material;
- The appropriateness of the referral to a treatment resource, if applicable;
- A copy of Form DMH-508, "Certificate of Completion Form";
- Documentation explaining the requirements for reinstatement of the driver's license, including duration of course work and fees, student contacts and other relevant transactions, i.e., referrals and/or non-compliance issues and outcomes;
- Pre-test and post-test scores, and homework assignments, if any; and
- A copy of a signed authorization for release of information, giving the facility permission to report the individual's progress to DMH/DD/SAS, Division of Motor Vehicles, and other agencies, as needed.

A record shall be maintained in the administrative files for each student. This service does not require a service plan unless treatment services are indicated and a full clinical service record is opened. An individual may voluntarily move from student status to service recipient status when it has been determined that the individual is in need of active treatment or rehabilitation and is accepted as a service recipient. Once a student becomes a treatment service recipient, a service record shall be opened and the staff will incorporate the ADETS record into the service record.

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Drug Education School [DES]

Documentation for school records in Drug Education Schools shall include:

- Information regarding the initial assessment to determine eligibility to attend the school;
- The appropriateness of the referral to a treatment resource, if applicable;
- A copy of Form DMH-4401, “Drug Education School Completion Form”;
- Documentation of other relevant transactions and student contacts, e.g., referral to another county and/or non-compliance issues and outcomes;
- Pre-tests and post-tests; and
- Homework assignments, if any.

A record shall be maintained in the administrative files for each student. This service does not require a service plan unless treatment services are indicated and a full clinical service record is opened. An individual may voluntarily move from student status to service recipient status when it has been determined that the individual is in need of active treatment or rehabilitation and is accepted as a service recipient. Once a student becomes a treatment service recipient, a service record shall be opened and the staff will incorporate the DES record into the service record.

Assessment-Only Driving While Impaired [DWI] Services

For individuals participating in the DWI program for the purpose of assessment only, a service plan is not required, and documentation of services shall be maintained in a pending file. However, if the participant becomes enrolled in treatment services, a full record must be opened and a service plan is required. See the *Driving While Impaired [DWI] Services* section below for assessment requirements.

DEVELOPMENTAL DAY SERVICES – BEFORE/AFTER SCHOOL AND SUMMER

There shall be a service plan developed which identifies the goals that will be addressed while the child is present in the before/after school developmental day service. In addition, a copy of the Individualized Education Plan [IEP] shall be filed in the service record. The IEP is included in the record for continuity of care; however, the IEP shall not be used in lieu of an individualized service plan for the developmental day service.

Documentation of this service shall be entered in the service record on a full service note on a quarterly basis. Please note that for day/night services requiring a quarterly note, but reported/billed in 15-minute increments, the total amount of time spent performing the service per day must be documented in the service record. This information may be indicated with the attendance information or included in the quarterly service note.

DIAGNOSTIC ASSESSMENT

A Diagnostic Assessment is a specific type of comprehensive clinical assessment and must be conducted by a team consisting of at least two licensed or certified clinicians as specified in the service definition. The Diagnostic Assessment must include the following elements:

1. A chronological general health and behavioral health history [includes both mental health and substance use disorders] of the individual’s symptoms, treatment, treatment response and attitudes about treatment over time. This general and behavioral health history must emphasize the factors that have contributed to or inhibited previous recovery efforts;
2. Biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
3. A description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
4. Strengths/problems summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;

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5. All relevant diagnoses according to the DSM-5 or any subsequent edition of this reference material. The DSM-5 diagnosis should always be recorded by name in addition to listing the code;
6. Evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
7. A recommendation regarding target population [benefit plan] eligibility; and
8. Evidence of the individual's participation, including families, or when applicable, guardians or other caregivers.

In addition, for individuals with a substance use disorder diagnosis, a Diagnostic Assessment recommends a level of placement using the American Society of Addiction Medicine [ASAM] Criteria. For Diagnostic Assessments with a substance use focus, the diagnostic tool designated by DMH/DD/SAS for these specific benefit plan populations shall be used.

The Diagnostic Assessment is a multidisciplinary evaluation that requires face-to-face participation in performing the assessment with the individual by both clinicians, each within his or her scope of practice. The Diagnostic Assessment report requires the signature of each clinician to verify his or her part in completing the assessment. The Diagnostic Assessment may not be completed solely by one clinician in consultation with another clinician, as this service must be performed by a two-person team. It can be completed together in one session or separately; one clinician would then write the report for both to sign.

DRIVING WHILE IMPAIRED [DWI] SERVICES

There are very specific documentation requirements for Driving While Impaired Services. A DWI substance abuse assessment shall only be provided by a licensed substance abuse treatment facility as specified in 10A NCAC 27G .0400 (Licensing Procedures), or by a facility which provides substance abuse services and is exempt from licensure under G.S. § 122C-22. In addition, in order to perform DWI assessments, the facility must be authorized by the Division of MH/DD/SAS to provide these services.

The selection of instruments used in assessing DWI offenders is limited to the approved list published by DHHS. The assessment documentation includes a standardized test, a clinical face-to-face interview, a review of the individual's complete driving history from the DMV, Blood Alcohol Content verification, diagnosis according to the DSM-5 or any subsequent edition, ASAM Criteria, written consent for release of information, notification of provider choice, recommendations and requirements for driver's license reinstatement, and assessment date completed on DMH Form 508-R. An assessor who has met the qualifications and requirements in G.S. § 122C-142.1(b1), as amended per Session 2003, House Bill 1356, shall conduct the clinical face-to-face interview, which includes administering standardized testing to the individual. The provider who signs the face-to-face clinical assessment shall be the person who conducted the assessment.

Additional documentation requirements include evidence of the individual's signature for all of the following:

- Verification of receipt of a complete list of DWI assessment/service providers within the individual's service area;
- Verification that the individual was apprised of all the requirements necessary to reinstate the driving privilege; and
- Verification of signed consent for release of confidential information in accordance with 10A NCAC 27G .3807(d).

Requirements for substance use services for DWI offenders fall under the auspices of the Rules for MH/DD/SAS Facilities and Services and are outlined in detail in 10A NCAC 27G, Section .3800. The specific documentation requirements are outlined in Subsection .3814 below:

10A NCAC 27G .3814 DOCUMENTATION REQUIREMENTS

(a) When conducting the assessment for an individual charged with, or convicted of, offenses related to Driving While Impaired (DWI), a DMH Form 508-R shall be completed.

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(b) If treatment is recommended, client record documentation shall include, but not be limited to the following minimum requirements for each DWI Category of Service listed in Rule .3805 of this Section, except for the ADETS category:
  (1) all items specified in the “clinical interview”, as defined in Rule .3805 of this Section;
  (2) results of the administration of an approved “standardized test”, as defined in Rule .3805 of this Section;
  (3) release of information as set forth in Rules .3807 and .3810 of this Section; and
  (4) release of information covering any collateral contacts, and documentation of the collateral information.

(c) Substance abuse facility policies and operational procedures shall be in writing and address and comply with each of the requirements in 10A NCAC 27G .0201.

(d) Substance abuse treatment records shall comply with the elements contained in 10A NCAC 27G .0203, .0204, .0206 of this Subchapter and 10A NCAC 27G .3807 and 10A NCAC 27G .3810.

If the individual participates in or receives DWI services which result in an assessment only, the documentation is filed and maintained in a pending record; however, if the individual becomes involved in treatment services, then a full service record must be opened, which includes a written service plan.

DROP-IN CENTER SERVICES

This service is a day/night service for service recipients and non-service recipients. According to the service definition, documentation for drop-in center services is required in a service record, or in a pending record [some type of form that identifies the individual by name or unique identifier]. There is no identified service plan requirement for this service, as participation is considered ‘spontaneous’ (not scheduled); regular service provision cannot be anticipated. It is recommended that the documentation be entered on a daily basis.

LONG-TERM VOCATIONAL SUPPORT SERVICES

Unless otherwise specified by the individual, this service must occur twice a month at the work site. If off-site monitoring is established, it must include one contact each month with the employer. Each of these contacts must be clearly documented in the individual’s service record. The individual has the right to decline this service at any time, but this must be thoroughly documented in the person’s service record. Please also see Chapter 7 – “Service Notes” for additional information about service note documentation requirements for this service.

MEDICALLY SUPERVISED OR ADATC DETOXIFICATION/CRISIS STABILIZATION

Detoxification rating scale tables, e.g., Clinical Institute Withdrawal Assessment – Alcohol, Revised [CIWA-AR], and flow sheets, which include tabulation of vital signs, are to be used as needed. A documented discharge plan, which has been discussed with the individual, must be included in the individual’s service record. A PCP is not required for this service.

MEDICATION ADMINISTRATION

All providers who dispense and/or administer any medications to an individual in their care are subject to the requirements outlined in this section. The requirements for documenting the dispensing and administration of medication, as well as other requirements, including the documentation of medication errors, shall be made in accordance with 10A NCAC 27G .0209 MEDICATION REQUIREMENTS. This administrative code addresses the dispensing, packaging and labeling, administration, disposal, storage, review, education, self-administration requirements, documentation requirements of a Medication Administration Record [MAR], special documentation requirements for medication review and medication education, and the requirements for documenting medication errors. All non-licensed staff administering any medication to an individual must show documented evidence of having received the required training and privileging as outlined in item (c) below.

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Sections of 10A NCAC 27G .0209 are below in their entirety (c,f-h). Each section references the documentation requirements for medication administration:

10A NCAC 27G .0209 MEDICATION REQUIREMENTS

(c) Medication administration:
  (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.
  (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician
  (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.
  (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:
    (A) client's name;
    (B) name, strength, and quantity of the drug;
    (C) instructions for administering the drug;
    (D) date and time the drug is administered; and
    (E) name or initials of person administering the drug.
  (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

(f) Medication review:
  (1) If the client received psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be [sic] performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated.
  (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.

(g) Medication education:
  (1) Each client started or maintained on a medication by an area program physician shall receive either oral or written education regarding the prescribed medication by the physician or their designee. In instances where the ability of the client to understand the education is questionable, a responsible person shall be provided either oral or written instructions on behalf of the client.
  (2) The medication education provided shall be sufficient to enable the client or other responsible person to make an informed consent, to safely administer the medication and to encourage compliance with the prescribed regimen.
  (3) The area program physician or designee shall document in the client record that education for the prescribed psychotropic medication was offered and either provided or declined. If provided, it shall be documented in what manner it was provided (either orally or written or both) and to whom (client or responsible person).

(h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.

NON-HOSPITAL MEDICAL DETOXIFICATION SERVICES

Detoxification rating scale tables, e.g., Clinical Institute Withdrawal Assessment – Alcohol, Revised [CIWA-AR], and flow sheets, which include tabulation of vital signs, are to be used as needed. A documented discharge plan, which has been discussed with the individual, must be included in the individual's service record. A PCP is not required for this service. See APSM 30-1, *Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services*.

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OPIOID TREATMENT

A Medication Administration Record [MAR] shall be utilized to document each administration of methadone, buprenorphine, naltrexone, or other medication ordered for the treatment of addiction. In addition, this service requires a record of all take-home doses ordered by a program physician and prepared for the individual, and each Opioid Treatment Program [OTP] Exception Request and Record of Justification submitted to the State Operated Treatment Administrator and Center for Substance Abuse Treatment under 42CFR § 8.11 (h). A modified service note is required for documenting OTP patient clinical events. Any of the following occurrences is considered a clinical event:

- A change in medication or medication dose,
- A medication error (only that which qualifies as a Level I incident),
- An adverse reaction to medication,
- A caution or advisory regarding a potential medication interaction,
- An OTP Exception Request and Record of Justification,
- A take-home level change,
- A positive alcohol or drug screening result,
- An unsuccessful bottle call-back or pill count,
- An unexpected finding for the individual from an OTP query of the NC Controlled Substance Reporting System or other state prescription monitoring program,
- A report of possible medication diversion,
- A concern regarding safe medication storage, or
- An event related to patient instability or non-compliance with program requirements, including required program attendance and adherence with behavioral expectations in the clinic setting.

In addition to the medication-related documentation, a modified service note shall be written at least weekly for the first three months following the date of OTP patient admission, transfer, or readmission, or per date of service if the individual receives the service less frequently than weekly.

A full service note is required for documenting all counseling sessions and for any and all significant events, changes in status, or situations outside the scope of medication administration.

A documented discharge plan shall be discussed with the individual and included in the service record. Use the link above for APSM 30-1 for more information on Opioid Treatment.

OUTPATIENT TREATMENT AND MEDICATION MANAGEMENT SERVICES

See *Basic Benefit Services* section.

PROFESSIONAL TREATMENT SERVICES IN FACILITY-BASED CRISIS PROGRAM

A Person-Centered Plan is not required for this service due to the short-term nature of the service; however, a treatment plan is required. For Medicaid-covered beneficiaries, a service order must be made prior to or on the day services are initiated, and utilization review must be conducted after the first seven (7) days of service provision. State-funded services recommend that a service order be in place. Utilization review (to determine current need) must occur after the first 72 hours. This service requires, at a minimum, a service note per shift.

For children and adolescents, a pre-admission screening shall be completed by a Registered Nurse to determine medical appropriateness of placement. In addition to requiring a treatment plan, the Licensed Professional working with the family is to develop a crisis plan that will direct treatment and interventions during admission. A CCA is also required prior to discharge in order to document medical necessity.

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PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES [PRTF]

Documentation of PRTF services must meet the requirements of the accrediting body, Medicaid, and federal regulation. 42 CFR Part 441, Subpart D – *Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs* requires the completion of a Certificate of Need [CON] statement prior to or upon admission to a PRTF facility when the individual is Medicaid-eligible or when Medicaid eligibility is pending. The last dated signature on the CON determines the effective date of the CON and authorization for payment. A copy of the CON must be maintained in the individual's service record. The specific requirements for the CON can be found in DMA's *Clinical Coverage Policy 8-D-1*.

Seclusion and restraint may only be ordered by a physician, a nurse practitioner, a licensed psychologist, or a physician assistant. A registered nurse may issue the written order based on a verbal authorization from one of the authorized individuals. The required one-hour assessment following restraint may be conducted by a physician, a nurse practitioner, a physician assistant, or a registered nurse. Since one purpose of this assessment is to address potential medical issues arising from the restraint, this assessment may not be conducted by a licensed psychologist. Any observations are to be placed in the service record.

PSYCHOSOCIAL REHABILITATION [PSR]

When the Qualified Professional responsible for the development, implementation, and revisions to the Person-Centered Plan is a PSR provider, he or she must include all the services that the individual is receiving in addition to PSR, such as outpatient treatment, medication management, etc., in the PCP. The QP is also responsible for developing the crisis plan, which is a required component of PCP development, and there must be evidence of coordination with the LME-MCO and the individual to identify local crisis services that can be accessed.

For individuals receiving Psychosocial Rehabilitation services, the PCP shall be reviewed every six months. Providers of PSR may choose to use the PSR service note form found in Appendix B of the companion manual to document PSR services rendered. The following guidance is outlined below for providers to follow when using this format.

Guidance for Documenting PSR Service Provision

Psychosocial Rehabilitation must be documented on a full service note, no less frequently than weekly, but may be documented per date of service, following the guidelines below:

- The individual's name, Medicaid ID number and service record number / unique identifier must be entered on each page of the service notes.
- The date of service and the duration [actual amount of time spent performing the interventions] per day must be entered in the service record for each PSR episode. Regardless of the frequency of documentation [daily or in a composite weekly note], the total amount of time spent performing the service per date of service must be documented in the service record. This information may be indicated with the attendance information or included in the service note.
- Purpose of Contact: Enter the goals that were the focus of the interventions. [If using the PSR service note form, the individual's goals may be preprinted in the Purpose of Contact section.]
- Interventions/Activities: Each note must describe the interventions and activities provided. When using the PSR service note form to document services, each service record must contain a description of the interventions and activities provided in order to provide additional information beyond the items checked on the form, and should serve as a "key" for the interventions/activities that are indicated on the form. Staff is to check the activities that the individual participated in and write in any additional comments.
- Effectiveness: Documentation of effectiveness must include the individual's response to the interventions and progress toward goals accomplished by the individual.
- All entries must be properly signed by the staff providing the service. When PSR is provided to an individual by more than one staff member at the same time, one of the members of the team who provided the service may write and sign the service note. The service note must include the other

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participating staff members involved and describe their role in providing the service. However, it is not necessary for all the staff to sign the note.

When this service is documented on a weekly basis, it is vital that the weekly composite note is reflective of the entire array of interventions used, all the staff who were involved in the delivery of the service, the individual's response to each of the interventions used, and progress noted throughout the week. See Chapter 7 – "Service Notes" for additional guidance in writing service notes, as well as Attachment 1 of Implementation Update #70, which provides detailed guidance in writing weekly PSR service notes.

RESIDENTIAL RECOVERY PROGRAMS FOR INDIVIDUALS WITH SUBSTANCE ABUSE DISORDERS AND THEIR CHILDREN

For individuals receiving these services, the Person-Centered Plan shall also include goals for parent-child interaction, and progress toward meeting these goals shall be documented in the individual's service record. These services also include:

- Therapeutic parenting skills,
- Basic independent living skills,
- Educational groups,
- Child supervision,
- Aftercare,
- Follow-up, and
- Access to preventive and primary health care, which shall all be documented in the parent's record.

Additionally, discussion of the discharge plan with the individual must be documented in the service record.

Substance Abuse Non-medical Community Residential Treatment

Residential recovery programs for women and children shall provide documentation of all services provided to the children in the program. Person-Centered Plan goals for parent-child interaction shall be established, and progress toward meeting these goals shall be documented in the service record. A TB screening is completed in accordance with federal requirements, and a referral is made if necessary. Additionally, discussion of the discharge plan with the individual must be documented in the service record.

RESPITE SERVICES

When respite is the only service provided, a modified service record is permitted. [See Chapter 7 – "Service Notes & Grids", and Chapter 10 – "Documentation Requirements for Modified Records".] However, service records for respite must contain enough information for the provider to be able to ensure the safe and proper care for the individual entrusted to the respite provider, regardless of the type of record used. See Chapter 2 – "The Clinical Service Record" – for the additional requirements for a full service record when a modified record is not permitted for respite.

SOCIAL SETTING DETOXIFICATION SERVICES

Documentation of vital signs, withdrawal symptoms, and symptoms of secondary complications to alcohol/drug abuse is to be entered into the service record. A PCP is not required for this service; a discharge plan, discussed with the individual, is to be documented and included in the service record. See APSM 30-1 for more details.

SUBSTANCE ABUSE HALFWAY HOUSE

At a minimum, this service requires a full service note for each day the person resides in the Halfway House, as well as a documented discharge plan that is discussed with the individual and included in the service record. A TB screening is completed in accordance with federal requirements, and a referral is made if necessary.

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THERAPEUTIC LEAVE

1. Documentation shall reflect the number of days of leave and include verification of the specific therapeutic leave days.
2. Documentation related to the therapeutic leave shall include:
    a. The length of time for the leave;
    b. Justification for each therapeutic leave episode; and
    c. A statement regarding the individual's condition prior to and after return from the leave.
3. For Medicaid-eligible children or adolescents in a Level II, Level III, Level IV residential treatment facility, or PRTF for which Medicaid is paying reimbursement for these services, the necessity of therapeutic leave and the expectations involved in such leave shall be documented in the child or adolescent's PCP, and the therapeutic justification for each instance of such leave entered in to the individual's record shall be maintained at the residential treatment facility or PRTF site.
4. For Residential Levels II-IV and PRTF facilities, an individual is allowed up to 45 days of therapeutic leave during the calendar year, but not to exceed 15 days of therapeutic leave each calendar quarter.
5. Therapeutic leave must be documented in the PCP for residential care; it does not require a separate prior authorization, as it is part of the above-named residential services. Facilities shall keep a cumulative record of therapeutic leave days taken by each individual for reference and audit purposes.

TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES [TASC]

The procedures and guidelines specified in the *TASC Standard Operating Procedures Manual*, revised June 30, 2007, shall be followed. TASC's role and function include assessing for substance use disorders and screening for mental health issues in the criminal justice population, matching offenders to appropriate services, ensuring placement, and monitoring and reporting on all progress. The TASC assessment process includes a structured interview and the use of a standardized instrument. The information collected and documented includes demographics, employment, education, legal, drug and alcohol use, family and social relationships, family history, medical status, psychiatric status, mental health screening, diagnostic impression according to the DSM-5 or any subsequent edition, American Society for Addiction Medicine (ASAM) Criteria, assessment outcome, and staff signature with credentials. The TASC SOP Manual contains guidance throughout the document, but certain sections, such as "Section II: Care Management", may prove to be especially helpful in finding information regarding the documentation requirements under the TASC Program.

TUBERCULOSIS (TB) SCREENING FOR INDIVIDUALS PARTICIPATING IN SUBSTANCE USE DISORDER TREATMENT

In accordance with 10A NCAC 27A .0213, 10A NCAC 27A .0216, and Public Law 102-321 (Title II), TB screenings are required with the aim of identifying individuals who are at high risk of becoming infected with tuberculosis. Persons with substance use issues and with limited access to medical care are at increased risk for tuberculosis infection. Per P.L. 102-321, entities receiving Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds for treatment services must conduct TB screenings of individuals entering such services. Providers are to query service applicants about their health history as it relates to TB signs and symptoms. There is no prescribed format providers are expected to use when documenting TB screenings. The Division of MH/DD/SAS requires the following elements to be included in the provider's screening documentation:

- Medical treatment in the past three months,
- Current place of residence (jail, streets, shelter, etc.),
- History of TB tests (prior positive skin tests, proximity to others diagnosed with TB in the past year), and
- Physical/visible symptoms of TB, such as night sweats, prolonged cough, shortness of breath, and unexplained weight loss.

A sample screening tool and accompanying guidance can be found in the Appendix. Based upon an individual's positive responses to symptoms in the screening tool, a referral must be made to the local county health

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department or the individual's medical practitioner for follow-up testing and care. The completed screening and any required follow up must be documented in the service record.

UNIVERSAL PREVENTION DOCUMENTATION REQUIREMENTS

Documentation for service records shall include:

1. Person/agency receiving consultation;
2. Type of group participating in educational or prevention program;
3. Approximate number of participants by age, race, and gender;
4. Date and duration/time of the event;
5. Preventive strategy;
6. Description of the event including name of evidenced-based practice; and
7. Staff member participating in the event.

This service alone does not require a service plan. A TB screening is completed in accordance with federal requirements, and a referral is made if necessary. If treatment services are indicated, then a full clinical service record is opened.

WORK FIRST / SUBSTANCE ABUSE INITIATIVE

Substance use screening is an integral part of the Work First application process. The AUDIT and DAST-10 shall be used for screening alcohol and drug use disorders for all adult Work First applicants/recipients by the Qualified Substance Abuse Professional or the DSS worker. An assessment for substance use disorders is required for all Work First applicants/recipients who are found to be high risk on the screening and is administered by a QSAP. The SUDDS-5, or other standardized assessment tool approved by DMH/DD/SAS, is used as part of the comprehensive clinical assessment for this population. An applicant/recipient may also be referred to a QSAP based on the documented results of the Substance Abuse Behavioral Indicator Checklist II. Screening for mental health issues is voluntary. The Emotional Health Inventory is used when screening mental health issues for adult Work First applicant/recipients. Additional documentation shall include any barriers to services.

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Chapter 10: Documentation Requirements for Modified Records

A modified record is a clinical service record which has requirements that are either different from those that are usually associated with a full clinical service record, or a record which contains only certain components of a full service record. The use of modified records is limited to specific services that have been approved by the Division of MH/DD/SAS, and only when there are no other services being provided. Modified records may only be used for the following services:

- Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations;
- PATH Program;
- Respite;
- Universal Prevention Services; and
- Other services, when approved by the Division.

When an individual receives services in addition to those listed above, a full service record shall be opened, using the same record number, and information contained in the modified service record should be merged into the full service record.

BEHAVIORAL HEALTH PREVENTION EDUCATION SERVICES FOR CHILDREN AND ADOLESCENTS IN SELECTIVE AND INDICATED POPULATIONS

The following documentation is required if Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations is the only service being provided:

- Assessment, which shall include:
  - Documentation of the findings on a child or adolescent risk profile that identifies one or more designated risk factors for substance use;
  - Documentation of individual risk factor(s), history of substance use patterns, if any, and attitudes toward use; and
  - Other relevant histories and mental status sufficient to rule out other conditions, suggesting the need for further assessment and/or treatment for a substance use disorder and/or a co-occurring psychiatric diagnosis.
- Service plan, which shall:
  - Be based on an identification of the child's, adolescent's, and/or family's problems, needs and risk factors, with recognition of the strengths, supports, and protective factors;
  - Match the child or adolescent risk profile with appropriate evidence-based Selective or Indicated Substance Abuse Prevention goals that address the child's or adolescent's and/or family's knowledge, skills, attitudes, intentions, and/or behaviors; and
  - Be signed by the participant and the parent/legally responsible person, as appropriate, prior to the delivery of services.
- Service documentation, following the delivery of each service, that shall include on a service grid:
  - Identification of the evidence-based program being implemented;
  - Full date and duration of the service that was provided;
  - Listing of the individual child or adolescent and/or his or her family members that were in attendance;
  - Identification of the curriculum module delivered;
  - Identification of the module goal;

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- Identification of the activity description of the module delivered;
- Initials of the staff member providing the service which shall correspond to a signature with credentials identified on the signature log section of the service grid; and
- In addition to the above, notation of significant findings or changes in the status of the child or adolescent that pertain to the appropriateness of provision of services at the current level of care and/or the need for referral for other services.

For additional information about Behavioral Health Education Services for Children and Adolescents in Selective and Indicate Populations, please see *Appendix D* in the companion manual.

PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) PROGRAM

Providers receiving funding from the PATH Program to address homelessness must maintain a client file, which at a minimum will include an intake (or eligibility) form, a PATH [service] plan, and service notes for all persons enrolled and served. The information collected on the intake form is utilized to determine eligibility for enrollment. The service plan, which shall be reviewed no less than every three months, shall contain at least the following goals:

- Obtaining community mental health services;
- Obtaining needed service, including services relating to shelter, daily living activities, personal and benefits planning, transportation, habilitation and rehabilitation services, prevocational and employment services, and permanent housing;
- Obtaining income and income support services, including housing assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, and Supplemental Security Income / Social Security Disability Insurance (SSI/SSDI); and
- Obtaining other appropriate services.

All contacts made with or on behalf of an individual enrolled in PATH require a full service note. In the course of a day, one PATH staff may provide more than one activity/intervention; these may be documented in one service note. If a second PATH staff person provides an activity/intervention/service to the same individual on the same day, that staff will write a separate service note. In addition to the requirements for a full service note as stated in Chapter 7 – *Service Notes and Grids* – a PATH service note must also include any referrals made and the date/time/location for the next [scheduled] contact. All service notes generated through the NC Homeless Management Information System (HMIS) shall be printed and signed/dated by the staff person providing the service. Providers utilizing an electronic medical record system to maintain service records may follow the requirements of an EMR.

The following forms are also required components of individual client files:

- Release of Information / Statement of Confidentiality, and NCHMIS release,
- NCHMIS PATH Entry Form
- PATH Eligibility Verification form [which also serves as the initial service note],
- Vulnerability Index Service Prioritization Decision Tool (VI-SPDAT) or National alliance to End Homelessness (NAEH) Coordinated Assessment Tool,
- Security Deposits Assistance (Rent/Utilities),
- Lease Agreement, when obtained,
- Utility company letter indicating the amount individual requires for utility deposits,
- One-time Rent Assistance to Prevent Eviction (if necessary), and
- PATH Discharge Summary form [which also serves as the final service note].

RESPITE SERVICES

When respite is the only service provided, a modified service record is permitted. However, service records for respite must contain enough information for the provider to be able to ensure the safe and proper care for the individual entrusted to the respite provider, regardless of the type of record used. The respite service record shall contain sufficient demographic and contact information, crisis and emergency information, medical and nutritional

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information [including all medications and all allergies], behavioral information, any special precautions and instructions specific to the needs and requirements of the individual receiving care, as well as any other information that will aid in the delivery of the appropriate level of care for the individual. See Chapter 2 – "The Clinical Service Record" for the additional requirements for a full service record when a modified record is not permitted for respite.

Documentation for the provision of respite services shall include the following minimum requirements in the service record:

- Identification/face sheet and diagnostic information
- Although no specific service plan is required for respite care, special instructions regarding behavioral conditions, nutritional and medical information, medications to be administered, and other information or procedures that are pertinent to the caregiving needs of the individual shall be given to the respite provider, filed in the service record, and followed as instructed.
- Respite[††][‡‡] must be documented per date of service on a modified service note, a service grid, or a combination of a modified service note and service grid/checklist. Respite service notes shall include:
  - Name;
  - Either the service record number of the individual along with the Medicaid Identification Number, or unique identifier [on every service note page];
  - The service provided [i.e., Respite];
  - Date of service;
  - Duration of the service;
  - Tasks performed, including notations or comments on any behaviors, etc., which are considered relevant to the individual's continuity of care;
  - Any significant events that occurred during the provision of respite services;
  - Documentation that special instructions were followed as necessary; and
  - Signature and position of the individual who provided the service. [See Chapter 7 – "Service Notes" for more information about signing service notes.]
- The respite provider shall obtain all necessary information and instruction regarding the steps to take and whom to contact in the event of a crisis or emergency. This information shall be kept in the individual's service record.
  - If the individual has a PCP, the needed information from the crisis plan shall be given to and reviewed with the respite provider.
  - If there is no PCP and respite is the only service being provided, then the respite provider must ensure that all necessary emergency information is obtained in order to appropriately respond to a crisis or emergency while the individual is in the care of the respite provider.
- When any medication is administered, the provider must meet all the requirements in accordance with 10A NCAC 27G .0209 ADMINISTRATION OF MEDICATION, including the maintenance of a Medication Administration Record [MAR] and documentation of medication errors. See the section in this chapter entitled *Medication Administration* for details.

UNIVERSAL PREVENTION SERVICES

See Chapter 9 – "Special Service-Specific Documentation Requirements & Provisions" for documentation requirements.

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[††] For Community Respite [YP730], if using a service grid alone, documentation is required per date of service; if using a combination of a modified note and a service grid, documentation frequency is per date of service if the duration of the service was no longer than a day. If longer than a day, documentation shall be for the duration of the event, but not less than weekly.

[‡‡] Institutional Respite shall follow the state Developmental Centers' documentation requirements.

Chapter 11: Accessing & Disclosing Information

This section of the *Records Management and Documentation Manual* discusses the individual's right to request access to information contained in his or her own service record, as well as issues dealing with disclosure. This chapter addresses a few of the most significant provisions of the privacy and confidentiality laws previously outlined in Chapter 2 – "The Clinical Service Record", and does not attempt or purport to describe all provisions fully. In addition, this chapter does not address the specific requirements of G.S. § 130A-143 related to individuals with AIDS or related conditions; providers must follow those requirements as appropriate. Service providers must consult the actual text of all the laws and other educational resources for comprehensive understanding of the confidentiality laws and how they apply under various circumstances. When there are differences among the various laws, providers must follow the most stringent requirements.

INDIVIDUAL ACCESS TO SERVICE RECORDS

North Carolina General Statutes and the Department of Health and Human Services make provisions for the individual and the legally responsible person to access the information contained in one's own service record. However, there are certain circumstances where access to the service record may be limited. When an individual or his or her LRP is granted limited access to the record, proper justification for restricting access to the complete record must be clearly indicated in the service record. Individuals and their legally responsible person have the right to appeal such a determination.

For further information contained in the General Statutes about an individual's or LRP's access to information in the service record, please see Article 3, Part 1 [Client's Rights], of the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, § 122C-53, particularly items (c) and (d), cited below:

Excerpt from § 122C-53:

(c) Upon request a client shall have access to confidential information in his client record except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, the facility director or his designee. If the attending physician or, if there is none, the facility director or his designee has refused to provide confidential information to a client, the client may request that the information be sent to a physician or psychologist of the client's choice, and in this event the information shall be so provided.

(d) Except as provided by G.S. 90-21.4(b), upon request the legally responsible person of a client shall have access to confidential information in the client's record; except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, the facility director or his designee. If the attending physician or, if there is none, the facility director or his designee has refused to provide confidential information to a client, the client may request that the information be sent to a physician or psychologist of the legally responsible person's choice, and in this event the information shall be so provided.

The Omnibus HIPAA final rule provides individuals with the right to request to inspect and obtain a copy of his or her health information, such as individually identifiable medical and billing/payment information contained in "designated record sets", which would include the service record.

DHHS Privacy Policy speaks to the right of an individual to access his or her medical record. In addition, and in accordance with the policy, the legally responsible person who is acting on behalf of an individual is afforded the

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same rights as the individual unless otherwise specified by state or federal law. For further information on procedures related to access to service records, please see the *DHHS Policy and Procedure Manual*, Section VIII: "Privacy and Security".

Although this DHHS policy uses general language ["DHHS agency"] in reference to agencies providing services, it is important to understand that the application of this policy extends to mental health, intellectual or developmental disabilities, and substance use service providers, in accordance with § 122C. One excerpt from this policy document includes the following:

> Right to Request Access to Individually Identifiable Health Information
>
> Client Right
>
> Each client of a DHHS agency has the right to request access to inspect and obtain a copy of his/her health information for as long as the information is maintained by the agency in a designated record set. [Refer to DHHS Privacy Policy, Client Rights Policies, Designated Record Sets.] If the agency does not maintain the health information that is the subject of the client's request for access, but knows where the requested information is maintained, the agency must inform the client where to direct his or her request for access.
>
> Each client's request for access to his/her personal health information must be in writing. DHHS agencies may require the requester to:
>
> - Complete agency form for request;
> - Submit own written request; or
> - Submit electronic request via e-mail.
>
> Agency Responsibility
>
> DHHS agencies are required to comply with DHHS Privacy Policy, Client Rights Policies, and Designated Record Sets, which requires agencies to identify records that are used to make decisions about clients. The client's right to request access to records applies only to those records that have been identified as a "designated record set". If the same information requested by the client or personal representative is contained in multiple designated record sets, the agency can limit access to a single designated record set. DHHS agencies must determine the process for addressing a client's request to access, inspect, and copy his/her records. All requests from clients or their personal representative must be in writing and forwarded to the agency's privacy official, or other designee, who is responsible for ensuring the request is processed in a timely manner, not to exceed 30 days (with a one-time 30-day extension if the record cannot be accessed within the original 30 days). The agency is required to notify the requester in writing of any extension outlining the reasons for the delay.

Designated record sets is also addressed in this same policy ("Privacy and Security").

Provider agencies are required to develop procedures for processing requests of individuals receiving services for access to their health information, such as determining acceptable methods for requesting access, setting response timelines, designating the privacy official [or designee] responsible for receiving and processing access requests, establishing criteria to be used in determining access or limitations, and other procedures. In addition, agencies are required to establish a process that outlines how to provide the individual with access or copies, where access will be given, and how it will be handled, including how questions will be answered.

For mental health, intellectual or developmental disabilities, or substance use services, when an individual's access to his or her service record is granted, it is recommended that the agency includes in its procedures a

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provision that a clinician [preferably one who is involved in the provision of services for that individual] be available to review the information in the record with the individual so that he or she understands the nature of the contents of the record, and has access to a qualified clinician to answer any questions he or she might have related to the documentation contained in the service record. If the individual feels there is an error in his or her service record, s/he has the right under 45 CFR 164.526 to request an amendment to the record. The agency should develop protocol to address the procedure the agency will follow to document the concern of the individual and the correction/amendment made to the record. The approved amendment shall then be sent to any other agency that had also been sent that information. Documentation should be in the service record pertaining to the discrepancy and resulting resolution concerning the individual's protected health information. More information on a patient's right to amend PHI can be found at 45 CFR 164.526.

OVERVIEW OF CONFIDENTIALITY RULES AND LAWS

The Omnibus HIPAA final rule, in particular Parts 160 and 164, and the state confidentiality law applicable to mental health, intellectual or developmental disabilities, and substance use service providers [G.S. § 122C-51 through 122C-56 and 10A NCAC 26B] prohibit the disclosure of information related to individuals receiving mental health, intellectual or developmental disabilities, or substance use services, except as permitted or required by the privacy rule and state confidentiality law. The federal substance abuse records law [42 CFR Part 2] prohibits the disclosure of substance abuse treatment information received or acquired by a federally assisted alcohol or drug abuse program except as permitted by the federal substance abuse records law.

Each of these laws defines the entities or providers subject to the law, defines the class of information protected by the law, permits or requires disclosure without consent of authorization in certain circumstances and in other circumstances requires consent or authorization for the disclosure of protected information.

- The Omnibus HIPAA final rule governs "protected health information" or PHI, which is essentially any information related to health [physical or mental] that can be identified with a particular individual (45 CFR 160.103).
- The state confidentiality law applies to any information, whether recorded or not, relating to an individual served by a mental health, intellectual or developmental disabilities, or substance use facility and received in connection with the performance of any function of the facility.
- The federal substance abuse confidentiality law applies to any information, whether recorded or not, that identifies an individual as an alcohol or drug user and is information obtained by a federally assisted alcohol or drug use program for treating alcohol or drug use disorders, making a diagnosis for that treatment, or making a referral for that treatment [42 CFR 2.12(a)(1)].
- Information which, if disclosed, risks the possibility of discrimination, social stigma or harm is considered to be sensitive health information. This includes disclosure of a mental health or substance use condition, present or past, or of a sexually transmitted disease, including HIV/AIDS.

DISCLOSING INFORMATION FOR COORDINATION OF CARE

When a service provider agency enters into a contract with an LME-MCO, the provider agency agrees to show good faith efforts to coordinate supports and services with other provider participants. Service providers will need to share clinical information in order to cooperate in serving the same individual or in order to transfer care for an individual between providers. When circumstances requiring coordination of care occur, providers are required to work together to ensure efficient communication for a seamless transition from one provider to another. Except for substance abuse information [as discussed further in this chapter], providers will find that both the Omnibus HIPAA final rule and the state confidentiality law permit the sharing of service recipient information for purposes of coordinating care and treatment without the individual's written consent or authorization. Under the Omnibus HIPAA final rule, a covered provider may use or disclose PHI (protected health information) for its own treatment activities or the treatment activities of another health care provider. Service recipient authorization is not needed when sharing information for these purposes. [See 164.506(c)(1) and (2) and HIPAA definition of "treatment" to understand the scope of activities subject to this rule.] Under G.S. § 122C, mental health, intellectual or

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developmental disabilities, or substance use service programs that are operated by or are under contract with an LME-MCO, or are a part of a state-operated facility, may share confidential information regarding program service recipients when necessary to coordinate appropriate and effective care, treatment, or habilitation of the individual. Consent of the service recipient is not needed for this information exchange [G.S. § 122C-3(14) and 122C-55(a)].

Exception – Substance Abuse Information

The federal law governing substance abuse treatment information requires the individual's written authorization before a provider subject to the law may disclose information to other treatment providers. An exception to this rule is that personally identifying information may be disclosed to medical personnel who have a need for information in order to treat a medical condition that poses an immediate threat to the health of any individual and requires immediate medical intervention (42 CFR 2.13 and 2.51).

DISCLOSING INFORMATION FOR SERVICE AUTHORIZATION AND REIMBURSEMENT

When seeking authorization and payment for services, although the Omnibus HIPAA final rule permits a health care provider to disclose protected information for payment activities without the service recipient's written authorization [164.506(c)(1) and (2)], providers of mental health, intellectual or developmental disabilities, and substance use services are subject to the state confidentiality law's more restrictive provisions. They are also subject to the restrictions of 42 CFR Part 2. Except for information related to substance use, a provider of services to LME-MCO service recipients may, without the individual's consent, exchange confidential information regarding its service recipients with the LME-MCO, other providers, and state-operated facilities when necessary to conduct payment activities. [Payment activities are defined in G.S. § 122C-55(a2) as activities undertaken to obtain or provide reimbursement for the provision of services and may include, but are not limited to, preauthorization of services, determinations of eligibility or coverage, coordination of benefits, determinations of cost-sharing amounts, claims processing, billing and collection activities, medical necessity reviews, utilization management and review, concurrent and retrospective review of services.]

With the exception of substance use service records, which are subject to 42 CFR Part 2, whenever there is reason to believe that an individual is eligible for benefits through a DHHS program, mental health, intellectual or developmental disabilities, and substance use service providers that are operated by or under contract with an LME-MCO, or are a part of a state-operated facility, may share confidential information regarding program participants with the Secretary of DHHS, and the Secretary may share confidential information regarding any individual with providers, LMEs, and state facilities. With the exception of the disclosure of substance use information, consent for disclosure is not required as long as disclosure is limited to that information necessary to establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the individual [G.S. § 122C-55(a3)].

Exceptions – Third Party Payers/Insurers and Substance Use Information

Providers of mental health, intellectual or developmental disabilities, and substance use services must obtain consent to disclose confidential information to private, third party payers, such as health insurers, for authorization and other payment activities. In addition, the federal law governing substance abuse treatment information requires the individual's written authorization before a provider subject to the law may disclose substance abuse treatment information to *any* third party payer, including both private insurance companies and government entities and their agents who are administering government benefits programs (42 CFR Part 2.11). Thus, a mental health, intellectual or developmental disabilities, and substance use service provider or LME-MCO must obtain the individual's written authorization to disclose substance use service recipient identifying information to a third party.

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DISCLOSING INFORMATION FOR OTHER PURPOSES

DHHS policy allows for certain disclosures in situations where there may be a need to disclose a service recipient's information for law enforcement purposes, to avert a serious threat to the health and safety of a person or the public [unless the agency learned such information when treating, counseling, or providing therapy for such criminal conduct; or if the individual requested to be referred for treatment, counseling, or therapy for such criminal conduct], and in keeping with specialized government functions, such as the Red Cross, CIA, FBI, etc., and others. Please see items 6-8 in the chapter entitled "Use and Disclosure Policies, Use and Disclosure" in Section VIII (Privacy and Security) of the *DHHS Policy and Procedure Manual* for detailed guidance for these and other situations.

DOCUMENTATION REQUIREMENTS WHEN DISCLOSING INFORMATION

Under all three confidentiality laws applicable to mental health, intellectual or developmental disabilities, and substance use services, a service provider *must* obtain an individual's written authorization for disclosure of confidential information, unless the use or disclosure is required or otherwise permitted by the applicable law. Each law requires specific elements to be contained in a consent form [also referred to as an authorization or release form]. For the most part, these requirements are the same for each law, and one consent or authorization form may be constructed to meet the requirements of all three laws. However, because there are some minor differences in the required elements under each law, the preparer of a form designed to meet any or all three laws should consult the applicable provisions of each law. For HIPAA, see 45 CFR 164.508(c); for state law, see 10A NCAC 26B .0202; for the substance abuse law, see 42 CFR 2.31.

The following rules regarding consent or authorization to disclose information apply to the information governed by all three confidentiality laws.

1. The authorization must be in writing.
2. The individual's authorization must be *voluntary*.
3. The individual's authorization must be *informed*. This means that the individual signing the authorization must understand what information will be exchanged, with whom it will be shared, and for what purpose.
4. An authorization to disclose confidential information *permits*, but does not require, the covered provider to disclose the information. [Disclosure is mandatory only when the individual requests disclosure to an attorney. See G.S. § 122C-53(i).]
5. When a covered provider obtains or receives an authorization for the disclosure of information, any disclosure must be consistent with the authorization. This means that covered providers are bound by the statements provided in the authorization.
6. An individual may revoke the authorization at any time except to the extent that the covered provider has taken action in reliance on the authorization.

The following are some general requirements regarding disclosures and documentation of disclosures:

- When disclosing or releasing protected or confidential information, even when permitted or required under confidentiality law, mental health, intellectual or developmental disabilities, and substance use service providers must adhere to the Omnibus HIPAA final rule provisions that apply generally to many kinds of disclosures. For example, before making any disclosure of protected health information (PHI), the Omnibus final rule [164.514(h)] requires a covered entity generally to:
    - Verify the identity of the person requesting PHI and the person's authority to have access to PHI, if the identity and authority of the person is not already known to the covered entity, and
    - Obtain any documentation, statements, or representations that are required by the Omnibus HIPAA final rules from the person requesting the PHI.
- In addition, the minimum necessary standard of the privacy rule requires a covered entity, when *using or disclosing* PHI or when *requesting* PHI from another covered entity, to make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request [164.502(b)].

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- The Omnibus HIPAA final rule (164.528) gives an individual the right to an accounting of disclosures of PHI made by a covered entity or its business associate(s). The covered entity must account for disclosures of PHI made in the six years prior to the date of the individual's request. The accounting does not have to include disclosures made before the Privacy Rule compliance date [April, 2003], and the rule does not apply to every disclosure of PHI. When an accounting is required, the service record must reflect this. At a minimum, provider agencies must keep an accounting of release and disclosure log in the individual's service record that contains the following information:
  - Name of the individual
  - Medical record or ID number
  - Date the information was released/disclosed
  - Provider/Entity/Agency/Individual to whom the information was released
  - Purpose of the release/disclosure
  - Description of the specific information released/disclosed
  - Name of person disclosing the information [not required, but recommended]
- Providers must have policies and procedures in place that ensure compliance with privacy and confidentiality rules.

RE-DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Re-disclosure of protected health information is prohibited, except as provided by G.S. § 122C-53 through G.S. § 122C-56. Confidential information received concerning a service recipient cannot be transmitted to another provider without the written consent of the recipient or legally responsible person for re-disclosure to the other provider from the original source. LME-MCOs, provider agencies and state facilities releasing confidential information must inform the recipient that re-disclosure of such information is prohibited without client consent and the documents initially disclosed shall be marked with a statement to that effect. A stamp may be used to fulfill this requirement. General Statute 122C can be accessed through this link.

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