

RECORDS MANAGEMENT AND DOCUMENTATION MANUAL

for

Providers of Publicly-Funded MH/DD/SA Services

CAP-MR/DD Services

and

Local Management Entities



**North Carolina
Department of Health and Human Services**

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

APSM 45-2

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Preface

Revision of the Service Records Manual as a Function of Mental Health Reform

Since 2001, the Division of Mental Health/Developmental Disabilities/Substance Abuse Services [DMH/DD/SAS] has been engaged in the re-design of the MH/DD/SA service system and in the provision of publicly-funded services for persons with mental health, developmental disability, and substance-related issues. This system transformation brings with it consequent changes in the way the system works.

State Plan 2005: Blueprint for Change indicates that a core aspect of the vision for reform is that:

All human service agencies that serve people with mental health, developmental disabilities, and substance abuse problems will work together to enable individuals to live successfully in their communities [page 13].

One of the key ways that the system is evolving to meet this goal is the development of a broad network of service providers in the community. *State Plan 2005: Blueprint for Change* goes on to indicate that the transformation of our service system involves providers and managers having:

Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided, and that contain only those elements necessary to substantiate specific outcomes required [page 13].

For further information about Mental Health System Transformation, please see the following link:

<http://www.ncdhhs/mhddsas/stateplanimplementation/index.htm>

The DMH/DD/SAS Service Records Manual has been revised and renamed as the “Records Management and Documentation Manual for Providers of Publicly-Funded MH/DD/SA Services, CAP-MR/DD Services, and Local Management Entities” [APSM 45-2] to reflect an expansion in scope as further addressed in this section, and in order to facilitate the emergence of a service system in keeping with the above vision of transformation. As a result, the new manual is intended to:

- Be user-friendly;
- Link the user to more detailed information;
- Provide the most up-to-date information;
- Reflect policy changes as our system evolves; and
- Be responsive to and encourage Continuous Quality Improvement [CQI].

The development of our service system is built upon the principles of CQI. The Records Management and Documentation Manual has been designed with a view to incorporating these principles. Consistent review and adjustment of processes through CQI can be challenging, and guidance documents need to reflect changes in a timely manner. As a result, this manual has been designed to be a mechanism through which providers can access current information. In addition, this manual is designed to reflect current policy in order to ensure ongoing provider compliance and accountability.

In keeping with this philosophy, the Records Management and Documentation Manual now includes web-based links that allow users to access new information as new policy decisions are made and as source documents are revised. This manual is designed to be a fluid document that provides its users access to valuable information, even as system transformation continues. As the public MH/DD/SA system is transformed, there will be periodic updates of this manual and its associated links. This will assist the large and diverse provider network in staying abreast of service records and documentation requirements as services are defined, implemented, and revised.

The guidelines and requirements outlined in this manual reflect current policy unless superseded by subsequent changes in DMH/DD/SAS or DMA policies, updates, or requirements in the specific service definitions. While every effort will be made to keep this manual current to reflect ongoing policy and procedural changes, providers are encouraged to keep abreast of policy changes and other communications to the provider network through regular reference to the Division of MH/DD/SAS and the Division of Medical Assistance web sites, found here:

<http://www.ncdhhs.gov/mhddsas/>

<http://www.ncdhhs.gov/dma/prov.htm>

Scope

The requirements and guidelines addressed in this manual have incorporated Medicaid standards, DMH/DD/SA rules, policies, and procedures, as well as other applicable regulations, such as HIPAA, etc. in an effort to move toward greater uniformity in record-keeping. The standards identified in this manual apply to MH/DD/SA services provided to consumers by individuals or agencies that are either:

- Endorsed by a Local Management Entity as a Community Intervention Service Agency for direct Medicaid enrollment;
- Providing services through a contract with a Local Management Entity;
- Providers of CAP-MR/DD services; or
- 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.

This manual does not apply to providers of outpatient and medication management services who are not required to be endorsed by an LME and are directly-enrolled with Medicaid and/or who are providing these services to individuals who pay privately. DMA's *Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers* is the applicable policy document for providers of these services to Medicaid-funded individuals. This policy can be accessed at the following link:

<http://www.ncdhhs.gov/dma/bh/8C.pdf>.

NOTE: If an LME is a direct provider of outpatient treatment and medication management services to Medicaid-funded individuals, the LME is subject to both DMA's *Clinical Coverage Policy 8C*, and the applicable requirements of this manual.

Agencies providing behavioral health services [including outpatient treatment and medication management services] through a contractual arrangement with an LME to receive reimbursement with state dollars, or LMEs providing these services directly to individuals who are not eligible for Medicaid, are subject to the applicable requirements of this manual.

How to Use This Manual

The revisions to the Records Management and Documentation Manual have been made to reflect Mental Health System Transformation and to represent the decisions that have been made up to the time this document is published. Additional decisions will be made that will affect the content of this manual. As

these decisions are made, the appropriate sections of the manual will be updated to reflect these decisions.

For the reasons discussed earlier, this manual has been designed to integrate with resources that are available on the internet, especially the Division's web site, accessible below at the following link:
<http://www.ncdhhs.gov/mhddsas/index.htm>.

These internet resources may include policy documents as well as information regarding detailed service records requirements. The body of this document also includes policy statements and detailed service records requirements.

It is the intent of this document to be a stand-alone service records manual whose utility is augmented by electronic links to pertinent source documents, which provide more background and detail on certain requirements. This manual reflects current policy by outlining required and recommended procedures regarding service records management and maintenance. This manual is intended to be an online reference with a search function to facilitate successful navigation through the manual to find specific topics of interest. In addition, by utilizing the search feature, a user can pull up all references to the topic of interest [e.g., the CAP-MR/DD waiver]. This feature will be especially helpful to the new provider.

Chapter 1: General Records Administration and Reporting Requirements

The Value of Recordkeeping

Recordkeeping is a fundamental component of any business, public or private, and careful, accurate recordkeeping is critical to business success. A solid appreciation of good record-keeping practices by everyone within an agency will go far in ensuring accountability and will reduce legal and other risks. It is crucial that leaders demonstrate a commitment to vigilance in recordkeeping practices and elicit the same commitment from all of their employees.

Recordkeeping 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/DD/SA system.

Diligent recordkeeping 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 treatment and services 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 and support 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 sound recordkeeping and reporting practices in order to verify compliance and to demonstrate the organizational integrity of their agency. 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 additional administrative requirements for maintaining and managing MH/DD/SA records. These requirements include personnel records, an index of individuals served, the assignment of a service record number, and compliance with policies governing the retention and destruction of records. For LMEs, this includes the establishment of an administrative record for each individual 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 the required educational, licensure, credentials, and other qualifications of staff performing the service. This includes evidence of any required criminal background checks and/or 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 supervision, and documentation of clinical 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 for State and Area Facilities* 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 by all service provider agencies:

- Master Index - This index is a file of persons served.
- Service Record Number Control Register - This register controls the assignment of service record numbers. Any individual admitted shall retain the same service record number on subsequent admissions.

Record Retention and Disposition

Each entity, including the LME and service providers, owns the records that they generate and bears an inherent responsibility for the maintenance and retention of those records per prescribed guidelines. The two schedules which address the retention and disposition requirements for publicly-funded MH/DD/SA services are the *DHHS Records Retention and Disposition Schedule for Grants* and the *Records Retention and Disposition Schedule for State and Area Facilities*, Division Publication, APSM 10-3. LMEs and community providers are subject to the applicable standards outlined in both schedules.

APSM 10-3 is currently under revision and in some cases, has been superseded by more recent requirements, some of which are discussed below. This section is intended to give the reader some basic information about record retention and disposition requirements. 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.

LME Responsibility

The "Record Retention" section of the performance contract between the Department of Health and Human Services [DHHS] and each LME states that "in order to protect documents and public records that may be involved in litigation, the Department will notify the LME when documents may be destroyed, disposed of, or otherwise purged." LMEs 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, then the longest applicable retention period must be applied.

The LME shall facilitate and monitor the compliance of its providers with applicable record retention and disposition requirements.

Provider Responsibility

Service provider agencies have responsibility for fulfilling the record retention and disposition requirements for all the records generated within their agency. Record retention is addressed in the provider MOA/contract with the LME as well as in the Community Intervention Service Agency contract with DMA for direct enrollment to provide Medicaid services. Providers must manage their records in accordance with the requirements discussed below.

When an individual—changes providers, relevant clinical and person-specific information should be copied and sent to the new provider in a timely manner [with the appropriate written consent when such consent is required] to ensure continuity of care. Custody of the original record generated by the provider shall be retained by the provider agency. For additional details on releasing person-specific information, see *Chapter 12 – Accessing and Disclosing Information*.

In the event that a provider agency ends services in a given region, or dissolves for any reason, the provider is required to make arrangements to continue the safeguarding of both the clinical and fiscal records per the record retention guidelines described in this section. If the service record is classified as an historic record [i.e., the original service record created by the Area Program when the Area Program was still a service provider in the pre-LME world] 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 that created the record.

Records Management Requirements

The original service record remains the property and responsibility of the provider and should 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 LMEs 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.

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 these purposes "reimbursement information" includes any administrative records that document that the staff providing billed services held the proper credentials to do so.]

DHHS Records Retention and Disposition Schedule for Grants

The *DHHS Records Retention and Disposition Schedule for Grants* from the Department of Health and Human Services [DHHS] Office of the Controller incorporates records management requirements for federal funds disbursed by the Department of Health and Human Services. All financial and programmatic records, supporting documents, statistical records, and all other records pertinent to a federal award must be retained in accordance with this schedule. When applicable, the *DHHS Records Retention and Disposition Schedule for Grants* provides permission from DHHS to dispose of records as described in the performance contract between DHHS and the LMEs, which currently states, “In order to protect documents and public records that may be involved in DHHS litigation, the Department will notify the LME when documents may be destroyed, disposed of, or otherwise purged through the biannual Records Retention and Disposition Memorandum from the DHHS Controller’s Office.”

LMEs and service providers are subject to this retention schedule and must adhere to the requirements of this document, published by the DHHS Office of the Controller on a biannual basis. The schedule and related record retention documents [a memorandum and a background document] are found on the DHHS Office of the Controller's website [scroll down to the *Records Retention and Disposition Schedule* links]:

<http://www.dhhs.state.nc.us/control/>.

The *DHHS Records Retention and Disposition Schedule for Grants* applies to all records supporting expenditure of specific federal funding.

Records Retention and Disposition Schedule for State and Area Facilities

LMEs and providers of services as specified in this manual shall comply with the *Records Retention and Disposition Schedule for State and Area Facilities*, Division Publication, APSM 10-3, found here:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm10-3retentionupdated5-05.pdf>.

A copy may be obtained by contacting the Communications and Training Team at 919/715-2780.

This schedule determines the procedures for the management, retention, and destruction of records by the Division of MH/DD/SAS facilities, the LMEs, and service provider agencies. General principles and procedures related to records retention are outlined in this document. Specific guidance related to the following areas is also provided:

- Administrative and management records
- Budget and fiscal records
- Client records
- Disaster assistance
- Legal records
- Machine readable public records
- Microfilm
- Office administration records
- Personnel records
- Public relations records
- Student records

Clinical service records have longer retention requirements than most fiscal or organizational records. If not subject to other retention requirements, clinical service records of adults may be destroyed 11 years after the date of the last encounter, and the clinical service records of minor children and youth who are no longer receiving services may be destroyed 12 years after the minor has reached the age of majority [18 years of age]. [See pages 18-19 in the schedule].

For records supporting expenditures for state appropriations and federal funds, the four-year retention period outlined in the Standard 2: Budget and Fiscal Records section of the *Records Retention and Disposition Schedule for State and Area Facilities*, has been superseded by the implementation of more recent state and federal regulations, e.g., the *DHHS Records Retention and Disposition Schedule for Grants*, which requires a five-year retention period for those records, as previously discussed in this chapter. Since these regulations were written subsequent to the publication of the *Records Retention and Disposition Schedule for State and Area Facilities*, all references to a four-year retention period in the schedule should be read as five years for all records supporting the expenditure of state and federal funds.

Medicaid Records Retention Requirements

The *Basic Medicaid Billing Guide*, found at the following link, requires that records that “disclose the extent of service rendered to recipients and billed to the N. C. Medicaid Program” be kept for a period of five years:

<http://www.ncdhhs.gov/dma/medbillcaguide.htm>.

While Medicaid requires that records be kept for a period of five years, providers of MH/DD/SA services are subject to the more stringent schedule for retaining clinical service records outlined above and the *DHHS Records Retention and Disposition Schedule for Grants*. When records are subject to two or more sets of standards, records must be retained for the longest period identified.

Destruction of Records Not Listed in a Schedule

Authorization from the Division of MH/DD/SAS and the Division of Historical Resources shall be secured for destruction of records not listed in a schedule. To obtain authorization, use the “Request for Disposal of Unscheduled Records” form, which is included in the revised *Records Retention and Disposition Schedule for State and Area Facilities*.

The LME Administrative Record for Individuals Seeking or Receiving Services

Many of the documents regarding service delivery that are maintained by the LME are administrative in nature. The LME 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 administrative record shall include the documents used when the LME performs functions related to a specific individual. For example, the following documents, when they are utilized, should be kept in the administrative record: Screening, Triage, and Referral [STR] Registration documents, indication of choice of service provider[s], referral information, Consumer Data Warehouse [CDW] information, registration forms, Person-Centered Plans [PCPs], admission forms, authorizations, care coordination documents, system of care [SOC] documents, hospital liaison documentation, release of information forms, etc. The LME administrative record for individuals receiving services shall be retained until notified by the Department that such record may be destroyed.

Transfer of Records When an LME Dissolves or Merges

When a Local Management Entity dissolves, the successor organization is obligated to assume responsibility for the records of the dissolved LME for the duration of the retention schedule for those records per the *Records Retention Schedule for State and Area Facilities* [APSM 10-3]. This includes service records, administrative records, and other records covered by the retention schedule. The successor LME has the option of scanning the records and disposing of the paper copies, or renting storage space and retaining the records in storage. These records can be disposed of when the retention schedule requirements for the records have been met. Records which have met the retention schedule requirements shall be destroyed if these records are not subject to audit, investigation, or litigation.

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 abuse records is protected by 42 CFR Part 2. In order to ensure the security and privacy of these records, any substance abuse records that are transferred need to be put in sealed envelopes labeled, "Records of [insert name of program] required to be maintained under GS 121 and *DHHS Record Retention Schedule* found in DMH APSM 10-3 until a date not later than [insert appropriate date.]"

While it is recommended that written permission be obtained from the individuals to transfer their records, when this is not possible, 45 CFR Section 164 provides for the transfer of the records without written permission or authorization by the individual because of the LME's responsibility for facilitating continuity of care and the oversight of MH/DD/SA services in the community.

Administrative Staff Signature File

It is recommended that agencies maintain an administrative signature file for all staff that 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 staff signature file for staff entering information in the clinical record is required. Specific instructions in this area can be found in *Chapter 9 – General Documentation Procedures*. All staff signatures may be kept in a single file rather than separating out administrative staff from the staff signatures that are entered into the service record.

Data Reporting Requirements

As a function of the relationship of the service provider with the Local Management Entity [LME], either by contract with the LME or through the provider endorsement process, certain information is submitted by the provider to the LME. It is vital that service providers understand and fulfill their responsibility in submitting all pertinent information to the LMEs about each individual's entry into, progress within, and exit from the MH/DD/SA service system.

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 MH/DD/SA 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 Screening, Triage, and Referral [STR] and Registration, CDW, and NC-TOPPS, reporting to the Medicaid authorization agency[ies], and Incident and Death Reporting, as detailed below.

Documentation and Coordination of Standardized Processes for Screening, Triage, and Referral [STR], 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'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 their entry into the service system shall be sent to the LME. The standardized screening interview and registration document achieves both of these objectives.

Providers are required to submit the completed Standardized Consumer STR Interview and Registration Form to the LME within five business days of screening or service initiation per DMH/DD/SAS guidelines. 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.

For community service providers, STR documents are handled as pending records unless or until a clinical service record is opened. Please see the *Pending Records* section in *Chapter 2 – The Clinical Service Record*.

For more information about STR, please see the link to the Standardized Consumer STR Interview and Registration Form, complete with instructions, below:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/strregistrationform12-05-08.doc>

Information is also gathered from providers through the *LME Consumer Admission and Discharge Form*. This form is completed as a part of the PCP and must be submitted to the LME [along with the appropriate authorization request form when requesting State-funded services] for individuals receiving:

- Any service, which includes, but is not limited to:
 - Approved regular and alternative services
 - Assessment,
 - Crisis services,
 - Drop-In services,
 - Evaluation,
 - Intake,
 - Outreach services,
 - Support;
- IPRS services;
- Medicaid Enhanced Benefit Services;
- Non-UCR advances and cost reimbursement;
- Single stream funding;
- Waiver program services.

The *LME Consumer Admission and Discharge Form* must be submitted upon admission, updated periodically, particularly when there is new or revised information, at the conclusion of an LME episode of care, and at discharge. This form and instructions are included in *Appendix A* of this manual and can also be found at the link below:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/lmeconsumeradmission12-31-08a.doc>

Consumer Data Warehouse [CDW] Reporting by LMEs

The Consumer Data Warehouse [CDW] is a data repository that contains demographic, clinical, outcomes, and satisfaction data regarding individuals receiving MH/DD/SA services. The data stored in the CDW is used for planning and evaluation of services. CDW data is also the main source of information regarding block grant programs and is used to fulfill legislative requests. [See section entitled, "Overview" in the CDW LME/Area Programs Reporting Requirements document, which can be accessed at the link in the next paragraph.]

Information regarding service recipients is gathered from providers through methods that include, but are not limited to, the STR, 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/Area Programs Reporting Requirements*. For detailed information

regarding implementation of CDW reporting by LMEs, please see the program reporting requirements document, found here:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/forms/cdw-report-require-100108.pdf>

As noted in the reporting requirements document, [in the section entitled, "Reading the Data Dictionary,"] the *Consumer Data Warehouse Data Dictionary*, [link below] is a guide to the technical aspects of the data. Please refer to the Reporting Requirements as the correct source of requirement information. The dictionary is for reference only. It is found here:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/forms/cdw-datadictionary-100108.pdf>

A demographics record provides admission and descriptive information about individuals and is mandatory for all new service recipients who are receiving crisis services or who are a presumed member of a target population. A demographics record is sent to the CDW when any of the following occurs:

- For each new service recipient [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 the following occurs:

- When an individual completes an episode of care [is discharged] during the report period. An episode of care is defined by the end of service [60 days uninterrupted time period when there is no billable service for the individual to the Integrated Payment and Reporting System (IPRS) or Medicaid, or NC-TOPPS], except for the Adult Mental Health Stable Recovery Population who may experience up to a 365-day break in service before a discharge record is required.

When the above information is submitted to the LME, the appropriate updates are made in the CDW. Compliance with these reporting requirements is essential, not only for reporting purposes, but also for ongoing communication with the LME in carrying out continuity of care responsibilities.

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

NC-TOPPS is the program by which the Division of MH/DD/SA Services measures 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 LMEs in their responsibility for monitoring treatment services.

NC-TOPPS is required to be completed by the clinical home provider with individuals who receive qualifying mental health or substance abuse services and who have been assigned a service record number by the LME. NOTE: A complete list of qualifying services can be found on the NC-TOPPS web site at the following link:

<http://www.ncdhhs.gov/mhddsas/nc-topps/systemusers.htm>.

NC-TOPPS is administered in a face-to-face interview as a regular part of developing and updating an individual's Person-Centered Plan [PCP] and providing services.

NC-TOPPS uses a number of interview forms for on-line data collection. The Initial Interview is completed when an individual begins services. The Update Interview is completed at scheduled intervals [3 months, 6 months, 12 months, and every 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 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 catchment area;
- Has been incarcerated or institutionalized; or
- Has died.

For more detailed information, please see the NC-TOPPS support materials, linked here:

<http://www.ncdhhs.gov/mhddsas/nc-topps/reports.htm#presentations>.

Please find the web portal for NC-TOPPS data entry below:

<http://www.ncdhhs.gov/mhddsas/nc-topps/index.htm>

Service End-Date Reporting to Medicaid Authorization Agencies and LMEs

Service providers are required to notify the Medicaid authorization agency, which is the agency responsible for fulfilling the utilization review and service authorization functions for all Medicaid-covered MH/DD/SA services, and the LME when an individual changes providers or ends a service that the Medicaid authorization agency or the LME has authorized. End-dating is service-specific and may occur throughout the course of treatment. When a service is authorized, it covers a specific period of time. The end-date is the date on which a specific authorization is cancelled, or when the authorization expires. Providers have responsibility not only in obtaining authorizations, but also in canceling them when a service ends, e.g., if an individual has elected to receive the same service from a new provider, or if the individual terminates treatment prior to the end of the authorization period. See *Chapter 6 - "Service Authorization,"* for additional procedural information. See also the link below to access the required forms used for notification to the current Medicaid authorization agency:

http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Providers should follow the reporting requirements specified by the LME for end-dating State-funded services.

Incident and Death Reporting Documentation

Each service provider shall comply with the death reporting requirements specified in 10A 27G .0200, incident response, reporting, and documentation requirements specified in 10A 27G .0600, restricted intervention documentation specified in 10A NCAC 27E.0104, and Client Rights rules as specified in *Client Rights in Community Mental Health, Developmental Disabilities, and Substance Abuse Services* [APSM 95-2] and General Statute.

Reports on incidents, including deaths and the use of restrictive interventions shall be submitted as required above, using the standardized forms [QM02, QM04, and QM11] and procedures required by the Secretary of DHHS. The Incident and Death Response System Manual [Guidelines for Providers], as well as the required forms and other information, are available electronically in the Forms section at the following link:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm#forms>.

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.

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-Centeredness*, *Chapter 8 – Service Notes and Service Grids*, or *Chapter 9 – 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. It is the legal business record for an agency, 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 communicate important information to other providers. The individual's service record helps to ensure that the individual's needs are met, and that care is coordinated among providers. 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.

A service record is required to 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 which the individual has received and is an essential element in contributing to a high standard of care.

A service record may be paper-based or computer-based. A computer-based record is defined as an electronic service record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data, clinical support systems, and links to medical knowledge. In addition to these resources, electronic records systems 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. 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 and treatment;
- Provides a record of the provision and continuity of services;
- 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 full accounting of the provision of services;

- 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 practice;
- Provides justification of medical necessity for services;
- Substantiates treatment and services for the reimbursement of services provided;
- Documents involvement of the individual to whom the 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 provider;
- 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, and utilization review.

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 previously addressed in *Chapter 1 – General Records Administration and Reporting Requirements*. For the purposes of this manual, each term has been defined as follows:

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 clinical 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 treatment.

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

1. Screening, Triage, and Referral [STR] and related information, unless or until a subsequent full clinical service record is opened;
2. Court-ordered consultation and/or evaluations that do not result in a subsequent MH/DD/SA service [See *Chapter 10 – Special Service-Specific Documentation Requirements and Provisions* for additional guidance for documenting services in this category];
3. Assertive Outreach; and
4. Drop-In Center Services.

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 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 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 should be merged into the full service record. For more information about the use of modified records, please see *Chapter 11 – Documentation Requirements for Services Using Modified Records*.

Full Clinical Service Records

A full clinical service record is one that is used to document the majority of the MH/DD/SA 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. Providers should record and retain billing records and related information according to the specific requirements of the payers involved. Please see the *Basic Medicaid Billing Guide* at the following link for more information:

<http://www.ncdhhs.gov/dma/medbillcaguide.htm>.

Additionally, part of Communication Bulletin # 44, which outlines the provider endorsement process, contains a *Core Rules Self-Study Checklist*. The first section of this document called, the *Client Records Checklist*, outlines some of the specific requirements for service records. The basic contents of this document have been incorporated in the listing below. For more detailed information, the *Client Record Checklist* has also been included in Appendix B. The full *Core Rules Self-Study Checklist* can be found at the link below:

<http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm>

Though additional information may be needed for specific situations, the clinical service record should include the following information or items when applicable:

- Individual's name [must be on all pages in the service record that were generated by the agency]
- Service record number [must be on all pages in the service record that were generated by the agency]
- Medicaid ID number [must be on all service notes/grid pages, accounting of release and disclosure logs, CAP-MR/DD Cost Summary, billing records, and other documents or forms that have a place for it, for Medicaid-eligible individuals]
- Demographic information included on a Service Record Face Sheet, including the individual's full name, service record number, date of birth, race, gender, marital status, admission date, and discharge date
- Emergency information which shall include the name, address, and telephone number of the person to be contacted in case of sudden illness or accident, and the name, address, and telephone number of the individual's preferred physician
- Informed written consent for treatment
- Informed written consent for planned use of a restrictive intervention [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 [26B .0202 and .0203]
- 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 [Medicaid ID number required for Medicaid-eligible individuals]
- Evidence of a written summary of client rights given to client/legally responsible person, according to 10A NCAC 27D .0201, and as specified in G.S. § 122C, Article 3
- Documentation that client rights were explained to the individual/legally responsible person

- Screening, which shall include an assessment of the individual's presenting problem/needs, whether or not the provider agency can provide services that can address the individual's 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
- 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 according to the DSM-5 or any subsequent edition of this reference material published by the American Psychiatric Association. The DSM-5 diagnosis 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 abuse, medical, vocational, etc., as appropriate to the needs of the individual
 - Mental status, as appropriate
 - Recommendations
- Health history, risk factors
- Documentation of mental illness, developmental disability, or substance abuse diagnosis, according to the DSM-5 or any subsequent edition and the ICD-9-CM or any subsequent edition.
- Person-Centered Plan [PCP] [must include Medicaid ID number for Medicaid-eligible individuals]
- Cost Summary for CAP-MR/DD Person-Centered Plans [must include Medicaid ID number]
- Service plan/treatment plan [for situations when a PCP is not required]
- Service order by one of the approved signatories, when required. [For all Community Intervention Services covered by Medicaid and other MH/DD/SA services where a service order is recommended, the service order is indicated by the appropriate professional's signature entered on the PCP. If a service plan/treatment plan other than a PCP is used, then a separate service order is required for services that require an order.
- Written notifications, consents, approvals, and other documentation requirements per 10A NCAC 27E .0104(g) whenever a restrictive intervention is used as a planned intervention
- Inclusion of any planned restrictive interventions in the individual's service plan according to 27E .0104(f), whenever used
- Documentation in the service record that meets the specific requirements of 27E .0104(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 [27E .0104(g)].
- Documentation of incidents, including description of the event, action taken on behalf of the individual, and the individual's condition following the event. NOTE: Incident reports are to be filed separately from the service record.
- Service notes [or service grids when allowed] for documentation of services provided, including interventions, treatment, effectiveness, progress toward goals, service coordination and other case management activities, and entering other important information
- Copies of any relevant legal papers, such as guardianship/legally responsible person designation
- Documentation of medication allergies, other known allergies, and adverse reactions, as well as the absence of known allergies.
- Documentation of medications, dosages, medication administration, medication errors, and a Medication Administration Record [MAR], per 10A NCAC 27G .0209
- Medication orders
- Copies of lab tests
- Identification of other team members
- Documentation of coordination with the rest of the individual's team
- Clinical or level of functioning measurement tools
- Referral documentation [sending or receiving]
- Treatment decision-making process, including thought processes and the issues considered

- Advance directives
- Service authorizations
- Incoming and outgoing correspondence, including copies of STR and admission/discharge forms, NC-TOPPS assessments, etc.
- Discharge plans
- Discharge summaries

MH/DD/SA Service Array and Documentation Requirements

A complete listing of the MH/DD/SA services can be found in *Appendix C*. This listing contains the procedure codes, categorizes the services by service type, delineates the minimum frequency requirements for documentation, indicates whether a service order is required for the service, and denotes if the service is covered by Medicaid.

Many service definitions contain documentation requirements that are specific to those services. For this reason, each service definition should be consulted to ensure compliance with the documentation requirements specific to that definition. The links listed below should be used to obtain detailed implementation information regarding the DMH/DD/SA service definitions. The array of MH/DD/SA service definitions can be accessed on the Service Definitions page of the DMH/DD/SAS web site, found here:

<http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm>.

Some longstanding State-defined service definitions also contain certain documentation requirements. These definitions can be found at the same Service Definitions page above or at the following link:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/apsm1026servicedef1-03.pdf>

The official posting of many of the MH/DD/SA service definitions is found within the various clinical coverage policies published by DMA. These definitions are located on the Clinical Coverage Policy page of the DMA web site, which includes, but is not limited to, the following clinical coverage policies:

- A4 Services for Individuals with Mental Retardation/Developmental Disabilities, and Mental Health/Substance Abuse Co-Occurring Disorders
- 8A Enhanced Mental Health and Substance Abuse Services
- 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- 8D-1 Psychiatric Residential Treatment Facilities for Children Under the Age of 21
- 8D-2 Residential Treatment Services

These policies and service definitions are posted at the following link:

<http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

In general, the elements for documenting a particular service are defined by the service type [e.g., 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 [i.e., the *LME Consumer Admission and Discharge Form*, the *Introductory and Complete Person-Centered Plan (PCP) Forms*, and the *CAP-MR/DD Residential Support and Home Support Grid*], which can be found in *Appendix A*. In addition, *Appendix D* includes an assortment of sample forms which may be used as a guide or prototype for meeting the service documentation requirements.

In addition, there are other forms which are administrative in nature that are required in certain situations [e.g., authorization request forms, incident and death reporting forms, etc.]. 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 Service Records

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 CDW. 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 for updates in the CDW whenever the consumer 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 LMEs 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 National Outcome Measures, 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 terminate or discharge the individual from CDW after 60 days of no billable services and report this to the data system. One exception to this rule is the Adult Mental Health Stable Recovery population, which may be sustained without billable services for 365 days before a statistical termination is required. In either situation, the clinical service record may remain open.

When an individual returns for services after being discharged from CDW, a new admission must be sent to the LME 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 a new STR, updating demographic and contact information, and 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, consent forms and release of information forms, 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.

When a clinical service record is terminated or closed, all the treatment documents contained in the closed record, including Person-Centered 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 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 and 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 should 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 payor.

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 12 – 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 to how such information will be protected against loss, theft, destruction, unauthorized access, and natural disasters. Prior to the development of policies and procedures, it is recommended that a risk assessment be done to assess 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 ameliorate 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 HIPAA. 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.

For additional information about HIPAA, please see the North Carolina Department of Health and Human Services [DHHS] HIPAA web site, using the following link:

<http://hipaa.dhhs.state.nc.us/index.html>

Safeguards

Policies/procedures regarding the following assurances shall be developed:

1. 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.
2. 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:
 - a. Loaning and using portable computers;
 - b. Purging confidential data from returned computer prior to assigning the same computer to the next user;
 - c. Avoid the maintenance of confidential information on portable computers by storing confidential information 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 disk(s) and transporting the disks separately from the computer case is preferred.
 - d. Encrypting the information that is stored on a portable device, as well as password protecting the device.

3. 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 verifying the fax number with the receiving party and checking to ensure that the fax was received;
4. If email is used to communicate confidential information, a policy regarding how the confidential 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 should 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 confidential information if the information is stored in a file that is password protected [i.e., in a Word document with a password] and no Protected Health Information [PHI] or identifying information is included in the body or subject line of the email, including the password. The individual should contact the recipient via telephone to give them the password for the document. Again, the practice of communicating PHI 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:

1. A policy, which defines the classifications of information [data sets] to which different users, may have access.
2. A policy, which specifies that only authorized users have access to service recipient information, based on the minimum necessary principles defined in the HIPAA regulation. 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:

1. Information in service records for individuals who receive mental health and developmental disabilities services shall be disseminated in accordance with G.S. § 122C-51 through G.S. § 122C-56 and the Confidentiality Rules codified in 10A NCAC 26B [Division publication APSM 45-1, updated 1/1/2005], found here: <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm45-1confidentialityrules1-1-05total.pdf>.
2. Information in service records for those individuals who receive substance abuse 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.
3. 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.
4. 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:

1. 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, service records shall be secured in a locked compartment [e.g. locked car, locked trunk, or locked briefcase].

2. 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.
3. In situations where the facility determines it is not feasible or practical to copy the service record or portions thereof, service records 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 should be stored and maintained in a manner consistent with the principles of privacy and security outlined above. As a result:

1. Records should be protected from theft, unapproved use, and damage or destruction. Safeguards should cover the possibility of harm by fire, water, and natural disasters.
2. Records must be destroyed in a manner that safeguards confidentiality and privacy.
3. Though service records should be safeguarded carefully, they also must be available to be used.

Providers should implement systemic processes in order to fulfill the above guidelines. Electronic records pose special challenges. *The North Carolina Guidelines for Managing Public Records Produced by Information Technology Systems*, developed by the Government Records Branch [part of the Archives and Records Section, North Carolina Division of Historical 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 Branch information about electronic records can be accessed below:

http://www.ah.dcr.state.nc.us/records/e_records/default.htm

The Centers for Medicare and Medicaid Services [CMS], which is the federal agency that administers Medicare, Medicaid, and State Children's Health Insurance Program, has published *The Health Insurance Portability & Accountability Act of 1996 [HIPAA] Security Information Series*, which is a group of educational papers with a section titled, "Security Standards for the Protection of Electronic Protected Health Information." The link to this information can be accessed below:

http://www.cms.hhs.gov/EducationMaterials/04_SecurityMaterials.asp#TopOfPage

These papers provide an introduction to organizational security issues and guidance regarding standards for administrative safeguards, physical safeguards, technical safeguards, and organizational policies. They also offer 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:

- Assess current security, risks, and gaps;
- Develop an implementation plan;
- Implement solutions;
- Document solutions; and
- Reassess periodically.

Providers should be prepared for the policies and procedures they have developed to be reviewed by various oversight agencies.

Records, including paper and digital storage media and hardware, are vulnerable to a variety of physical threats - internal and external forces - that can damage or destroy their readability. Community service providers should analyze their records storage processes for risks such as fire, flood, theft, etc. Some of these physical threats include:

- Instability over time due to deterioration of material;
- Improper storage [temperature, humidity, dust, light];

- Overuse;
- Natural disaster;
- Infrastructure failure [plumbing, electrical, climate control];
- Inadequate hardware maintenance;
- Malfunction of hardware;
- Human error and improper handling; and
- Sabotage [theft, vandalism].

Providers should implement policies and procedures to mitigate any potential risks and document the risk analysis, the resulting policies and procedures, as well as their implementation. The entire records storage system should be reassessed on a regular basis to ensure that all current risks and changes have been addressed.

Chapter 3: Initial Clinical Assessments and Evaluations

Service Access for Individuals Entering the Service System

The Screening/Triage/Referral [STR] process, which operates on a 24/7/365 basis by an LME or provider agency, is the starting point for individuals with MH/DD/SA issues to access needed services. The STR process is completed by a Licensed Professional, or a Qualified Professional who is supervised by a Licensed Professional. 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, one of the next steps is to connect the individual with the appropriate clinical home provider to assist in providing or arranging 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 elements of the comprehensive clinical assessment are described in greater detail further along in this chapter. Please refer to *Accessing Care: A Flow Chart for New Medicaid and New State Funded Consumers*, found in *Appendix E*, for more detail on accessing services for individuals who are new to the MH/DD/SA service system.

Prior to the completion of the comprehensive clinical assessment or the development of the Person-Centered 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 comprehensive clinical assessment], 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 assists in determining an individual's 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 in the development of the PCP. 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 payor.

Individuals may be referred directly from the STR process to a provider of outpatient services for a comprehensive clinical assessment, to access outpatient treatment, or a combination of the two, allowing for eight adult/26 child unmanaged visits [Medicaid] or as authorized by the LME [State-funded].

The Clinical Home Provider

The clinical home provider functions as the lead service provider agency with the designated responsibility for the coordination of a person's services. Licensed Professionals or Qualified Professionals carry out the clinical home functions. Clinical home provider agencies are specifically responsible for the following requirements:

- Clinical home functions are carried out by a Licensed Professional or a Qualified Professional;
- Assurance that a comprehensive clinical assessment is completed upon service entry for individuals who are new to the MH/DD/SA service system, or for individuals who show significant changes in level of functioning over time;
- Development, implementation, and revision of the PCP and Crisis Plan;
- Submission of the *LME Consumer Admission and Discharge Form*, NC-TOPPS and NC-SNAP;
- Submission of the ITR/ORF-2/CTCM Form for prior authorization; and
- Assurance of first response to emergencies or crises. [Child and Adolescent Residential

Treatment service providers, which are non-clinical homes, retain responsibility for first response.]

Typically, the clinical home provider is the provider agency that has the most experience with and knowledge of the individual's needs, preferences, and progress. All clinical home providers of Medicaid-funded services are endorsed by the LME and enrolled with DMA as Community Intervention Service Providers.

For children and youth, the clinical home provider is responsible for convening the Child and Family Team for the purposes of person-centered planning.

An individual may be referred directly from the STR process to a provider agency performing the functions of a clinical home provider. The choice of services is listed below:

- Assertive Community Treatment Team
- Community Support - Adults
- Community Support - Children/Adolescents
- Community Support Team
- Intensive In-Home Services
- Multisystemic Therapy
- Substance Abuse Comprehensive Outpatient Treatment
- Substance Abuse Intensive Outpatient Program
- Targeted Case Management

The Comprehensive Clinical Assessment

The completion of a comprehensive clinical assessment [CCA] by a Licensed Professional [licensed clinician] prior to service delivery is required, except for situations when this prerequisite would impede access to crisis or other emergency services. A comprehensive clinical assessment is a clinical evaluation performed by a 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 with the individual. The comprehensive clinical assessment supports the person-centered planning process. Upon completion of the CCA process, the clinical practitioner(s) should work directly with the clinical home provider in the development of the PCP for services, natural supports, and crisis prevention activities.

A CCA offers an opinion as to whether the individual is appropriate for and can benefit from services. It also evaluates the individual's level of readiness and motivation to engage in treatment, and for individuals with substance abuse conditions, recommends a level of placement using the ASAM Criteria. For individuals with developmental disabilities, the CCA provides a basis for identifying an individual's comprehensive service and support needs and to facilitate the completion of the NC-SNAP.

A CCA is not a service definition, but rather a face-to-face evaluation[s] whose purpose is to assess the individual's presenting mental health, developmental disability, and/or substance-related conditions and symptoms, resulting in the issuance of a written report, and providing the clinical basis for the development of the PCP and initiation of needed services. In addition, a CCA assists the clinician in gathering the information essential to arriving at a clinical diagnosis and formulating a clinical opinion about a recommended course of action in terms of services, supports, and treatment. The results of a comprehensive clinical assessment also contribute to the establishment of medical necessity. A service order 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]

- Evaluation/Intake – 90801 or 90802
- Behavioral Health Assessment – H0001
- Mental Health Assessment – H0031
- Evaluation & Management [E/M codes]
- State-Funded Substance Abuse Assessment – YP830 [not reimbursable by Medicaid]

A CCA may consist of evaluations from multiple sources. There is not a standardized format for documenting the CCA; however, the CCA must include the following elements:

- A chronological general health and behavioral health history [including both mental health and substance abuse] of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
- Biological, psychological, familial, social, developmental, and environmental dimensions and identifies strengths, weaknesses, risks, and protective factors in each area;
- A description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- A strengths/protective factors/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- Evidence of recipient participation, including families, or when applicable, legally responsible persons or other caregivers in the assessment, as well as discussion of results;
- A recommendation regarding target population eligibility [needed only for State-funded services];
- An analysis and interpretation of the assessment information with an appropriate case formulation;
- Diagnoses according to the DSM-5 or any subsequent edition of this reference material; and
- Recommendations for additional assessments, services, supports, or treatment, based on the results of the comprehensive clinical assessment.

A person's condition at intake may suggest that the individual has previously been in treatment. Service providers should cooperate and work together to facilitate the individual's access to services. 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 written consent] to ensure 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 abuse confidentiality law [42 CFR], obtaining written consent for disclosure of information is not required for individuals with substance abuse issues in cases of medical emergencies; otherwise, written consent must be obtained.

Disability-Specific Guidelines for the Comprehensive Clinical Assessment

Services for Children

In the case of children/youth and their families, the comprehensive clinical assessment should:

- Address the prior existence and work of the Child and Family Team
- Recommend members of the Child and Family Team that the family and Qualified Professional will convene if the family is new to services
- Assess the strengths of the child/youth and their family and consider utilizing a strength-based assessment tool. For information on Strength-Based Assessments, go to:
<http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm>
- Utilize information such as reports from psychological testing and/or Individual Education Plans.

Mental Health Services

For all adults with a diagnosis of a major mental illness, the assessment should identify the clinical services appropriate to treat the diagnosed condition. The assessment should incorporate principles of psychoeducation, wellness and recovery, and empowerment in developing an inter-dependent 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.

Developmental Disability Services

In many cases, persons with developmental disabilities have multiple disabilities and present with complex profiles that necessitate a more comprehensive approach to addressing their needs. Since 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 evaluation]. A person with a developmental disability may require periodic assessments to determine ongoing needs.

Substance Abuse Services

The information gathered in the comprehensive clinical assessment should be utilized to determine the appropriate level of care using the American Society of Addiction Medicine Patient Placement Criteria [ASAM-PPC] as a clinical guide. The ASAM level of care recommendation must be included in the disposition of the comprehensive clinical assessment.

Other Instruments Used to Complete the Comprehensive Clinical Assessment

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 10 – 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 and published by DHHS. This list can be accessed at the following link:

<http://www.nctasc.net/ncdwiservices/providers/screenassess10-31-06revised4-3-07.doc>.

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, ASAM Patient Placement 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 10 – Special Service-Specific Documentation Requirements and Provisions* for other requirements related to DWI assessments and protocol.

Managing Access for Juvenile Offender Resources and Services [MAJORS]

The MAJORS Assessment System [MAS] is a standardized assessment protocol to aid clinicians in determining the presence of a substance abuse or dependence diagnosis. All youth referred to MAJORS complete three self-report, audio-assisted modules:

- Substance Abuse Screening [CASAA],
- Mental Health Screening, and
- Readiness for Change Questionnaire [RCQ].

The CASAA helps counselors determine the presence of a substance abuse diagnosis and is intended as a supplement to a full clinical assessment. At discharge, MAJORS counselors are responsible for completing the MAJORS Services Survey [MSS] as part of the MAS.

NC-SNAP for Individuals with Developmental Disabilities

The North Carolina Support Needs Assessment Profile [NC-SNAP] is an assessment protocol used to assess the level of intensity of services and supports needed by an individual with developmental disabilities. The NC-SNAP is required for all individuals with 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 go to the following link:

<http://www.ncdhhs.gov/mhddsas/ncsnap/index.htm>

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

As previously discussed in *Chapter 1 – General Records Administration and Reporting Requirements*, 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 clinical home provider with individuals who receive qualifying mental health or substance abuse services. The 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 LMEs in their responsibility for monitoring treatment services. Please see *Chapter 1 – General Records Administration and Reporting Requirements*, which outlines in more detail the use and completion of the NC-TOPPS. In addition, the link below contains the NC-TOPPS support materials, linked here:

<http://www.ncdhhs.gov/mhddsas/nc-topps/reports.htm#presentations>.

The web portal for NC-TOPPS data entry can be found below:

<http://www.ncdhhs.gov/mhddsas/nc-topps/index.htm>

Treatment Accountability for Safer Communities [TASC]

The assessment process for TASC includes a structured interview and a standardized instrument. The information collected and documented includes demographics, employment, education, legal, 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 level of care, assessment outcome, and staff signature and credentials. See *Chapter 10 – Special Service-Specific Documentation Requirements and Provisions* for other requirements related to TASC, as well as the *TASC Standard Operating Procedures Manual*, found at the following link:

<http://northcarolinatasc.org/>

Work First/Substance Abuse Initiative

Substance abuse screening is an integral part of the Work First application process. The AUDIT and DSAT-10 shall be used for screening alcohol and drug abuse issues for all adult Work First applicants/recipients by the Qualified Professional in Substance Abuse or DSS worker. An assessment for substance abuse issues is required for all Work First applicants/recipients who are found to be high risk on the screening and is administered by a Qualified Professional in Substance Abuse. The SUDDS-IV, 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 Qualified Professional in Substance Abuse, based on the documented results of the Substance Abuse Behavioral Indicator Checklist. 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.

Medical Review of the Comprehensive Clinical Assessment

In 2008, the North Carolina General Assembly enacted new legislation [House Bill 2436] 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 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 comprehensive clinical 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.

DHHS shall report the failure of a licensed professional to comply with the above requirements to the licensed professional's occupational licensing board.

Chapter 4: Person-Centeredness

General Guidelines for Developing the Person-Centered Plan

The Person-Centered Plan [PCP] is the foundation upon which all planning for treatment, services, and support is built. The purpose for this requirement is to instill within the MH/DD/SA system a framework of values and principles on which person-centered thinking and planning is based. The PCP should reflect these values in the process of establishing the appropriate services, supports, and treatment for the individual served. In addition, person-centered thinking fosters a holistic approach in developing a comprehensive and meaningful plan for the individual. The PCP should not be developed in isolation. The general goal is to bring forth a unified, inclusive plan that incorporates the various aspects of the individual's life and charts a course to facilitate the individual's progress toward achieving his or her desired life, recovery, and/or habilitation goals.

A Person-Centered Plan is required for most Medicaid-funded MH/DD/SA services. A PCP is required for all Community Intervention Services delineated in DMA's *Clinical Coverage Policy 8A* and those same services when they are State-funded, except for assessments and crisis services, e.g., the Diagnostic Assessment, Mobile Crisis Management, and detoxification services. A PCP is also required for all other services, including State-defined services, when they are provided in conjunction with a MH/DD/SA Community Intervention Service. The link to *Clinical Coverage Policy 8A* can be accessed here:

<http://www.ncdhhs.gov/dma/bh/8A.pdf>

There are some services for which a Person-Centered Plan is not required. A PCP is not required for individuals receiving only outpatient and/or medication management. 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. For additional information, please see the Medicaid *Clinical Coverage Policy 8-C - Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*:

<http://www.ncdhhs.gov/dma/bh/8C.pdf>.

The clinical home provider is responsible for developing the Person-Centered Plan. The PCP must be developed by a Qualified Professional [QP] or a Licensed Professional [LP] according to the requirements of the service definition and in collaboration with the individual, family members [when applicable], and all service providers in order to maximize unified planning. The person responsible for developing the PCP should include 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, family members, significant others, and professionals should have equal and respectful input into the ultimate request for services included in the PCP.

For children and adolescents, the Child and Family Team develops the PCP. The Qualified Professional or Licensed Professional 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 person responsible for writing the PCP should incorporate information from the individual, family members, and others, as appropriate, in the final PCP. For more information on Child and Family Teams, please see the link below to access the *NC System of Care Handbook for Children, Youth, and Families*:

<http://www.ncdhhs.gov/mhddsas/childandfamily/familydriven/soc-familyhandbook1-06.pdf>

The contents of this chapter provide only some of the basic components of the PCP and the requirements primarily related to authorization, content, and documentation. A *Person-Centered Planning Instruction Manual* has been developed to guide providers in developing the PCP. This document outlines the overarching 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. To access the *Person-Centered Planning Instruction Manual*, please use the link below:

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

The Introductory Person-Centered Plan

The Introductory PCP is an initial plan which may be used for an individual who is new to the MH/DD/SA service system, or an individual who has been completely discharged from services and has not received any MH/DD/SA services for 60 days or longer. The provision of an Introductory PCP allows the provider to quickly gather the information needed to request authorization from the Medicaid authorization agency, or the LME [for individuals not covered by Medicaid], and to move people into services as swiftly as possible. The Introductory PCP may only be used when an individual presenting for services:

- is completely new to the MH/DD/SA service delivery system, or
- has been completely discharged and has received no MH/DD/SA services for 60 days.

If the individual is not new to the service system and/or has not been fully discharged for at least 60 days, the Complete PCP must be used.

For a new individual entering the service system through STR, the Introductory PCP must be completed by a Qualified Professional or Licensed Professional from the chosen provider agency for any of the services listed below which perform the function of a clinical home provider:

- Assertive Community Treatment Team
- Community Support - Adults
- Community Support - Children/Adolescents
- Community Support Team
- Intensive In-Home Services
- Multisystemic Therapy
- Substance Abuse Comprehensive Outpatient Treatment
- Substance Abuse Intensive Outpatient Program
- Targeted Case Management

The Introductory PCP comprises the following elements:

- Action Plan
- Crisis Prevention/Crisis Response/Diagnostic Information [Continuation] - the second page of the Crisis Plan reflecting contact and other information
- Summary of Assessments/Observations [Required information from this section: diagnoses, current medications, and all known allergies.]
- Signature Page from the PCP, including:
 - a. Confirmation of Medical Necessity/Service Order - dated signature in the appropriate signature section, which includes addressing all the check boxes related to the signature on the service order.
 - b. Person Receiving Services - dated signature [required when the person is his or her own legally responsible person]
 - c. Legally Responsible Person - dated signature [required when the person receiving services is not his or her own legally responsible person]
 - d. Person Responsible for the Plan - dated signature. For individuals under age 21 [Medicaid], or 18 [State-funded] who are receiving enhanced services and are involved with the Department of Juvenile Justice and Delinquency Prevention or the Criminal

Court System, the signature section of the PCP requires that additional attestations be confirmed by the person responsible for the plan by checking the appropriate boxes and entering the corresponding dates as indicated.

The following documents are required to process an initial authorization:

- The Introductory PCP, including all the required signatures and attestations
- ITR/ORF-2/CTCM form [for the Medicaid authorization agency],
- *LME Consumer Admission and Discharge* Form [for submission to the LME].

Requests for authorization with check boxes left blank will be denied/not processed by the authorizing agency as the PCP is considered incomplete. Check boxes left blank renders the service order invalid.

The template for the Introductory PCP may be found in Appendix A or on the following web page:

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

The Complete Person-Centered Plan

This section outlines the process of moving from an Introductory PCP to the development of a Complete PCP. Services that were authorized from the Introductory PCP are in effect for the duration indicated by the authorization agency. From this point forward, no additional authorizations will be granted based on the Introductory PCP. The first PCP following an Introductory PCP will not require new service orders unless new service is planned for the individual and added to the Complete PCP; otherwise, the service orders in place on the Introductory PCP are still valid through the life of the first Complete PCP.

Completion of the following pages of the PCP will meet the requirements for a Complete PCP:

- Identifying Information
- Participants Involved in Complete Plan Development
- Personal Dialogue/Interview
- Family, Legally Responsible Person, Informal Supports Dialogue/Interview
- Service Provider Dialogue/Interview
- Summary of Assessment and Observations
- Action Plan and Action Plan/Continuation
- Crisis Prevention/Crisis Response
- Crisis Prevention/Crisis Response (Continuation)
- Signatures [with all appropriate attestations addressed as previously discussed]
- Did We Get It Right? [recommended]
- Learning Log to go with Update/Revision pages [recommended]

The following must be completed and submitted to the Medicaid authorization agency [LME for State-funded services] for further authorization to occur.

- A new ITR/ORF-2/CTCM form,
- The Complete PCP [for the first authorization after the submission of the Introductory PCP]

The template for the Complete PCP may be found in Appendix A or on the following web page:

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

The PCP is sent to the LME for administrative review and authorization of State-funded services. For Medicaid services, a copy of the PCP is sent to the Medicaid authorization agency with the request for authorization of Medicaid services, as well as to the LME to include in the individual's administrative record for purposes which include, but are not limited to:

- Care coordination;
- Quality management;

- Review of a sample of PCPs for individuals in the LME's catchment area who receive Medicaid-funded services; and
- Monitoring the effectiveness of the PCPs.

[See HB 2077, SECTION 1. G.S. §122C-142(a) and 122C-115.4.(2), (3), and (5)].

The Person-Centered Plan Format

DMH/DD/SAS and the Division of Medical Assistance [DMA] have developed and approved standardized templates for the PCP: the Introductory PCP and the Complete PCP templates. These Person-Centered Plan formats are used as standardized forms by providers across North Carolina, and should not be altered. Providers of individuals for whom a Person-Centered Plan is required shall use the standard Person-Centered Plan templates. Clinical home providers must also complete the *LME Consumer Admission and Discharge Form* for submission to the LME.

The PCP templates are attached as *Appendix A* of this manual. They are also available on the DMH/DD/SAS web site and can be found at the following location:

Introductory and Complete PCP Templates – Word Format

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

In addition to the PCP, the submission of an accompanying *LME Consumer Admission and Discharge Form* to the LME is required. To access this form, complete with instructions, please see the link below:

LME Consumer Admission and Discharge Form and Instructions –Word format:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/lmeconsumeradmission12-31-08a.doc>

Dating the Person-Centered Plan

The date of the plan [Date of Plan] 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 Plan, please refer to the table on the next page, which was taken from the Person-Centered Plan Instruction Manual.

	Introductory PCP	1 st Complete PCP	All Other Complete PCPs	CAP-MR/DD PCPs
DATE OF PLAN	The <i>Date of Plan</i> is the date that the QP/LP (per the Service Definition) <i>completes and signs</i> the Introductory PCP.	The <i>Date of Plan</i> on the 1 st Complete PCP is the same Date of Plan as on the Introductory PCP. The date of the 1st Complete PCP if prior plan was an Intro PCP is the date the QP/LP completes and signs the new plan.	The <i>Date of Plan</i> on the PCP is the date that the QP/LP (per the Service Definition) <i>completes and signs</i> the PCP.	The <i>Date of Plan</i> is the date that the PCP planning meeting occurred and must occur in the month prior to the birth month of the individual.
TIME PERIOD THAT PCP IS VALID	The Introductory PCP is valid for the first authorization period approved by the Service Authorization Agency	The 1 st Complete PCP following an Intro PCP is valid for 12 months from the Date of Plan, carried over from the Intro PCP.	12 months from the Date of Plan	12 months from the Effective Date of Plan
TARGET DATES	Target dates should not exceed the period of the first authorization. If they do, the Intro PCP is still only valid through the first authorization period.	Target dates may not exceed 12 months from the Date of Plan: <i>Intro PCP + 1st Complete PCP = 12 months.</i>	Target dates may not exceed 12 months from the Date of Plan.	Target dates may not exceed 12 months from the Effective Date of Plan.
MEDICAL NECESSITY & SERVICE ORDERS	Must be in place for the Introductory PCP to be valid for billing.	<ul style="list-style-type: none"> • If no new services were added, the service order on the Intro PCP is valid through the life of the 1st Complete PCP – for 12 months. • If new services are added in the 1st PCP, a new service order is needed and is valid only for the remainder of the first 12 month period. • If new services are added during an Update/Revision to the PCP, a new service order must be obtained and is valid only for the remainder of the first 12 month period. 	<ul style="list-style-type: none"> • Must be in place for the PCP to be valid for billing. • A new service order/ verification of medical necessity must be obtained with each annual rewrite of the PCP. • If new services are added during an Update/Revision to the PCP, a new service order must be obtained. 	<ul style="list-style-type: none"> • Services must be ordered by the Targeted Case Management QP. • A new service order/ verification of medical necessity must be obtained with each annual CNR. • If new services are added during an Update/Revision to the PCP, a new service order must be obtained.
SIGNATURES / PCP EFFECTIVE DATES	No signatures, including the licensed professional, the legally responsible person and the QP/LP responsible for the PCP may precede the Date of Plan. If any of the 3 required signatures above were entered after the Date of Plan, the latest date is the date on which the PCP is effective and the date billing for services may begin. However, the Date of Plan is still in effect for target dates and the annual rewrite date.	<ul style="list-style-type: none"> • The Intro PCP is valid through the end-date of the first service authorization. In order to have continuous billing from the Intro PCP through the 1st Complete PCP, signatures for the Complete PCP must be obtained and dated no later than the day after the 1st authorization expires. • No signatures, including the licensed professional, the legally responsible person and the QP/LP responsible for the PCP may precede the 1st Complete PCP date. • If any of the 2 or 3 (if there is a new service order) required signatures above were entered after the 1st Complete PCP date, the latest date is the date on which the PCP is effective and the date billing for services may begin. However, the Date of Plan is still in effect for target dates and the annual rewrite date. 	<ul style="list-style-type: none"> • No signatures, including the licensed professional, the legally responsible person and the QP/LP responsible for the PCP may precede the Date of Plan. • If any of the 3 required signatures were entered after the Date of Plan, the latest date is the date on which the PCP is effective and the date billing for services may begin. However, the Date of Plan is still in effect for target dates and the annual rewrite date. 	<ul style="list-style-type: none"> • Signatures of QP/LP ordering services, the legally responsible person and the QP/LP responsible for the PCP must be obtained prior to the effective date of the plan. • The effective date of the plan is the first day of the month following the birthday month, contingent upon PCP approval.
ANNUAL REWRITE / CONTINUED NEED REVIEW (CNR)	N/A	<ul style="list-style-type: none"> • The <i>Date of Plan</i> on the first Complete PCP is the date on which the annual rewrite of the PCP is based. • A new service order/ verification of medical necessity must be obtained with each annual rewrite of the PCP. 	<ul style="list-style-type: none"> • The <i>Date of Plan</i> on the Complete PCP is the date on which the annual re-write of the PCP is based. • Medical necessity must be verified and services ordered with each annual rewrite of the PCP, even if the last verification/service order is less than 12 months old. 	<ul style="list-style-type: none"> • The CNR takes place during the month before the birthday month. • Medical necessity must be verified and services ordered with each CNR.

The Crisis Plan as a Required Component of the Person-Centered Plan

The PCP contains a section for a Crisis Plan, which is a required component of all PCPs. A PCP is not considered complete without a Crisis Plan, except as outlined above within the context of an Introductory PCP and the Complete PCP. At a minimum, the Crisis Plan shall address the following when the PCP has been completed:

- Supports/interventions aimed at preventing a crisis [proactive]
- Supports/interventions to employ if there is a crisis [reactive]
- Health and behavioral concerns that may trigger the onset of a crisis
- Crisis prevention and early intervention strategies
- Strategies for crisis response and stabilization
- Specific recommendations for interacting with the person at a Crisis and Assessment Service
- Strategies for determining, after the crisis, what worked and what did not work
- Strategies to be followed after crisis to put changes in place in the PCP and the Crisis Plan
- Consents/Releases related to the Crisis Plan
- Contact list, including First Responder information
- Advance directives
- Emergency Contacts
- Crisis Plan distribution list

The Person-Centered Plan or Individuals Who Receive CAP-MR/DD Funding

The Person-Centered Plan format replaces the CAP-MR/DD Plan of Care, effective on the date announced by DMH/DD/SAS. Unless otherwise specified, CAP-MR/DD providers shall follow the person-centered planning requirements contained in this manual and the *Person-Centered Planning Instruction Manual*. For CAP-MR/DD-funded individuals, the PCP, the MR2, and Cost Summary identified in the *CAP-MR/DD Manual* shall be used for service planning. A new PCP shall be completed annually during the individual's birthday month, effective on the first day of the month following the individual's birthday. All CAP-MR/DD-related information, including the *CAP-MR/DD Manual* is found here:

<http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm>

For additional guidance specific to CAP-MR/DD providers, please refer to the *Person-Centered Planning Instruction Manual* found on the web page below:

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

The PCP templates are attached as *Appendix A* of this manual. They are also available on the DMH/DD/SAS web site and can be found at the following location:

Introductory PCP Template and Complete PCP Template – Word Format

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

The link to the Cost Summary [also in Appendix A] can be accessed at the following link:

<http://www.ncdhhs.gov/mhddsas/cap-mrdd/capwavercostsummary6-07.xls>

In addition to the PCP, the submission of a completed *LME Consumer Admission and Discharge Form* to the LME is required. To access this form, complete with instructions, please see the link below:

LME Consumer Admission and Discharge Form and Instructions –Word format:

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/lmeconsumeradmission12-31-08a.doc>

Signing the Person-Centered Plan

The Person-Centered Plan Instruction Manual specifies who should 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.
- 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 [Section I] and when providing services to children and youth who are involved with the court system [Section IV]. [See PCP signature pages for details.]
 - To address these requirements, certain sections of the PCP signature page, notably, Sections I, III, and IV, contain specific questions that must be answered by the person entering his or her signature in order for the service order to be valid and for the services listed on the PCP to be authorized.
 - As a prompt, the specific questions, with yes/no check boxes, etc., have been placed underneath the signature line when there is a question that the individual must answer.
 - Authorization requests with check boxes left blank will be denied/not processed by the authorizing agency as the PCP is considered incomplete and the service order invalid.
- For medical necessity of Medicaid-covered services, one of the following professionals must sign and date the PCP in 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 DO],
 - Licensed psychologist,
 - Licensed physician assistant, or
 - Licensed family nurse practitioner.

Exception: For Targeted Case Management and certain CAP-MR/DD services, Medicaid allows a QP or LP other than one of the four noted above to sign the required service orders for those services only; otherwise, one of the above signatories must sign the order.
- For medical necessity of State-funded services, it is recommended that one of the same four signatories noted above sign the PCP in Section A of the service order section. If not, it is recommended that a QP or LP other than one of the four noted above sign the order in Section B of the service order section when service orders are indicated. NOTE: When a service order is completed via Section A of the PCP signature page for state-funded services, the check boxes must also be completed as outlined above and in previous sections of this manual. Failure to do so will constitute an invalid service order.
- The Qualified Professional or Licensed Professional who represents the individual's clinical home and is responsible for developing the PCP must sign and date the PCP.
- The person receiving the services is required to sign and date the PCP, indicating confirmation and agreement with the services/supports outlined in the PCP, as well as confirming choice of service providers if the person is his or her own legally responsible party.
- The legally responsible person, if not the person receiving the services, signs and dates the PCP confirming involvement and agreement.
 - If the provider 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.

- When this occurs, there shall be ongoing attempts to obtain the signature as soon as possible.
- Other team members involved in the development of the PCP may also sign the PCP to confirm participation and agreement with the services/supports listed, but these signatures are not required.
- When children or youth who are receiving or are in need of an enhanced service and are court-involved [adjudicated youth or individuals under probation supervision with the Division of Community Corrections, Department of Corrections], documentation that the provider has convened or scheduled the Child and Family Team meeting or assigned TASC Care Management as deemed appropriate, and that the provider has conferred with the clinical staff at the LME for care coordination, is required.
 - Check boxes that confirm that these requirements have been met by the provider are on the signature page of the PCP.
 - The appropriate boxes must be checked and included when requesting services in order to ensure that the child or youth receives the appropriate services.
- When the CEO of an LME is the legal representative/legally responsible person for an individual, and the CEO delegates this authority to another LME staff person to act on his or her behalf in activities requiring the participation or actions of a legally responsible person, this assignment of authority must be in writing in the form of a delegation letter. At a minimum, a delegation letter should be written on the LME letterhead and must:
 - designate the staff person by name and title;
 - specify that the designee is acting on behalf of the CEO of the LME as the legally responsible person for the individual receiving services;
 - specify that the designee has full signatory authority;
 - specify any specific limits on this authority, if any; and
 - be signed by the CEO.

There is no need for the individual's name to be specified in the delegation letter. By the possession and presentation of this letter by the LME designee named in the letter, the delegation letter serves to establish the authority of the designee to participate in PCP and other meetings requiring the actions of a legally responsible person, including signatory actions. A copy of the delegation letter should be presented at the meeting to establish or verify the authority of the designee and then filed in the individual's service record. The designee must sign the PCP, indicating that he or she is signing for the actual guardian, i.e., Suzie Smith [CEO] by John S. Doe [LME designee].

- When the local department of social services has 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 ordering the service[s], with appropriate check boxes completed;
2. Dated signature of the person to whom the PCP belongs [or legally responsible person] with the appropriate check boxes completed; and
3. Dated signature of the Qualified Professional who wrote the PCP [clinical home provider], with the appropriate check boxes completed when required.

For additional information on signatures, please see *Chapter 9 – General Documentation Procedures*.

Signatures of Minors

One of the signatures referenced 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, found here:

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.5.html; and

- G.S. § 122C-223, found here:

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_122C/GS_122C-223.html.

From these documents, the following policy conclusions have been derived concerning the signature of a minor:

1. There are some situations where a minor's consent for treatment is sufficient. According to G.S. § 90-21.5,
 - (a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis, and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the...admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222 [Admission to State Facilities]. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.
 - (b) Any minor who is emancipated may consent to any medical treatment, dental, and health services for himself or for his child."

Under the above circumstances, the minor's signature on the plan is sufficient. However, once the legally responsible person becomes involved, the legally responsible person shall also sign the plan.
2. For minors receiving outpatient substance abuse services, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law [G.S. § 90-21.5], the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent/agreement to the plan.
3. For an emergency admission to a twenty-four hour facility, per G.S. § 122C-223(a), "in an emergency situation when the legally responsible person does not appear with the minor to apply for admission, a minor who is mentally ill or a substance abuser and in need of treatment may be admitted to a twenty-four hour facility upon his own application." In this case, the minor's signature on the plan would be sufficient.
4. For an emergency admission to a twenty-four hour facility, per G.S. § 122C-223(b), "within 24 hours of admission, the facility shall notify the legally responsible person of the admission unless notification is impossible due to an inability to identify, to locate, or to contact him after all reasonable means to establish contact have been attempted." Once contacted, the legally responsible person is required to sign the plan.
5. For an emergency admission to a twenty-four hour facility, per G.S. § 122C-223(c), "if the legally responsible person cannot be located within 72 hours of admission, the responsible professional shall initiate proceedings for juvenile protective services." In this case, the individual designated from juvenile protective services shall sign the plan.

NOTE: For minors receiving substance services 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.

NOTE: Within Substance Abuse Non-Medical Community Residential Treatment [SANMCRT], Residential Recovery Programs for Individuals with Substance Abuse Disorders and Their Children, the PCP shall also include goals for the parent-child interaction.

Review, Revision, and Annual Rewrite of the Person-Centered Plan

At a minimum, the PCP shall be rewritten annually, based on the Date of Plan on the Complete PCP. A revision may not be written in lieu of a required annual rewrite. The PCP must be reviewed and revised whenever the following situations occur:

- The target dates assigned to each goal are due to expire and the goals are in need of review;
- The individual's needs change and a new service is being 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;
- The designated service provider changes; or
- It is time for the annual rewrite of the PCP, based on the Date of Plan on the Complete PCP.

NOTE: For CAP-MR/DD-funded individuals, the new PCP shall be completed annually during the individual's birthday month.

NOTE: Target dates may not exceed twelve (12) months. The required signatures must be obtained for all PCP reviews on the Plan Update/Revision Signature page, whether or not the review resulted in a change to the plan. When a new PCP is written, all signatures are entered on the new PCP.

Reminder: A licensed professional - a licensed physician [MD or DO], licensed psychologist, licensed physician assistant, or a licensed family nurse practitioner [for Medicaid], or a licensed professional or Qualified Professional [for State-funded individuals when service orders are recommended] must sign and date the review and revision of the PCP whenever the following occur:

- A new service is requested; or
- It is time for the annual review to re-establish medical necessity for the services identified on the PCP and execute a new service order.

Detailed instructions for reviewing and revising PCPs are contained in the Person-Centered Planning Instruction Manual, which can be accessed on the following web page:

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

Chapter 5: Medical Necessity and Service Orders

Most MH/DD/SA services are based upon a finding of medical necessity. Medical necessity is established by an assessment of the individual's needs by a professional who is licensed or certified to diagnose MH, DD and/or SA issues, and who is operating within the scope of practice, knowledge base, and experience of that professional. Service orders are required for all Medicaid services, except assessments and evaluations, and are recommended for all State-funded services whose definitions indicate the need for a service order in order to corroborate medical necessity. [See the *MH/DD/SA Service Delivery Table* in *Appendix C*, which delineates when service orders are required or recommended.]

Medical Necessity

All Medicaid services are based upon a finding of medical necessity. Medical necessity is determined by generally accepted community practice standards. There must be a current diagnosis reflecting the need for treatment. All covered MH/DD/SA services must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the individual.

- Preventive means to anticipate the development of a condition and preclude its occurrence.
- Diagnostic means to examine specific symptoms and facts to understand or explain a condition.
- Therapeutic means the treatment of disorders; may also serve to preserve health.
- Rehabilitative means to restore that which one has lost, to a normal or optimum state of health.

Medical Necessity and Early Periodic Screening, Diagnosis, and Treatment

Early Periodic Screening, Diagnosis and Treatment [EPSDT] is a federal law that requires Medicaid to provide medically necessary health care services to Medicaid-eligible children through the age of 20 even if the services are not normally covered by Medicaid or are only covered for recipients 21 years of age and older. Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment.

When submitting requests for prior authorization to the Medicaid authorization agency, diagnostic information, which may be fulfilled through a comprehensive clinical assessment, should reflect medical necessity to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner to be reviewed under EPSDT criteria. See *Chapter 6 – Service Authorization* for more information on submitting requests to the Medicaid authorization agency for prior authorization for services.

Establishing Medical Necessity for Individuals with Developmental Disabilities

For developmental disabilities, medical necessity is established when the definition of developmental disability as defined in G.S. §122C-3(12a) is met. The definition and requirements for this designation are outlined below:

“Developmental disability” means a severe, chronic disability of a person which:

1. is attributable to a mental or physical impairment or combination of mental and physical impairments;

2. is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
3. is likely to continue indefinitely;
4. results in substantial functional limitations in three or more of the following areas of major life activity; self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
5. reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated; or
6. when applied to children from birth through four years of age, may be evidenced as a developmental delay.

Medical Necessity Criteria within CAP-MR/DD Service Definitions

All CAP-MR/DD-funded individuals must meet ICF-MR level of care criteria in order to be eligible for services under the CAP-MR/DD waiver. Medical necessity under CAP-MR/DD is established when the individual meets ICF-MR level of care criteria verified by signature of the physician or licensed psychologist on the MR2 form.

All CAP-MR/DD services shall be ordered at least annually and according to the requirements of the current *CAP-MR/DD Manual*. For detailed information regarding this process, please refer to the current *CAP-MR/DD Manual*, which can be found on the web page below:

<http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm>

Medical Necessity Criteria within DMH/DD/SA Service Definitions

For the provision of MH/DD/SA 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 meet the medical necessity criteria identified in the service definition. That judgment is made by a person who is licensed or certified to diagnose MH, DD and/or SA conditions, and who is operating within that professional's scope of practice, knowledge base, and experience.

Service Orders

All MH/DD/SA 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 Person-Centered Plan [PCP], must be re-ordered at the time of the annual re-write of the PCP.
- 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 signature constituting the service order to establish medical necessity for that service. This is reflected on the revision/update page of the PCP.
- New service orders added after the PCP was written are valid for the duration of the plan; when the PCP is due for an annual rewrite, all existing orders will need to be renewed as appropriate via new orders on the rewritten PCP.

To meet the Medicaid requirements for a valid service order, unless otherwise specified in the service definition, the signature must be entered by one of the following approved Licensed Professional signatories:

- Physician [MD] or Doctor of Osteopathy [DO],
- Licensed psychologist,
- Physician assistant [PA], or
- Nurse practitioner.

The Licensed Professional signing the order for Medicaid services must also address the following items in Section A of the PCP signature page:

- Whether or not he or she has had direct contact with the individual; and
- Whether or not he or she has reviewed the individual's comprehensive clinical assessment.

Authorization requests for services where check boxes are left blank will be denied/not processed by the authorizing agency as incomplete due to lack of information.

- Failure on the part of the licensed professional to check the boxes on the signature page of the Person-Centered Plan indicating whether or not he or she has had face-to-face contact with the individual and whether or not he or she has reviewed the clinical assessment[s] will constitute an invalid service order.
- Additionally, DHHS shall report the failure of a licensed professional to comply with the above requirements to the Licensed Professional's occupational licensing board.

Please see the section entitled, *Medical Review of the Comprehensive Clinical Assessment in Chapter 3 – Initial Clinical Assessments and Evaluations*, as well as the *Person-Centered Planning Instruction Manual* on the following web page:

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

For Targeted Case Management {TCM}, CAP-MR/DD services, and/or for State-funded services, the dated signature entered in Section B of the service order section of the PCP signature page by a Licensed Professional other than one of the approved signatories described above or a Qualified Professional serves as the order for those services. [When these services are funded by Medicaid, a service order is required in Section A, per the requirements above.] The Qualified Professional or Licensed Professional signing the order for TCM or CAP-MR/DD services must also address the following items in Section B of the PCP signature page:

- That medical necessity for the CAP-MR/DD services requested is present, constituting the service order;
- That medical necessity for the Medicaid TCM services requested is present, constituting the service order; and/or
- That medical necessity for the State-funded service[s] requested is present, constituting the service order..

For Medicaid, please note that Targeted Case Management and CAP-MR/DD services are the only services that may be ordered by a Licensed Professional other than one of the approved signatories described above or by a Qualified Professional. If additional services covered by Medicaid are included on the PCP, then Medicaid still requires the order to be signed by a physician, physician assistant, nurse practitioner, or licensed psychologist.

Although service orders are not required for 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 Section A of the PCP signature page as described above. Alternatively, services may be ordered in Section B on the signature page of the PCP.

While the appropriate signature on the PCP constitutes the service order for most MH/DD/SA services, there are some situations when a treatment plan is used in 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 service itself does not stipulate the need for an order. [Please refer to the *MH/DD/SA Service Delivery Table* found in *Appendix*

C that delineates when service orders are indicated.] The service order must be signed and dated by the appropriate professional as described above for Medicaid-covered services prior to or on the date of service, and filed in the individual's record. All service orders must be renewed annually. There is no standardized form issued by the State for this purpose. Provider agencies should have a policy indicating what constitutes a service order and validation of medical necessity when ordering services from a plan outside the auspices of the PCP.

Service Orders for CAP-MR/DD Services

In addition to the guidance in the above section, for individuals receiving CAP-MR/DD services, the PCP signed by a case manager with QP status constitutes the service order for all CAP-MR/DD services, with the exception of the following services: Augmentative Communication Devices, Home Modifications, Specialized Equipment and Supplies, and Vehicle Adaptations. These services require a physician's statement certifying medical necessity as a component of the request. Service orders indicated on the PCP under the CAP-MR/DD waiver must be renewed at least annually, or more often, as revisions occur.

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 situation 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, there are a few basic procedures that must be followed in order for the verbal order to be valid. Treatment may proceed on the basis of 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.

Clinical Coverage Policies for Medicaid Services

All MH/DD/SA services covered by Medicaid must meet medical necessity and are subject to the clinical coverage policies and procedures published by DMA and posted on the DMA web site. To access some of these behavioral health Medicaid clinical coverage policies, please go to the following Division of Medical Assistance [DMA] links as outlined below:

DMA Services for Individuals with Mental Retardation/Developmental Disabilities, and Mental Health/Substance Abuse Co-Occurring Disorders - A4:

<http://www.ncdhhs.gov/dma/APA/A4.pdf>

DMA Clinical Coverage Policy for Enhanced MH/SA Services – 8A:

<http://www.ncdhhs.gov/dma/bh/8A.pdf>

DMA Clinical Coverage Policy for Outpatient Behavioral Health Services – 8C:

<http://www.ncdhhs.gov/dma/bh/8C.pdf>

DMA Clinical Coverage Policy for Psychiatric Residential Treatment Facilities for Children Under the Age of 21 – 8D-1:

<http://www.ncdhhs.gov/dma/bh/8D1.pdf>

DMA Clinical Coverage Policy for Residential Treatment Services – 8D-2:
<http://www.ncdhhs.gov/dma/bh/8D2.pdf>

Chapter 6: Service Authorization

Most MH/DD/SA services require prior authorization, or prior approval, in order to assure that the service requested meets medical necessity and other service-specific criteria. The Medicaid authorization agency is the entity that conducts utilization review and service authorization for all Medicaid-reimbursed MH/DD/SA services, including services provided under the CAP-MR/DD Waiver. This means that providers must obtain prior authorization from the Medicaid authorization agency for all Medicaid-covered services, statewide, except for Medicaid recipients whose eligibility is established in one of the five counties in the Piedmont catchment area [Cabarrus, Davidson, Rowan, Stanly, and Union counties]. Prior authorization through the LME is required for the provision of all State-funded services, which are subject to the availability of funds.

The service authorization process establishes the provision of a service related to the scope, amount, and duration of a service. Requests for authorization for most services are required prior to initiation of the service and for continuation of the service beyond the current authorization period. [See the specific service definition for more information.]

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

Some limitations regarding service provision are built into the service definitions. However, Early Periodic Screening, Diagnosis, and Treatment [EPSDT] provides additional allowances for Medicaid-covered 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 authorization to the Medicaid authorization agency, the diagnostic information needed, which may be fulfilled through a comprehensive clinical assessment, should reflect medical necessity to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner to be reviewed under EPSDT criteria. To access the Request for Non-Covered Services form under EPSDT, please go to:

<http://www.dhhs.state.nc.us/dma/Forms/NonCoveredServicesRequest.pdf>

For more complete information regarding the provisions under EPSDT, please go to the following link on the DMA web site:

<http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

While CAP-MR/DD recipients under the age of 21 are eligible for any State Medicaid Plan services, or for any services covered by 1905 (a) of the Social Security Act, the waiver services themselves are not subject to EPSDT.

Required Forms for Authorization for Medicaid-Funded MH/DD/SA Services and CAP-MR/DD Services and Supports

It is strongly recommended that all completed authorization forms and service authorization response letters [approvals/denials] received be filed in the individual's service record.

The Medicaid authorization agency requires providers to submit written authorization requests for services. There are three major forms used in requesting services for Medicaid-eligible individuals: The Inpatient Treatment Report [ITR] Form, the Outpatient Review [ORF-2] Form, and the CAP/Targeted Case Management Request for Authorization [CTCM] Form. The service being requested dictates which form to use to obtain authorization from the Medicaid authorization agency .

The Inpatient Treatment Report [ITR] Form

The Inpatient Treatment Report [ITR] form is used for the following services:

- Ambulatory Detoxification Services
- Assertive Community Treatment Team
- Child and Adolescent Day Treatment
- Child and Adolescent Residential Treatment – Levels II Program Type - IV
- Community Support - Adults
- Community Support - Children/Adolescents
- Community Support Team
- Intensive In-Home Services
- Medically Supervised or ADATC Detoxification/Crisis Stabilization
- Multisystemic Therapy
- Non-Hospital Medical Detoxification Services
- Opioid Treatment
- Partial Hospitalization
- Professional Treatment Services in Facility-Based Crisis Programs
- Psychiatric Residential Treatment Facilities
- Psychosocial Rehabilitation
- Substance Abuse Comprehensive Outpatient Treatment
- Substance Abuse Intensive Outpatient Program
- Substance Abuse Medically-Monitored Community Residential Treatment
- Substance Abuse Non-Medical Community Residential Treatment

The Outpatient Review [ORF-2] Form

The Outpatient Review [ORF-2] form is used for the following services:

- Mobile Crisis Management Services
- Outpatient Services

The CAP/Targeted Case Management Request for Authorization [CTCM] Form

The CAP/Targeted Case Management Request for Authorization [CTCM] form is used for:

- CAP-MR/DD Continued Need Review
- CAP-MR/DD PCP Initial Review
- Discrete, provider-specific services under CAP-MR/DD, which include:
 - Day Supports
 - Enhanced Personal Care Services
 - Enhanced Respite Care Services
 - Home and Community Supports
 - Home Supports
 - Long Term Vocational Supports
 - Personal Care Services
 - Residential Supports
 - Respite, including Institutional, and Non-Institutional Nursing Based
 - Supported Employment
- PCP Revisions

- Targeted Case Management Services

There are a number of additional services under the CAP-MR/DD waiver that do not require prior approval if they are authorized on the individual's PCP. These services include:

- Adult Day Health
- Augmentative Communication Devices
- Crisis Services
- Home Modifications
- Individual/Caregiver Training and Education
- Personal Emergency Response System
- Specialized Consultative Services
- Specialized Equipment and Supplies
- Transportation
- Vehicle Adaptations.

The following link to the current Medicaid authorization agency outlines additional information needed for processing prior approval requests, including the links to the forms and the instructions for completing them:

http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Reauthorization for Concurrent Services

For Medicaid-funded services, all concurrent requests for authorization require an updated or revised PCP to be submitted to the Medicaid authorization agency or the request will be returned.

When submitting a request for reauthorization for a service to continue concurrently, the Medicaid authorization agency requires:

- An updated or revised PCP [at a minimum, a signed copy of the revision page];
- A new completed ITR/CTCM form; and
- Any additional information that will help in expediting the reauthorization.

Service Authorization for State-Funded Individuals

LMEs are responsible for carrying out the local authorization and utilization review process for services that are not covered by Medicaid and for individuals who are not eligible for Medicaid. Providers should work with the LMEs in submitting all the required information in order to obtain authorization and reauthorization for State-funded services.

NOTE: Per Implementation Update #34, for initial authorization of services outlined in the Introductory PCP, the information obtained and submitted must be consistent with the utilization review process at both the LME and the Medicaid authorization agency. The same information will be submitted for utilization review and authorization at VO for Medicaid services and at each LME for State-only services. There should be no additional LME requirements for data related to initial authorization of services beyond those noted in Implementation Update #32 for the Introductory PCP. For additional information, please see Implementation Updates #34 and #32, found at the links below:

<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh9-10-07update34.pdf>

<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh7-13-07update32.pdf>

Service End-Date Reporting to Medicaid Authorization Agencies and LMEs

Service providers are required to notify the Medicaid authorization agency and the LME when an individual changes providers or ends a service that the Medicaid authorization agency or the LME has previously authorized. Any time there is an open authorization and the individual is no longer participating in treatment, the provider needs to notify the authorizing agency 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 should use the Inpatient Treatment Report [ITR] form for mental health and substance abuse services, and the CAP/Targeted Case Management Request for Authorization Form [CTCM form] for CAP-MR/DD and Targeted Case Management under developmental disability services. Service providers must complete the demographic and discharge summary sections of these forms and send them to the Medicaid authorization agency within 10 days of the service end date. Both these forms for the current Medicaid authorization agency can be found at the link below:

http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Providers should follow the reporting requirements specified by the LME for end-dating State-funded service authorizations.

Appeals

An important records and documentation compliance issue is adherence to the timeframes for notification of the appeal rights of an individual when services are denied, reduced, suspended, or terminated. Both Medicaid recipients and individuals who are non-Medicaid recipients have appeal rights. The process and specific timeframes for notification of appeal rights for non-Medicaid recipients can be found in the DMH/DD/SAS Communication Bulletin # 67 at the following link:

<http://www.ncdhhs.gov/mhddsas/announce/commbulletins/communicationbulletin67-12-19-06.pdf>

Information regarding the DMA appeal process for Medicaid-covered individuals is available in the *DMA Clinical Coverage Policy No. 8A*, found here:

<http://www.ncdhhs.gov/dma/bh/8A.pdf>, or by contacting the North Carolina CARE-LINE at:

- 1-800-662-7030 [Voice/Spanish] or
- 1-877-452-2514 [TTY]

Chapter 7: 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, if the individual has specific medical problems. The medical examination shall also note the presence of any communicable diseases or a communicable 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"]. Medical examinations as a special admission requirement are as follows:

1. Developmental Disabilities Services
 - a. Day/Night Services
 - i. A child/adolescent with developmental disabilities shall have a health assessment before admission or within thirty (30) days following admission to any day/night service or program.
 - ii. An adult with developmental disabilities who has a medical history which indicates a need for a physical examination shall have a physical examination within twelve (12) months prior to admission, unless there is some unusual medical condition for which more frequent examination is customary practice.
 - b. Twenty-Four Hour Facilities, except Respite
 - i. Within 30 days prior to admission, the individual shall have a medical examination.
2. Mental Health and Substance Abuse Services
 - a. For Twenty-Four Hour Medical Treatment Facilities: [G.S. § 122C-211c]: "Any individual who voluntarily seeks admission to a 24-hour facility in which medical care is an integral component of the treatment shall be examined and evaluated by a physician of the facility within 24 hours of admission. The evaluation shall determine whether the individual is in need of treatment for mental illness or substance abuse or further evaluation by the facility. If the evaluating physician determines that the individual will not benefit from the treatment available, the individual shall not be accepted as a client."

The requirement of a medical examination within 24 hours of admission also applies to Non-Hospital Medical Detoxification, which does not include medical care as an integral part of treatment. Therefore, individuals admitted to a Non-Hospital Medical Detoxification setting must be examined by a physician and medically cleared within 24 hours of admission.
 - b. For Twenty-Four Hour Mental Health Treatment Facilities: [G.S. § 122C-211d]: "Any individual who voluntarily seeks admission to any 24-hour facility, other than one in which medical care is an integral component of the treatment, shall have a medical examination within 30 days before or after admission if it is reasonably expected that the individual will receive treatment for more than 30 days or shall produce a current, valid physical examination report, signed by a physician, completed within 12 months

prior to the current admission. When applicable, this examination may be included in an examination conducted to meet the requirements of G.S. 122C-223 or G.S. 122C-232.”

NOTE: Medical examinations can be performed by a physician or a physician extender. Per G.S. § 90-18.3, “Whenever a statute or State agency rule requires that a physical examination shall be conducted by a physician, the examination may be conducted and the form signed by a nurse practitioner or a physician’s assistant, and a physician need not be present.” Therefore, for the physical examinations required in this section, the examination may be performed by licensed medical doctors and physician extenders [i.e., nurse practitioners, or physician assistants].

Discharge Planning

Discharge planning begins at the point of admission to a service. Service providers must think about how an individual’s service needs can be fully 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 required elements of the service to facilitate continued progress.

Discharge Planning for All Disabilities in Twenty-Four Hour Facilities

Prior to discharge, G.S. § 122C-61 requires:

1. An individualized written discharge plan which contains recommendations for further services designed to enable the individual to live as normally as possible; and
2. A copy of the plan shall be furnished to the individual or to his or her legally responsible person and with the consent of the individual, to his/her next of kin. However, a discharge plan may not be required when it is not feasible because of an unanticipated discontinuation of an individual’s treatment.

Discharge Planning for Individuals Receiving Substance Abuse Services

Per Division publication APSM 30-1, Rules for Mental Health, Developmental Disabilities, and Substance Abuse Facilities and Services, before discharging an individual receiving substance abuse services, the facility shall complete a discharge plan and refer the individual to the appropriate level of treatment or rehabilitation in accordance with the person’s needs.

Chapter 8: 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, 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. Interventions, treatment, and supports must all address the goal(s) listed in the service plan [the Person-Centered Plan, in most cases]. They should be written in a meaningful way so that the notes 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 to be avoided. Examples of canned notes are notes that are cut and pasted from a personal computer or photocopied, with new dates and/or signatures attached, or notes that are copied verbatim, or almost verbatim by hand from previously-written notes. Each service note should have its own value as documentation of a separate and unique event and should reflect:

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

Service notes that have been "cut and pasted" raise "red flags." Documentation should be specific and individualized and should accurately reflect the service provided per event. Each service note deserves its own newly-composed evidence of the service provided.

Documenting Service Provision in a Service Note or Grid

In most cases, when an individual receives a service, the person who provided that service shall write and sign the service note. This requirement is applicable for all periodic and twenty-four hour services.

For some services where the frequency requirement for documentation of progress spans a range of time, e.g., monthly or quarterly, 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 [one of whom directly provided the service during the time frame in which the service was provided] 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 individualized goals that were the focus of intervention for the time period being addressed in the service note.

Timely Documentation and Late Entries for Service Notes and Grids

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.

For most MH/DD/SA 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.

There are a few day/night and twenty-four hour services, where the requirement is that certain categories of service notes, i.e., monthly notes or quarterly notes, are written or dictated on the closing date of a specified 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

Late Entries – Billable

In order for any note or grid to meet reimbursement requirements, the documentation to support the service provided must be written or dictated within seven work days that the staff member is on duty from the date of service [or from the closing date of the service period for some day/night and twenty-four hour services].

- The note shall be entered as a late entry and must include a dated signature.
- Corrections or revisions to service note entries must also be completed within the seven-day time frame in order to meet reimbursement requirements. For additional information regarding entering corrections in the service record, see *Chapter 9 – “General Documentation Procedures.”*

Late Entries – Not Billable

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 services provided is accurate and up to date. There should 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 considered a late entry, must be indicated as such, and a dated signature is required.
- When a service note is written, dictated, or revised after the seven-day time frame, the service may not be billed.

Below 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 Closing Date of Service Period							
Day 1 [DOS, or Closing DOS Period]	Day 2 [Within 24 hours of DOS, or Closing DOS Period]	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
Service Note Due	Service Note Due	Late Entry; Dated Signature					
May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct MAY NOT BILL

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 services provided shall be documented on the day that the service was provided, or within twenty-four hours of the day of service, in order to be considered timely documentation. Any service note or grid written or dictated after twenty-four hours from the date of service is considered a late entry and must include the applicable documentation requirements below:

1. 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 8/14/08 for 8/12/08."
2. The late entry service note requires a dated signature.

If an electronic health record is used and late entries are tracked/stamped in the system, 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 Requirements for Entering Services Notes* section later 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 certain types of day/night services provided. For more information about entering

service notes for specific day/night services, see the Frequency Requirements for Entering Services 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 a service note 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 to be considered timely documentation. Any service note or grid written or dictated after twenty-four hours from the date of service is considered 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 8/14/08 for 8/12/08."

The late entry service note requires a dated signature.

Day/Night Services Requiring Monthly or Quarterly Service Notes

When the frequency requirement for a day/night service is a monthly or quarterly note, the completion of a service note to reflect the services provided within the month or quarter shall be documented at the close of the service period, i.e., on the last day of the service period, or within twenty-four hours of the close of the service period, in order to be considered timely documentation. Any service note or grid written or dictated after twenty-four hours from the close of the service period is considered a late entry and must include the applicable documentation requirements below:

1. Each 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., closing date of service period. For example, "Late Entry made on 8/4/08 for service period ending July 31, 2008."
2. The late entry service note requires a dated signature.

If an electronic health record is used and late entries are tracked/stamped in the system, 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 twenty-four hour services provided. For more information about entering service notes for specific twenty-four hour services, see the Frequency Requirements for Entering Services 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 twenty-four hours of the date of service in order to be considered timely documentation. Any service note or grid written or dictated after twenty-four hours from the date of service is considered a late entry and must include the applicable documentation requirements below:

1. 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 8/14/08 for 8/12/08."
2. The late entry service note also requires a dated signature.

Twenty-Four Hour Services Requiring Monthly Service Notes

When the frequency requirement for a twenty-four hour service 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 twenty-four hours of the close of the service period, in order to be considered timely documentation. Any service note written or dictated after twenty-four hours from the close of the service period is considered a late entry and must include the applicable documentation requirements below:

1. 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 8/4/08 for service period ending July 31, 2008."
2. The late entry service note also requires a dated signature.

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

Contents of a Service Note

While there are no specific required formats for the documentation of service delivery, all services which require a service note must contain certain required elements. Appendix D comprises an assortment of sample formats which 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. Service record number of the individual [on every service note page]
3. Medicaid Identification Number for services reimbursed by Medicaid [on every service note page]
4. Full date the service was provided [month/day/year]
5. Name of the service provided [e.g., Community Support – Individual]
6. Type of Contact [face to face, phone call, collateral]
7. Place of service [when required by the service definition]
8. Purpose of the contact [tied to specific goal(s) in the service plan]
9. Description of the intervention(s)/treatment/support provided. Interventions must include active engagement of the individual and relate to the goals and strategies outlined on 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.
10. 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 service definition, Medicaid Clinical Coverage Policies, or the Medicaid State Plan]. Some of the services for which the provider must record the amount of time spent performing the interventions are listed on the *Service Duration Table* in *Appendix F*. 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 documented in the note to ensure coverage for the entire period, e.g., "Third Shift: 11:30 PM – 7:30 AM."
11. Effectiveness of the intervention(s) and the individual's response/progress toward goal(s).
12. 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 should also include the individual's professional status [e.g., QP or AP], and any other certifications the person may hold [e.g., CSAC]. The signature must be handwritten; however, the credentials, degree, or licensure may be typed, printed or stamped. Exceptions:
 - a. When using electronic signatures as permitted in the *Electronic Signatures* section in *Chapter 9 – General Documentation Procedures*, a handwritten signature is not required.
 - b. When the service provider has an approved and documented exception per the

Americans with Disabilities Act [ADA] for not being able to sign, then a stamp or other means for providing the signature is allowable.

13. For paraprofessionals: Signature and position of the individual who provided the service. The signature must be handwritten; the position may be typed, printed or stamped. Exceptions:
 - a. When using electronic signatures as permitted in the *Electronic Signatures* section in *Chapter 9 – General Documentation Procedures*, a handwritten signature is not required.
 - b. When the service provider has an approved and documented exception per the Americans with Disabilities Act [ADA] for not being able to sign, then a stamp or other means for providing the signature is allowable.

NOTE: For electronic signature requirements, see the *Electronic Signatures* section, found in *Chapter 9 – 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.

- All interventions, treatment, service coordination, and other significant information must be documented in the shift notes as described in the section above.
- 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, case management, 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 location or situation 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 above. However, using the same example, should the individual awaken during the night and receive any type of treatment or intervention, a full note as described in the section above, including the purpose of contact/interventions/effectiveness is required.
- 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 an intervention or treatment service is provided by someone other than shift staff during the shift, it should be included in the shift note, for example, “The LP conducted group therapy for one hour after dinner.” The specifics of these professional interventions should be documented by the person providing the intervention or treatment service 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, e.g., group therapy, Community Support – Group, there is no special procedure for writing a group note. All the requirements for a full service note as described in the previous section must be met. While 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 should be 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, 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 is provided to an individual by more than one staff member at the same time, as in the case of certain teams, such as ACTT or Day Treatment, etc., 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 participating staff members involved and describe their role in providing the service. While it may be prudent to have the other participating staff sign the note, there is no state requirement to do so.

Service Note Requirements for Case Management Services

Service notes for Targeted Case Management services, or for case management activities provided as a component within another service definition [e.g., Community Support], 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 9 and 11 in the *Contents of a Service Note* section above. A full service note is required for documentation of all case management services.

Service notes for Targeted Case Management, or for case management activities provided as a component within another service definition, shall include the following:

1. All the elements in Contents of a Service Note above, except items 9 and 11.
2. Description of the case management activity[ies] provided [i.e., assessing, arranging, informing, assisting, monitoring, etc.], which relates to a goal/activity in the Person-Centered Plan;
3. Description of the results or outcome of the case management activity[ies], any progress noted, and next steps, when applicable.

When documenting multiple case management activities 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.

Frequency and Other Requirements for Entering Service Notes

The frequency requirements for service notes are largely determined based on the type of service that was provided. However, in all cases, service notes shall be made more frequently than the requirements outlined below when necessary to indicate significant changes in the individual's status, needs, or changes in the PCP. When the frequency requirement for documentation of progress spans a range of time [e.g., monthly or quarterly], and one or more service providers within the same team/agency have carried out the same service to the individual on different days, then the Qualified Professional or other designated staff [one of whom directly provided the service during the time frame in which the service was provided] is responsible for gathering all the relevant information from other providers on the team and writing and signing a composite service note that outlines the individual's progress during that time period. Such documentation of progress must be based on the individualized goals that were the focus of intervention for the time period being addressed in the service note.

Most MH/DD/SA services are classified into three distinct categories: Periodic, Day/Night, and Twenty-Four Hour services. See *Appendix C* for a listing of all MH/DD/SA services, which delineates these service categories per service, as well as the minimum frequency requirements for writing service notes.

Periodic 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 mental illness, developmental disability, or substance-

related issues [APSM 30-1, Rules for MH/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. Please refer to *Appendix C* for more service-specific information regarding periodic services.

1. When a periodic service is provided, a full service note that reflects the elements noted above in the *Contents of a Service Note* section shall be documented per service by the individual who provided the service.
2. If a service grid is permitted, the documentation must meet the requirements outlined in the *Service Grid Documentation* section at the end of this chapter.
3. The following CAP-MR/DD services require a full service note:
 - a. Case Management
 - b. Crisis Services [including information as indicated in the individual's intervention plan];
 - c. Individual/Caregiver Training and Education; and
 - d. Specialized Consultative Services.

For other CAP-MR/DD periodic service documentation requirements and exceptions, see the *Services for Which a Modified Service Note May Be Used* and *Service Grid Documentation* sections 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, Rules for MH/DD/SA Facilities and Services]. 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 following the required elements noted above in *Contents of a Service Note*. The date(s) of attendance shall also be documented in the service record for day/night services. In addition, the following 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;
 - Long Term Vocational Supports [CAP-MR/DD];
 - Partial Hospitalization;
 - Psychosocial Rehabilitation; and
 - Substance Abuse Intensive Outpatient Program.

For day/night services requiring a service note per date of service [grid for Long Term Vocational Supports (CAP-MR/DD)] and reported/billed in 15-minute or hourly increments, such as Psychosocial Rehabilitation, or Child and Adolescent Day Treatment, the service note must indicate the total amount of time spent performing the service per day.

- The following day/night services shall be documented on a quarterly basis:
 - Adult Developmental Vocational Program [ADVP];
 - Community Rehabilitation Program [Sheltered Workshop];
 - Day/Evening Activity;
 - Developmental Day;
 - Long-Term Vocational Support Services [Extended Services]; and
 - Supported Employment.

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.

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 [APSM 30-1, Rules for MH/DD/SA Facilities and Services].

Service notes for the following twenty-four hour services shall be documented according to the frequency requirements as specified below:

1. Child and Adolescent Residential Treatment - Level II - Family Type: Per Date of Service;
2. Child and Adolescent Residential Treatment - Level II - Program Type: Per Shift;
3. Child and Adolescent Residential Treatment - Level III: Per Shift;
4. Child and Adolescent Residential Treatment - Level IV: Per Shift;
5. Family Living: Monthly, or duration of stay if less than a month;
6. Group Living: Monthly, or duration of stay if less than a month;
7. Medically Supervised or ADATC Detoxification/Crisis Stabilization: Per Date of Service;
8. Non-Hospital Medical Detoxification: Per Date of Service;
9. Professional Treatment Services in a Facility-Based Crisis Program: Per Shift;
10. Psychiatric Residential Treatment Facility [PRTF] for children: Per Shift;
11. Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders: Per Shift;
12. Social Setting Detoxification: Shift note for every 8 hours of service provided; and
13. Supervised Living: Monthly, or duration of stay if less than a month.

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

Services for Which a Modified Service Note May Be Used

When the following services are provided, it is required that they are documented per event, or per date of service, and the documentation must contain the following components: Name of the individual, the Medicaid ID number, the service provided, the date of service, duration of service, task performed, and signature [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]:

1. Personal Assistance;
2. Personal Care [CAP-MR/DD] may be documented using a combination of a grid/checklist and/or service note, unless provided by a home care agency that is following the home care licensure rules. When Personal Care [CAP-MR/DD] is provided within the context of Residential Supports, it may be documented using the *CAP-MR/DD Residential Support and Home Support Grid* as noted in the next section of this chapter;
3. Personal Care Services [DD] may be documented using a combination of a grid/checklist and/or service note, unless provided by a home care agency that is following the home care licensure rules;
4. Respite [CAP-MR/DD] - Non-institutional, Nursing;
NOTE: Providers of institutional respite shall follow the State Developmental Centers' documentation requirements;
5. Respite - The frequency of documentation for non CAP-MR/DD respite is as follows:
 - a. Community Respite [YA213]: Per Date of Service;
 - b. Community Respite [YP730]: Per Date of Service, if 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]; and
- c. Hourly Respite: Per Date of Service; and
- d. Crisis Respite: Per Date of Service.

For additional respite documentation requirements, see *Chapter 10 – “Special Service-Specific Documentation Requirements and Provisions.”*

A modified service note may also be used when providing Adult Day Health Services for CAP-MR/DD. To reference the documentation requirements for Adult Day Health services, see the *North Carolina Adult Day Care and Day Health Services Standards for Certification* manual at the Division of Aging website located here:

<http://www.ncdhhs.gov/aging/adcdhstd.pdf>;

See *Chapter 10 – Special Service-Specific Documentation Requirements and Provisions* for the documentation requirements for supports provided through the CAP-MR/DD waiver, such as, Home Modifications, Transportation, Specialized Equipment and Supplies, Personal Emergency Response System [PERS], Vehicle Adaptations and Augmentative Communications Devices.

Service Grid Documentation

A service grid is a form 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. The grid also contains an accompanying key which specifies the intervention/activity provided, as well as a key which 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 the Sample Grid in Appendix D*.

A grid 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:

1. Behavioral Health Prevention Education Services in Selective and Indicated Populations;
2. Child and Adolescent Residential Treatment - Level II - Family Type;
3. Day Supports [CAP-MR/DD];
4. Home and Community Supports [CAP-MR/DD];
5. Home Supports [CAP-MR/DD];
6. Long Term Vocational Supports [CAP-MR/DD].
7. *Personal Care [CAP-MR/DD], unless provided by a home care agency that is following their home care licensure rules. When Personal Care [CAP-MR/DD] is provided within the context of Residential Supports, it may be documented using the *CAP-MR/DD Residential Support and Home Support Grid*, which can be found at the end of Appendix D;
8. Personal Care Services [DD], unless provided by a home care agency that is following their home care licensure rules;
9. *Residential Supports [CAP-MR/DD];
10. Respite – all categories, except for Institutional Respite, which shall follow the State Developmental Centers' documentation requirements; and
11. Supported Employment Services [CAP-MR/DD].

*NOTE: All three components of Residential Supports and Home Supports - Habilitation, Personal Care, and Support - shall be addressed in the documentation. A grid has been developed specifically for documentation of Residential Supports and Home Supports, and includes a grid page for habilitation activities, as well as a combination checklist and service note page to address personal care and support activities. The habilitation aspect of the service may be noted by using a grid; however, personal care and support may be addressed by either using a grid, checklist, or service note. The *CAP-MR/DD Residential Support and Home Support Grid* can be found in *Appendix D*, or on the CAP-MR/DD page of the DMH/DD/SAS web site at the following location:

<http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm>

Required Elements of a Service Grid

A service grid shall include all the following required elements:

1. Name of the individual
2. The service record number
3. Medicaid ID number [for all Medicaid-eligible individuals]
4. Full date [month/day/year] that the service was provided
5. Goals addressed
6. A number or letter as specified in the appropriate key which reflects the intervention, activities, and/or tasks performed
7. A number or letter as specified in the appropriate key which reflects the assessment of the individual's progress toward goals
8. Duration [required for most services that are allowed to be documented on a grid]
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.
10. Space for entering additional information may be allocated on the grid as needed.

NOTE: For respite and personal care, the requirements for modified service notes outlined in the previous section should be followed when documenting these services on a grid.

Chapter 9: General Documentation Procedures

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.
- Each page of service notes shall include the Medicaid Identification Number for all Community Intervention 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 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 is not acceptable 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 treatment to an individual, each practitioner shall document a separate note in the service record for each discrete service provided.
- When a single, discrete service is provided by a team, 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. However, each staff member involved, 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 8 – Service Notes and Service Grids.]

General Documentation Dos and Don'ts

DO enter information that is:

- Accurate – document the facts as observed or reported;
- Timely – record significant information at the time of event since delays may result in inaccurate or incomplete information;
- Objective – record the facts and avoid drawing conclusions. When 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. Document pertinent findings, services/supports rendered, changes in the individual's condition and response to treatment/habilitation; and
- Clear – record meaningful information and write in non-technical terms when possible.

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 service recipients [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 letter/numbers, etc.
- Clearly identifies non-service-recipient(s), significant other [spouse, sibling, girl friend] 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 if the information should be disclosed.
- Is not based on fact, report, or observation.

Abbreviations

Agencies shall develop a 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. [See *Chapter 12- Accessing and Disclosing Information* for specific guidance related to the release of information]. When consent is obtained, it shall be filed in the individual's service record.

Consent for Treatment

1. A consent for treatment shall be signed by the individual and/or legally responsible person.
2. A written consent that grants permission to seek emergency medical care from a hospital or physician shall be obtained from the individual or legally responsible person.
3. A minor may seek and receive periodic services from a physician without parental consent in accordance with G. S. § 90-21.5. [See Appendix G].
4. Per 27D .0303(b), there must be informed written consent for planned use of a restrictive intervention.

Consent for Research

For research purposes, a 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 legally responsible person 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 pharmaceuticals 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 current and up-to-date. Timely documentation is important to ensure 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 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 information on late entries related to service notes, see *Chapter 8, "Service Notes and Service Grids."*

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 assure that all documentation in the record is correct and complete. All staff should make an ongoing effort to assure 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, etc. However, there is a difference between updating information in the service record and making corrections to errors in documentation.

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 following procedural guidelines. 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; however for quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing shall be properly completed within seven working days that the staff person is at work from the date the service was delivered, or from the close of the service period for certain day/night or twenty-four hour services. Therefore, for billing purposes, corrections must be made within these prescribed timeframes.

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:

1. Corrections must be made by the individual who recorded the entry;

2. Corrections shall be electronically signed and dated;
3. The original text shall not be deleted;
4. 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:

1. Corrections shall be made by the individual who recorded the entry;
2. One single thin line shall be drawn through the error or inaccurate entry, making certain that the original entry is still legible;
3. The corrected entry shall be recorded legibly above or near the original entry;
4. The date of the correction and initials of the recorder shall be recorded next to or near the corrected entry.
5. 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”];
6. 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.
7. Correction fluid or tape shall not be used for correction of errors.

Follow-Up Documentation

Follow-up documentation shall reflect attempts to ascertain why an individual is not participating in a service/support in accordance with the established schedule or plan.

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. The use of initials in lieu of a person's signature is only allowed when correcting an error, or when a service is documented on a service grid or checklist, and only if the provider's full signature is included on the page [or the back of the page for CAP-MR/DD service grids]. 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. 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; for non-licensed professionals, the full signature denotes the degree [e.g., BA, MSW] and should also include the individual's professional status [e.g., QP or AP], and any other

certifications the person may hold [e.g., CSAC]. The signature must be handwritten; however, the credentials, degree, or licensure may be typed, printed or stamped. Exceptions:

- a. When using electronic signatures as permitted in the *Electronic Signatures* section in Chapter 9 – “General Documentation Procedures,” a handwritten signature is not required.
 - b. 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 allowable.
- For paraprofessionals: Signature and position of the individual who provided the service. The signature must be handwritten; the position may be typed, printed or stamped. Exceptions:
 - a. When using electronic signatures as permitted in the *Electronic Signatures* section in Chapter 9 – “General Documentation Procedures,” a handwritten signature is not required.
 - b. 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 allowable.

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 - - *The Clinical Service Record*, for related guidance for conducting administrative closure of service records.

Staff Signature File

Provider agencies shall establish and maintain an official staff signature file. This file must contain the printed name, the appropriate credentials/titles, 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.

Use of Rubber Stamps

A rubber stamp shall be used only for medical reasons and Americans with Disabilities Act [ADA] accommodations. If the individual is unable to use the stamp for medical/physical reasons, the individual shall designate an individual authorized to use the stamp. This designation shall be in writing and kept on file in the agency.

Electronic Signatures

If an electronic signature is used, the following standards shall be followed:

1. When an electronic signature is used, 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.
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 also be dated and signed electronically.
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. 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.
 7. 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. Close deficiencies created when a staff member is not available to electronically sign documents.
 8. A list of staff who are authorized to use electronic signatures shall be maintained.
 9. The governing body shall authorize the use of the electronic signature.

NOTE: The above electronic signature standards are subject to revision based upon State law and/or HIPAA requirements.

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 and Person-Centered Plans, etc., the signature is authenticated when the responsible person enters the date next to his or her signature.

A handwritten signature requires a handwritten date, and an electronic signature may have a typed date. In either case, entering the date at the time that the signature is written confirms that the signature was made on that date. The date entered should be the date that the responsible person signs the document. The practice of pre- or post-dating signatures in any form or circumstance is prohibited.

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.

Signatures of Individuals, Parents, and Legally Responsible Persons

When individuals and/or parents/legal representatives sign their name on certain documents that are filed in the service record, their identity and/or their relationship to the service recipient should be indicated near their signature [if their identity/relationship is not designated on the document].

Countersignatures

Countersignatures of entries in the service record are not required by DMH/DD/SAS.

Legally Responsible Person [LRP] Issues

There are times when the signature of an individual's legal guardian, or legal representative, is required. The designation of a legal representative, hereinafter referred to as the 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]

This section, however, outlines some basic requirements and considerations for situations when the appointed LRP for an individual is the director [or designated staff] of a public agency.

When the LRP is the Local Department of Social Services

When the local department of social services 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.

When the LRP is the CEO of the Local Management Entity

When the CEO of an LME is the LRP for an individual, and the CEO delegates this authority to another LME staff person to act on his or her behalf in activities requiring the participation or actions of a legally responsible person, this assignment of authority must be in writing in the form of a delegation letter. At a minimum, a delegation letter should be written on the LME letterhead and must:

- designate the staff person by name and title;
- specify that the designee is acting on behalf of the CEO of the LME as the legally responsible person for the individual receiving services;
- specify that the designee has full signatory authority;
- specify any specific limits on this authority, if any; and
- be signed by the CEO.

There is no need for the individual's name to be specified in the delegation letter. By having possession of and presenting this letter by the LME designee named in the letter, the delegation letter serves to establish the authority of the designee to participate in PCP and other meetings requiring the actions of a legally responsible person, including signatory actions. The delegation letter should be filed in the individual's service record, and a copy of the letter should be presented to the appropriate party to establish or verify the authority of the designee. The designee should sign the PCP, indicating that he or she is signing for the actual guardian, i.e., Suzie Smith [CEO] by John S. Doe [LME designee].

In Loco Parentis and Consent for Minors

There may be times when the signature of a legally responsible person is required, but there has been no official action or provision for a legally-appointed designee to act on behalf of an absent parent when written consent for his or her minor child is needed.

"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 another individual without formally adopting that person. Chapter 122C-3 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, e.g., 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.

Documentation of Suspected/Observed Abuse/Neglect

1. Whenever abuse/neglect of an individual is observed or suspected, facts relative to the abuse/neglect or suspected abuse/neglect shall be documented in the service record, including reports made by the individual and actions taken by staff.
2. Opinions relative to the abuse/neglect or alleged abuse/neglect shall not be documented in incident reports or in the individual's record.
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 Director 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 Director 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 host LME, Home LME, and DMH/DD/SAS [as appropriate for the level of incident] whenever there is an allegation of abuse, neglect, or exploitation of an individual.
6. Per 10A NCAC 27G .0504(c), the LME 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 detailed information regarding incident reporting requirements.

Chapter 10: Special Service-Specific Documentation Requirements and 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 the 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. Prior to discharge, 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.

Assertive Community Treatment Team [ACTT] Services

For ACTT services, discharge documentation shall include:

1. The reasons for discharge as stated by both the recipient and the ACT Team.
2. The recipient's biopsychosocial status at discharge.
3. A written final evaluation summary of the recipient's progress toward the goals set forth in the treatment plan.
4. A plan developed in conjunction with the recipient for follow-up treatment after discharge.
5. The signature of the recipient, the recipient's service coordinator, the team leader, and the psychiatrist.

Basic Benefit Services

Basic benefit services, also referred to as outpatient treatment and medication management services, when provided by themselves, do not require a PCP, although a PCP may certainly be used. In lieu of a PCP, a 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 a service plan other than a PCP is used, a separate service order is required for all services that require an order at the point when any allowable unmanaged services are exhausted. NOTE: For State-funded basic benefit services, there is no allowance for unmanaged services; all require prior authorization.

When basic benefit services are provided in combination with any other MH/DD/SA service, a PCP is required.

Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations

Modified records shall be required for all children and adolescents who meet eligibility for selective and indicated population criteria for receiving Behavioral Health Prevention Education Services. See *Chapter 11 – “Documentation Requirements for Services Using Modified Records”* – for modified record requirements, and Appendix H in this 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 11*, is required.

CAP-MR/DD Waiver Supports

The following non-provider-specific supports have been approved as a component of the CAP-MR/DD Person-Centered Plan when such supports are needed by the individual. When any of these supports is provided, the documentation outlined below, specific to the type of support being provided, is required. A service note or grid as specified in *Chapter 8 – “Service Notes and Service Grids”* – of this manual is not required.

Augmentative Communication Devices

1. An assessment/recommendation signed and dated by a North Carolina Licensed Speech and Language Pathologist [SLP], with the SLP's license number, shall be submitted with the request. The assessment/recommendation is also signed and dated by other appropriate professionals as needed. The assessment and recommendation must be less than one year old from the date the request is received. The assessment confirms medical need for the equipment rather than educational need and identifies the person's need(s) with regard to the Augmentative Communication equipment being requested. A copy of the physician's statement certifying medical necessity shall be included with the request.
2. The request shall include clear documentation that the equipment is necessary to enable the individual to produce and engage in communication, either spoken, written, or both, in the absence of functional oral language. Information that includes the person's hearing status, visual status, physical status, access for the device requested [i.e., use of hand, visual scanning, auditory scanning, etc.], cognitive status, and primary communication method(s) shall be provided.
3. Outcomes for teaching the use of the device to the individual and his or her care providers that match the assessment results/device(s) requested shall be included.
4. When technical assistance is provided to individuals by a qualified Augmentative Communication technology professional in the selection of Augmentative Communication devices, outcomes related to the technical assistance and selection of the device must be included in the individual's Person-Centered Plan.
5. The estimated life of the equipment, as well as the length of time the person is expected to benefit from the equipment, shall be indicated in the request.
6. An invoice from the supplier that shows the date the Augmentative Communication was provided to the person, and the cost, including related charges [for example, applicable delivery charges], shall be maintained by the individual's case manager.

NOTE: All Augmentative Communication equipment purchased through CAP-MR/DD funds will utilize a bid or competitive invoice process to ensure the most efficient use of Medicaid funds.

Home Modifications

1. The assessment/recommendation for Home Modifications must be completed by an appropriate

professional and must identify the person's need(s) with regard to the Home Modification(s) being requested.

2. A copy of the physician's signature, certifying medical necessity shall be included with the request for Home Modifications. The physician may sign a statement on the assessment/recommendation, certifying that the requested adaptation is medically necessary or may sign a separate document.
3. Outcomes/goals related to training needs associated with the person/family's utilization and/or procurement of the requested adaptation(s) must be included in the Person-Centered Plan as appropriate.
4. All Home Modifications must meet applicable standards and safety codes.

NOTE: All Home Modifications purchased through CAP-MR/DD funds will utilize a bid or competitive invoice process when applicable to ensure the most efficient use of Medicaid funds.

Personal Emergency Response System [PERS]

It is required that the agency maintain a record that documents the date that the service is started, the dates that it is provided, and the date it is terminated.

Specialized Consultative Services

Specialized Consultative Services must be documented per date of service on a service note according to the *Contents of a Service Note* section in *Chapter 8 – Service Notes and Service Grids* within 24 hours of the date of service.

Specialized Equipment and Supplies

1. The assessment/recommendation shall be completed in writing by an appropriate professional that identifies the individual's need(s) with regard to the Specialized Equipment and Supplies being requested. Diagnostic information must be consistent with the recommended supplies/equipment. The assessment/recommendation must state the amount of an item the person needs. The assessment/recommendation must be updated if the amount of the item the person needs changes.
2. A copy of the physician's signature certifying medical necessity shall be included with the written request for Specialized Equipment and Supplies. The physician may sign a statement on the assessment/recommendation certifying that the requested supply/equipment is medically necessary or may sign a separate document.
3. Outcomes/goals related to the person/family's utilization and/or procurement of the requested supplies/equipment must be included in the Person-Centered Plan. If the equipment/supplies are related to outcomes/goals already in the Person-Centered Plan, this should be noted in the written request for the equipment/supplies. Outcomes must be consistent with the recommendations for the supplies/equipment.

Transportation

1. If the trip is being billed by the mile rather than by an established charge, a record shall be maintained that documents the date the service is provided, the specific activity that the person is being transported to/from, and the mileage related to transporting the person. The person providing the transportation shall sign this record.
2. If the trip is being billed with an established charge per trip, the signature of a representative providing the transportation is required.
3. The individual's Person-Centered Plan must reflect identified needs for transportation and corresponding outcomes.

Vehicle Adaptations

1. Recommended equipment or modification shall be justified by an assessment by a Physical Therapist/Occupational Therapist specializing in vehicle modifications, or a Rehabilitation Engineer or Vehicle Adaptation Specialist, and accompanied by a physician's signature certifying medical necessity for the person. All vehicles must be evaluated by an adapted vehicle supplier with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications. These assessments shall contain information regarding the rationale for selected modification, individual pre-driving assessment - if the CAP-MR/DD service recipient will be driving the vehicle, condition of the vehicle to be modified, insurance on the vehicle to be modified, and training plan for the use of the prescribed modification.
2. Recipients are often referred to the Division of Vocational Rehabilitation [VR] when appropriate. VR has staff with expertise in assessing the needs of the person and making specific recommendations for the type of modifications that will meet the needs of the person with the vehicle.
3. Documentation regarding each of the requirements specified above must be submitted in writing with the Person-Centered Plan in order to obtain approval for the requested Vehicle Adaptations.
4. All Vehicle Adaptations must meet applicable standards and safety codes.

NOTE: All vehicles purchased through CAP-MR/DD funds will utilize a bid or competitive invoice process to ensure the most efficient use of Medicaid funds.

NOTE: Vehicle Adaptations do not cover the cost of the vehicle to be modified or the cost of the rental of vehicles with adaptations on them. A family may choose to purchase a vehicle [new or used] that already has modifications on it. In such cases, the process for approval of the adaptation remains the same. The price of the lift on a vehicle must be assessed, and the current value must be approved. The assessed value of the adaptations is not inclusive of the cost of the vehicle, but only the modification component of the vehicle.

Child and Adolescent Day Treatment

For individuals receiving Child and Adolescent Day Treatment, the Person-Centered Plan shall include a Transition Plan, and 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 should be coordinated through the Child and Family Team and with member 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.

Child and Adolescent Residential Treatment – Level II - Family Type

Documentation is entered per date of service on a service note or service grid that includes a description of the staff's interventions and activities that are directly related to the child's identified needs, preferences or choices, specific goals, services, and interventions based on the Person-Centered Plan. In addition, documentation of critical events, significant events, or changes in status in the course of treatment shall be included in the service record as appropriate. If 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

Documentation requires a full service note per shift that records the interventions and activities that are directly related to the child's identified needs, preferences, or choices, specific goals, services and interventions indicated in the Person-Centered Plan. In addition, critical events, significant events, or changes in status in the course of treatment shall be included in the service record as appropriate. If 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

This service requires a full service note per shift that documents the interventions/activities that are directly related to the child's identified needs, preferences or choices, specific goals, services, and interventions indicated in the child's/adolescent/s Person-Centered Plan. In addition, documentation of critical events, significant events, or changes in status in the course of treatment shall be included in the individual's service record as appropriate. If 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 IV

This service requires a full service note per shift that documents the interventions/activities that are directly related to the child's identified needs, preferences or choices, specific goals, services, and interventions based on the child's/adolescent/s Person-Centered Plan. In addition, documentation of critical events, significant events, or changes in status in the course of treatment shall be included in the individual's service record as appropriate. If 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.

Community Rehabilitation Programs [Sheltered Workshop Programs]

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

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:

1. Information regarding the initial assessment to determine eligibility to attend school, including driving record, documentation of BAC and review of diagnostic criteria according to the DSM-5 or any subsequent edition of this reference material;

2. The appropriateness of the referral to a treatment resource, if applicable;
3. A copy of Form DMH-508, "Certificate of Completion Form";
4. 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;
5. Pre test and post test scores, and homework assignments, if any; and
6. A copy of an appropriate release of information giving the facility permission to report the individual's progress to DMH/DD/SAS, DMV, 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/habilitation and is accepted as a service recipient. Once a student becomes a service recipient, a service record shall be opened. A determination shall be made whether the ADETS record shall be incorporated into the service record.

Drug Education School [DES]

Documentation for school records in Drug Education School shall include:

1. Information regarding the initial assessment to determine eligibility to attend school;
2. The appropriateness of the referral to a treatment resource, if applicable;
3. A copy of Form DMH-4401, "Drug Education School Completion Form";
4. Documentation of other relevant transactions and student contacts, i.e., referral to another county and/or non-compliance issues and outcomes;
5. Pre and post tests; and
6. 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/habilitation and is accepted as a service recipient. Once a student becomes a service recipient, a service record shall be opened. A determination shall be made whether the DES record shall be incorporated 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 *Driving While Impaired [DWI] Services* section below for assessment requirements.

Developmental Day Programs

For each child receiving this service, the developmental day service record shall include an individualized Person-Centered Plan [PCP] and an attendance record which reflects the hours of attendance each day. The PCP shall include general strategies or activities that are the responsibility of the program as well as specific strategies or activities that are the responsibility of staff assisting the child to meet individual goals. Services must be listed on the child's PCP.

Staff assisting children with strategies or activities to meet individual goals shall document services as described in *Chapter 8 – "Service Notes and Service Grids."* The minimum standard is a quarterly service note which summarizes the child's progress toward the goals and outcomes listed in the PCP.

Developmental Day Services - Before/After School

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 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.

Diagnostic Assessment

A Diagnostic Assessment must be conducted by a team consisting of at least two licensed or certified clinicians as specified in the service definition. The DA must include the following elements:

1. A chronological general health and behavioral health history [includes both mental health and substance abuse] of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time;
2. This general and behavioral health history must emphasize the factors that have contributed to or inhibited previous recovery efforts; 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/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
5. 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 eligibility; and
8. Evidence of recipient participation including families, or when applicable, guardians or other caregivers.

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. This list can be accessed at the following link:

<http://www.nctasc.net/ncdwiservices/providers/screenassess10-31-06revised4-3-07.doc>.

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, ASAM Patient Placement 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. An assessor who has met the qualifications and requirements in G.S. § 122C-142.1, 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;
- Verification of signed consent for release of confidential information in accordance with 10A NCAC 27G .3807(d).

Requirements for substance abuse services for DWI offenders fall under the auspices of the Rules for MH/DD/SA Facilities and Services and are outlined in detail in 10A NCAC 27G, Section .3800. A link to these rules is provided at the end of this section. 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.
- (b) If treatment is recommended, documentation in the record shall include, but not be limited to the following minimum requirements for each DWI Category of Service listed in Rule .3805 [Definitions] of this Section, except the ADETS category:
 1. all items specified in the "clinical interview" as set forth in Rule .3805 of this Section;
 2. results of the administration of an approved "standardized test," as set forth in Rule .3805 of this Section;
 3. release of information as set forth in Rules .3807 [DWI Substance Abuse Assessment Elements] and .3810 [Responsibilities of Treatment and ADETS Providers]; 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 [Governing Body Policies].
- (d) Substance abuse treatment records shall comply with the elements contained in 10A NCAC 27G .0203 [Competencies of Qualified Professionals and Associate Professionals], .0204 [Competencies and Supervision of Paraprofessionals], .0206 [Client Records], of this Subchapter and 10A NCAC 27G .3807 and 10A NCAC 27G .3810.

The link below can be used to access 10A NCAC 27G in its entirety. When arriving at this site, select Chapter 27, and then go to the subchapter of your choice, listed on the left side.

<http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2010A%20-%20Health%20and%20Human%20Services.>

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 which identifies the individual by name or unique identifier]. It is recommended that the documentation be entered on a daily basis.

Employee Assistance Program [EAP] Documentation Requirements

Documentation requirements shall include:

1. Identifying information of employee;
2. Name of the company/firm where employee works;
3. Complaint or presenting problem of employee;
4. Assessment of problem(s) or need(s);
5. Disposition [referrals and/or recommendations];
6. Date of contact; and
7. Signature and credentials, degree or licensure of the staff member who provided the service.

This service does not require a service plan unless treatment services are indicated. When it is determined that an individual receiving EAP services is in need of treatment/habilitation and is accepted as a service recipient, a service record shall be opened. A determination shall be made whether the EAP record shall be incorporated into the service record.

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 8 – "Service Notes and Service Grids"* – for additional information about service note documentation requirements for this service.

Medically Supervised or ADATC Detoxification/Crisis Stabilization

Detoxification rating scale tables, e.g., the 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 Person-Centered Plan is not required for this service.

Medication Documentation Requirements

The requirements for documenting the dispensing and administration of medication, as well as the documentation of medication errors, shall be made in accordance with 10A NCAC 27G .0209 Medication Requirements in Division publication APSM 30-1, Rules for MH/DD/SA Facilities and Services. This administrative code addresses 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. Complete information regarding medication documentation requirements can be accessed at the following link:

http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/psm30-1_02-26-08.pdf

Non-Hospital Medical Detoxification Services

Detoxification rating scale tables, such as the Clinical Institute Withdrawal Assessment – Alcohol, Revised, 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 Person-Centered Plan is not required for this service. See APSM 30-1 Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services. [10A NCAC 27G .3103] See link below:

http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm30-1_02-26-08.pdf

Opioid Treatment

A full service note must be completed by the person providing the service for every counseling session. In addition, this service requires a daily record of dosing, including a record of all take home doses prepared. See APSM 30-1 Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services. [10A NCAC 27G .3600] See link below:

http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm30-1_02-26-08.pdf

Outpatient Treatment and Medication Management Services

Outpatient treatment and medication management services, also referred to as basic benefit services, when provided by themselves, do not require a Person-Centered Plan [PCP], although a PCP may certainly be used. In lieu of a PCP, a 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 a service plan other than a PCP is used, a separate service order is required for all services that require an order at the point when any allowable unmanaged services are exhausted. NOTE: For State-funded basic benefit services, there is no allowance for unmanaged services; all require prior authorization.

When these services are provided in combination with other MH/DD/SA service, a PCP is required.

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. A service order must be in place prior to or on the day that services are initiated. This service requires, at a minimum, a service note per shift.

Psychiatric Residential Treatment Facilities [PRTF]

Documentation of PRTF services must meet both the requirements of the accrediting body and Medicaid guidelines. 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 DMA's *Clinical Coverage Policy 8D-1* on the following web page:

<http://www.ncdhhs.gov/dma/mp/mpindex.htm>

Efforts for discharge to a less restrictive community residential setting shall be documented in the service record from the date of admission.

Psychosocial Rehabilitation [PSR]

For individuals receiving Psychosocial Rehabilitation services, the Person-Centered Plan shall be reviewed every six months.

Providers of PSR may choose to use the sample service note form found in Appendix D of this manual to document PSR services rendered. The following guidance is outlined below for providers to follow when using this format.

Guidance for Documenting Service Notes for PSR if Using the Sample Form

Psychosocial Rehabilitation must be documented per date of service, following the guidelines below:

- The individual's name, Medicaid ID number, and service record number must be entered.
- The date of service and the duration [time spent performing the interventions] are required elements and must be entered for each PSR episode.
- Purpose of Contact: Purpose of contact must be stated. [The individual's goals may be preprinted in this section.]
- Interventions/Activities: 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: Briefly record progress toward goals/things accomplished by the individual.
- All entries must be properly signed by the staff providing the service.

Respite Services

1. When the individual is receiving other MH/DD/SA services, respite should be listed on the Person-Centered Plan [PCP] or treatment plan as applicable. Respite may be documented on a service note or service grid/checklist. In addition:
 - a. Information regarding special behavioral conditions, nutritional, medical, medications to be administered, or other service needs of the individual shall be documented and given to the respite provider. There shall be documentation to demonstrate that these special requirements and conditions were given to the provider.
 - i. These special instructions shall be followed, and no specific service plan is required for respite care. For CAP-MR/DD-funded individuals, the Person-Centered Plan shall reference respite services.
 - ii. Service notes, regardless of the format used, shall include:
 - The date(s) of service, and for hourly respite, duration of the service event;
 - Tasks performed, including comments on any behaviors, etc., which are considered relevant to the individual's continuity of care;
 - Documentation that special instructions were followed; etc.; and
 - Signature [initials, if the full signature is included on the page when using a grid for documenting the service].
2. When an individual is only receiving respite services, the documentation requirements noted in *Chapter 11 – "Documentation Requirements for Services Using Modified Records"* – shall be followed.

Social Setting Detoxification Services

See APSM 30-1 Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services. [10A NCAC 27G .3203] A Person-Centered Plan is not required for this service. See link below:

http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm30-1_02-26-08.pdf

Substance Abuse Comprehensive Outpatient Treatment Program

This service requires that a documented discharge plan is discussed with the individual and included in the service record.

Substance Abuse Halfway House

At a minimum, this service requires a full service note for each day the person resides in the Halfway House.

Substance Abuse Intensive Outpatient Program

This service requires that a documented discharge plan is discussed with the individual and included in the service record.

Substance Abuse Medically Monitored Community Residential Treatment

This service requires that a documented discharge plan is discussed with the individual and included 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. Additionally, discussion of the discharge plan with the recipient must be documented in the service record.

Therapeutic Leave

1. Documentation shall reflect the number of days of service and include verification of 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. ICF-MR Facilities shall comply with Medicaid requirements pertaining to therapeutic leave.
4. For Medicaid-eligible children/adolescents in a Level II, Level III, Level IV Residential Facility, or PRTF for which the N.C. Medicaid Program is paying reimbursement for these services, the necessity of therapeutic leave and the expectations involved in such leave shall be documented in the child/adolescent's Person-Centered Plan [PCP] and the therapeutic justification for each instance of such leave entered in to the individual's record maintained at the residential/PRTF's site. Facilities shall keep a cumulative record of therapeutic leave days taken by each individual for reference and audit purposes.
5. Therapeutic leave must be documented in the Person-Centered Plan for residential care and therefore does not require a separate prior authorization.

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 abuse 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 a standardized instrument. The information collected and documented includes demographics, employment, education, legal, 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 level of care, assessment outcome, and staff signature and credentials. The TASC Standard Operating Procedures Manual, found at the following link, contains guidance throughout the document, but certain sections, such as Section II: Intake & Clinical Planning, particularly the chapters on assessment and person-centered planning, as well as Section III: Care Management, may prove to be especially helpful in finding information regarding the documentation requirements under the TASC Program:

<http://northcarolinatasc.org/>

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 does not require a service plan unless treatment services are indicated and a full clinical service record is opened.

Work First/Substance Abuse Initiative

Substance abuse screening is an integral part of the Work First application process. The AUDIT and DSAT-10 shall be used for screening alcohol and drug abuse issues for all adult Work First

applicants/recipients by the Qualified Professional in Substance Abuse or the DSS worker. An assessment for substance abuse issues is required for all Work First applicants/recipients who are found to be high risk on the screening and is administered by a Qualified Professional in Substance Abuse. The SUDDS-IV, 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 Qualified Professional in Substance Abuse, based on the documented results of the Substance Abuse Behavioral Indicator Checklist. 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.

Chapter 11: Documentation Requirements for Services Using 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 shall only be used for the following services:

1. Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Prevention Services;
2. Respite;
3. Universal Prevention Services; and
4. Other services, if 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:

1. The assessment of the participant shall include:
 - a. Documentation of the findings on a child or adolescent risk profile that identifies one or more designated risk factors for substance abuse;
 - b. Documentation of individual risk factor(s), history of substance use, if any, a description of the child's or adolescent's current substance use patterns, if any, and attitudes toward use; and
 - c. Other relevant histories and mental status that are sufficient to rule out other conditions, suggesting the need for further assessment and/or treatment for a substance abuse or dependence diagnosis and/or a co-occurring psychiatric diagnosis.
2. The service plan shall:
 - a. 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;
 - b. 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
 - c. Be signed by the participant and the parent/legally responsible person, as appropriate, prior to the delivery of services.
3. Following the delivery of each service, the minimum standard for documentation in the service record shall be a Service Grid which includes:
 - a. Identification of the evidence-based program being implemented;
 - b. Full date and duration of the service that was provided;
 - c. Listing of the individual child or adolescent and/or his or her family members that were in attendance;
 - d. Identification of the curriculum module delivered;

- e. Identification of the module goal;
- f. Identification of the activity description of the module delivered;
- g. 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
- h. 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 shall be documented.

For additional information about Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations, please see "Appendix H" in this manual.

Respite Services

Respite may be documented on a service note or service grid/checklist. The following documentation is required if respite is the only service being provided:

1. Identification/face sheet and diagnostic information;
2. Special behavioral conditions, nutritional, medical, medications to be administered, or other service needs of the individual. These special instructions shall be given to the respite provider, and no specific service plan is required for respite care.
3. Service notes shall include:
 - a. The date(s) of the service, and for hourly services, duration of the service event;
 - b. Tasks performed, including any comments on any behaviors, etc., which are considered relevant to the individual's continuity of care;
 - c. Documentation that special instructions were followed, etc.; and
 - d. Signature [initials, if the full signature is included on the page when using a grid for documenting the service].

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 does not require a service plan unless treatment services are indicated and a full clinical service record is opened.

Chapter 12: Accessing and 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, but providers must follow those requirements as appropriate. Service providers must consult the actual text of all the laws and other educational resources for a 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 law with the most stringent requirements.

Individual Access to Service Records

North Carolina General Statutes and the Department of Health and Human Services [DHHS] 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 legally responsible person 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 persons have the right to appeal such a determination.

For further information contained in the General Statutes about an individual's or legally responsible person's access to information in the service record, please see § 122C-53, particularly items (c) and (d) at the following link:

http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_122C/GS_122C-53.html

The HIPAA Privacy 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.

In addition, and in accordance with the DHHS Privacy Policy, the legally responsible person of a service recipient who is acting on behalf of a service recipient is afforded the same rights as the service recipient 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, Client Rights Policies, Rights of Clients*, at the link below:

http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-0/man/Client_Rights_Policies_Rights_of_Clients.pdf

See also the *DHHS Policy and Procedure Manual, Section VIII: Privacy and Security, Client Rights Policies, Designated Record Sets*, at the link below for more detail about designated record sets:

http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/Client_Rights_Policies_Designated_Record_Sets.pdf

For the full *DHHS Policy and Procedure Manual, Section VIII: Privacy and Security*, please use the link provided here:

<http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/>

Provider agencies are required to develop procedures for processing requests of service recipients 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 MH/DD/SA services, when an individual's access to his or her service record is granted, it is recommended that the agency include in their procedures a 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.

Overview of Confidentiality Rules and Laws

The HIPAA privacy rule [45 CFR Parts 160, 164] and the State confidentiality law applicable to MH/DD/SA service providers [GS § 122C-51 through 122C-56 and 10A NCAC 26B] prohibit the disclosure of information related to MH/DD/SA service recipients, 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 or authorization in certain circumstances, and in other circumstances requires consent or authorization for the disclosure of protected information.

- The HIPAA privacy 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. [See 45 CFR 160.103]. For more information about HIPAA and its application in North Carolina, please go to the following web site: <http://hipaa.ncdhhs.gov/>.
- The State confidentiality law applies to any information, whether recorded or not, relating to an individual served by an MH/DD/SA 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 would identify an individual as an alcohol or drug abuser and is alcohol or drug abuse information obtained by a federally assisted alcohol or drug abuse program for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment [See 42 CFR 2.12(a)(1)].

Disclosing Information for Coordination of Care

When a service provider agency has been endorsed by an LME and has subsequently signed the MOA with the LME, the provider agency has agreed 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 or a seamless transition from one provider to another. Except for substance abuse information [as discussed further in this chapter], providers of services to LME service recipients of area authorities or county programs performing local management entity functions

will find that both the HIPAA privacy rule and the State confidentiality law permit the sharing of service recipient information for purposes of coordinating care and treatment without the service recipient's written consent or authorization. Under the HIPAA privacy rule, a covered provider may use or disclose protected health information [PHI] 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's definition of "treatment" to understand the scope of activities subject to this rule]. Under GS § 122C, MH/DD/SA service programs that are operated by or are under contract with an LME, 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. [See GS § 122C-3(14) and 122C-55(a)].

Exceptions – Substance Abuse Information

The federal law governing substance abuse treatment information requires the service recipient'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. [See 42 CFR 2.13 and 2.51].

Disclosing Information for Service Authorization and Reimbursement

When seeking authorization and payment for services, although the HIPAA privacy 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 MH/DD/SA 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 abuse, a provider of services to LME service recipients may, without the individual's consent, exchange confidential information regarding its service recipients with the LME, other providers, and State-operated facilities when necessary to conduct payment activities. [Payment activities are defined at 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 abuse 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 Department of Health and Human Services [DHHS] program, MH/DD/SA providers that are operated by or under contract with an LME, 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 abuse 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. [See G.S. § 122C-55(a3)].

Exceptions – Third Party Payors/Insurers and Substance Abuse Information

Providers of MH/DD/SA 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. [See 42 CFR 2.11]. Thus, a MH/DD/SA

provider or LME must obtain the individual's written authorization to disclose substance abuse service recipient identifying information to a third party.

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, 7, and 8 in the Chapter: Use and Disclosure Policies, Use and Disclosure, Section III, of the DHHS Privacy Manual, at the following link for detailed guidance for those and other situations:

http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/Use_and_Disclosure_Use_and_Disclosure1.htm

Documentation Requirements When Disclosing Information

Under all three confidentiality laws applicable to MH/DD/SA 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 records 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, MH/DD/SA service providers must adhere to the HIPAA privacy rule provisions that apply generally to many kinds of disclosures. For example, before making any disclosure of protected health information [PHI], the HIPAA privacy 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 Privacy Rule 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).
- The HIPAA privacy rule [164.528] gives an individual the right to an accounting of disclosures of protected health information [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.

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